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Welcome

Welcome to your plan for healthy living

From preventive services to maintaining your health, to our extensive network of providers and resources, CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) are there when you need care. We will work together to help you get well, stay well and achieve any wellness goals you have in mind.

We know that health insurance is one of the most important decisions you make for you and your family—and we thank you for choosing CareFirst. This guide will help you understand your plan benefits and all the services available to you as a CareFirst member.

Please keep and refer to this guide while you are enrolled in this plan.

How your plan works

Find out how your health plan works and how you can access the highest level of coverage.

What’s covered

See how your benefits are paid, including any deductibles, copayments or coinsurance amounts that may apply to your plan.

Getting the most out of your plan

Take advantage of the added features you have as a CareFirst member:

- Wellness discount program offering discounts on fitness gear, gym memberships, healthy eating options and more.
- Online access to quickly find a doctor or search for benefits and claims.
- Health information on our website includes health calculators, tracking tools and podcast videos on specific health topics.
- Vitality magazine with healthy recipes, preventive health care tips and a variety of articles.

Visit carefirst.com/aacps for up-to-date information on your plan.
Know Before You Go
Your money, your health, your decision

Choosing the right setting for your care—from allergies to X-rays—is key to getting the best treatment with the lowest out-of-pocket costs. It’s important to understand your options so you can make the best decision when you or your family members need care.*

**Primary care provider (PCP)**
The best place to get consistent, quality health care is your primary care provider (PCP). If you have a medical issue, having a doctor who knows your health history often makes it easier to get the care you need.

**24-Hour Nurse Advice Line**
Registered nurses are available 24/7 to discuss your symptoms with you and recommend the most appropriate care. Call 800-535-9700 anytime to speak with a nurse.

**CareFirst Video Visit**
When your PCP isn't available and you need urgent care services, CareFirst Video Visit securely connects you with a doctor, day or night, through your smartphone, tablet or computer. In addition, you can schedule visits for other needs such as behavioral health support from a therapist or psychiatrist, guidance from a certified nutritionist or breastfeeding support from a lactation consultant. It’s a convenient and easy way to get the care you need, wherever you are. Visit carefirstvideovisit.com to get started.

**Convenience care centers (retail health clinics)**
These are typically located inside a pharmacy or retail store (like CVS MinuteClinic or Walgreens Healthcare Clinic) and offer care for non-emergency situations like colds, pink eye, strep tests and vaccinations. These centers usually have evening and weekend hours.

**Urgent care centers**
Urgent care centers (such as Patient First or ExpressCare) provide treatment for injuries and illnesses that require prompt medical attention but are not life-threatening (sprains, minor cuts, flu, rashes, minor burns). These centers have doctors on staff and offer weekend/after-hours care.

**Emergency room (ER)**
Emergency rooms treat acute illnesses and trauma. Go to the ER right away if you or a family member have sudden symptoms that need emergency care, including (but not limited to): chest pain, trouble breathing or head trauma. Prior authorization is not needed for emergency room services.

For more information, visit carefirst.com/aacps.

*The medical providers mentioned in this document are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.*
Know Before You Go

When you need care

When your PCP isn’t available, being familiar with your options will help you locate the most appropriate and cost-effective medical care. The chart below shows how costs* may vary for a sample health plan depending on where you choose to get care.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Sample cost</th>
<th>Sample symptoms</th>
<th>Available 24/7</th>
<th>Prescriptions?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video Visit (urgent care services)</td>
<td>$10</td>
<td>• Cough, cold and flu</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pink eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ear pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convenience Care (e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)</td>
<td>$10</td>
<td>• Cough, cold and flu</td>
<td>●</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pink eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ear pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care (e.g., Patient First or ExpressCare)</td>
<td>$10</td>
<td>• Sprains</td>
<td>●</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cut requiring stitches</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Minor burns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$85</td>
<td>• Chest pain</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Difficulty breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Abdominal pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24-Hour Nurse Advice Line</td>
<td>$0</td>
<td>• If you are unsure about your symptoms or where to go for care, call 800-535-9700, anytime day or night to speak to a registered nurse.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

To determine your specific benefits and associated costs:

- Log in to My Account at carefirst.com/aacps;
- Check your Evidence of Coverage or benefit summary;
- Ask your benefit administrator; or
- Call Member Services at the telephone number on the back of your member ID card.

For more information and frequently asked questions, visit carefirst.com/aacps.

Did you know that where you choose to get lab work, X-rays and surgical procedures can have a big impact on your wallet? Typically, services performed in a hospital cost more than non-hospital settings like LabCorp, Advanced Radiology or ambulatory surgery centers.

PLEASE READ: The information provided in this document regarding various care options is meant to be helpful when you are seeking care and is not intended as medical advice. Only a medical provider can offer medical advice. The choice of provider or place to seek medical treatment belongs entirely to you.
Away From Home Care®
Your HMO coverage goes with you

We've got you covered when you're away from home for 90 consecutive days or more. Whether you're out-of-town on extended business, traveling, or going to school out-of-state, you have access to routine and urgent care with our Away From Home Care program.

Coverage while you're away
You're covered when you see a provider of an affiliated Blue Cross Blue Shield HMO (Host HMO) outside of the CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C. and Northern Virginia). If you receive care, then you're considered a member of that Host HMO receiving the benefits under that plan. So your copays may be different than when you're in the CareFirst BlueChoice service area. You'll be responsible for any copays under that plan.

Enrolling in Away From Home Care
To make sure you and your covered dependents have ongoing access to care:

- Call the Member Service phone number on your ID card and ask for the Away From Home Care Coordinator.
- The coordinator will let you know the name of the Host HMO in the area. If there are no participating affiliated HMOs in the area, the program will not be available to you.
- The coordinator will help you choose a primary care physician (PCP) and complete the application. Once completed, the coordinator will send you the application to sign and date.
- Once the application is returned, we will send it to your Host HMO.

Always remember to carry your ID card to access Away From Home Care.

- The Host HMO will send you a new, temporary ID card which will identify your PCP and information on how to access your benefits while using Away From Home Care.
- Complete these steps annually as long as Away From Home Care benefits are needed.
- Simply call your Host HMO primary care physician for an appointment when you need care.

No paperwork or upfront costs
Once you are enrolled in the program and receive care, you don't have to complete claim forms, so there is no paperwork. And you're only responsible for out-of-pocket expenses such as copays, deductibles, coinsurance and the cost of non-covered services.
BlueCard® & Global Core

Wherever you go, your health care coverage goes with you

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

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

When you're outside of the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C., and Northern Virginia), you’ll have access to the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals in that area. You shouldn't have to pay any amount above these negotiated rates. Also, you shouldn't have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductibles, copayments, and coinsurance) that you’d pay anyway.

Within the U.S.

1. Always carry your current member ID card for easy reference and access to service.

2. To find names and addresses of nearby doctors and hospitals, visit the National Doctor and Hospital Finder at www.bcbs.com, or call BlueCard Access at 800-810-BLUE (2583).

3. Call Member Services for pre-certification or prior authorization, if necessary. Refer to the phone number on your ID card because it's different from the BlueCard Access number listed in Step 2.

4. When you arrive at the participating doctor's office or hospital, simply present your ID card.

5. After you receive care, you shouldn't have to complete any claim forms or have to pay up front for medical services other than the usual out-of-pocket expenses. CareFirst will send you a complete explanation of benefits.

As always, go directly to the nearest hospital in an emergency.
BlueCard & Global Core

Around the world

Like your passport, you should always carry your ID card when you travel or live outside the U.S. The Blue Cross Blue Shield Global® Core program (BCBS Global® Core) provides medical assistance services and access to doctors, hospitals and other health care professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- At hospitals in the BCBS Global Core Network, you shouldn't have to pay up front for inpatient care, in most cases. You're responsible for the usual out-of-pocket expenses. And, the hospital should submit your claim.

- At hospitals outside the BCBS Global Core Network, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the BCBS Global Core Service Center. The claim form is available online at bcbs.globalcore.com.

- To find a BlueCard provider outside of the U.S. visit bcbs.com, select Find a Doctor or Hospital.

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

Medical assistance when outside the U.S.

Call 800-810-BLUE (2583) toll-free or 804-673-1177, 24 hours a day, 7 days a week for information on doctors, hospitals, other health care professionals or to receive medical assistance services. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization if necessary.

Visit bcbs.com to find providers within the U.S. and around the world.
Find Providers and Estimate Treatment Costs

Quickly find doctors and facilities, review your health providers and estimate treatment costs—all in one place!

Find providers
carefirst.com/aacps

You can easily find health care providers and facilities that participate with your CareFirst health plan. Search for and filter results based on your specific needs, like:

- Provider name
- Provider specialty
- Distance
- Gender
- Accepting new patients
- Language
- Group affiliations

Review providers

Read what other members are saying about the providers you’re considering before making an appointment. You can also leave feedback of your own after your visit.

Make low-cost, high-quality decisions

When you need a medical procedure, there are other things to worry about besides your out-of-pocket costs. To help you make the best care decisions for your needs, CareFirst’s Treatment Cost Estimator will:

- Quickly estimate your total treatment costs
- Avoid surprises and save money
- Plan ahead to control expenses

Want to see how it works? Visit carefirst.com/aacps today!

Want to view personalized information about doctors in your plan’s network? Be sure to log in to My Account from your computer, tablet or smartphone.
# Medical Benefits Options

## Medicare Eligibles/Retirees Over 65—January 2022

<table>
<thead>
<tr>
<th>Product Line</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product Name</td>
<td>BlueChoice HMO Open Access</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NETWORK</td>
<td>BLUECHOICE</td>
</tr>
<tr>
<td>COPAYS</td>
<td>$10 PCP / $15 Specialist copay</td>
</tr>
</tbody>
</table>

### ANNUAL DEDUCTIBLE

- Individual: None
- Individual & Child: None
- Individual & Adult: None
- Family: None

### ANNUAL OUT-OF-POCKET MAXIMUM

- Medical: $2,000 Ind. / $6,000 Family

### LIFETIME MAXIMUM BENEFIT

Unlimited except on fertility services

### PREVENTIVE SERVICES

#### Well-Child Care

- 0–24 months: No Charge
- 24 months–13 years (immunization visit): No Charge
- 24 months–13 years (non-immunization visit): No Charge
- 14–17 years: No Charge

#### Adult Physical Examination

- No Charge

#### Routine GYN Visits

- No Charge

#### Mammograms

- No Charge

#### Cancer Screening (Pap Test, Prostate and Colorectal)

- No Charge

### OFFICE VISITS, LABS AND TESTING

#### Office Visits for Illness

- No charge

#### Diagnostic Services

- No copay (LabCorp)

#### X-ray and Lab Tests

- No copay (LabCorp)

#### Allergy Testing

- $10 PCP / $15 Specialist copay (if office visit copay paid, additional copay not required)

#### Allergy Shots

- $10 PCP / $15 Specialist copay (if office visit copay paid, additional copay not required)

#### Outpatient Physical, Speech and Occupational Therapy (Office Setting)

- $15 copay; (limited to 30 visits combined/condition/benefit period)

#### Outpatient Chiropractic

- $15 copay; (limited to 20 visits/condition/benefit period)

### EMERGENCY CARE AND URGENT CARE

#### Physician's Office

- $10 PCP / $15 Specialist copay

#### Urgent Care Center

- $10 PCP / $15 Specialist copay

#### Hospital Emergency Room

- $85 copay (waived if admitted)

#### Ambulance (if medically necessary)

- No charge
## Medical Benefits Options

### BlueChoice Triple Option Plan—Open Access—3 Health Care Plans in 1

<table>
<thead>
<tr>
<th>BlueChoice</th>
<th>Preferred Provider (PPO Blue Card)</th>
<th>Participating/Non-Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15 PCP/$15 Specialist</td>
<td>$20 PCP/$20 Specialist</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No charge</th>
<th>None</th>
<th>None</th>
<th>None</th>
<th>None</th>
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</thead>
<tbody>
<tr>
<td>$200</td>
<td>$300</td>
<td>$400</td>
<td>$600</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>$2,000 Ind./$6,000 Family</th>
<th>$2,000 Ind./$4,000 Family</th>
<th>$2,000 Ind./$4,000 Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlimited except on fertility services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 1 No Referrals Required</th>
<th>Level 2 No Referrals Required</th>
<th>Level 3 No Referrals Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge</td>
<td>No charge</td>
<td>80% AB, no deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
<td>80% AB, no deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
<td>80% AB, no deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
<td>80% AB after deductible</td>
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<tr>
<td>No charge</td>
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<td>80% AB after deductible</td>
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<tr>
<td>No charge</td>
<td>No charge</td>
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</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>$15 copay</td>
<td>$20 copay</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>$15 copay</td>
<td>$20 copay</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>$20 copay</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>$15 copay</td>
<td>$20 copay</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>$15 copay</td>
<td>$20 copay</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>$15 copay (limited to 30 visits per condition per year)</td>
<td>$20 copay (limited to 100 visits per year)</td>
<td>80% AB after deductible (limited to 100 visits per year)</td>
</tr>
<tr>
<td>$15 copay (limited to 20 visits per year)</td>
<td>$20 copay (unlimited visits)</td>
<td>80% AB after deductible (unlimited visits)</td>
</tr>
<tr>
<td>$15 copay</td>
<td>$20 copay</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>$15 copay</td>
<td>$20 copay</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>$85 copay (waived if admitted)</td>
<td>Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level</td>
<td>Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level</td>
</tr>
</tbody>
</table>

| No charge | Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level | Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level |

AB=Allowed Benefit
# Medical Benefits Options

<table>
<thead>
<tr>
<th>Product Line</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product Name</strong></td>
<td>BlueChoice HMO Open Access</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>HOSPITALIZATION</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>No charge</td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Physician Services</td>
<td>$10 PCP / $15 Specialist copay</td>
</tr>
<tr>
<td><strong>HOSPITAL ALTERNATIVES</strong></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>No charge</td>
</tr>
<tr>
<td>Hospice</td>
<td>No charge</td>
</tr>
<tr>
<td>Skilled Nursing Facility (limited to 365 days/benefit period)</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>MATERNITY</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Prenatal and Postnatal Office Visits</td>
<td>No charge</td>
</tr>
<tr>
<td>Delivery and Facility Services</td>
<td>No charge</td>
</tr>
<tr>
<td>Nursery Care of Newborn</td>
<td>No charge</td>
</tr>
<tr>
<td>Artificial Insemination—Subject to State Mandate (limited to 6 attempts per live birth)</td>
<td>50% of the AB</td>
</tr>
<tr>
<td>InVitro Fertilization Procedures—Subject to State Mandate (limited to 3 attempts per live birth &amp; $100,000 lifetime max)</td>
<td>50% of the AB</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)—SUBJECT TO FEDERAL MANDATE</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Services (requires Pre-authorization)</td>
<td>No charge</td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Services (MH &amp; SA)</td>
<td>$10 copay (office)</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>No charge</td>
</tr>
<tr>
<td>Medication Management Visit</td>
<td>$10 copay</td>
</tr>
<tr>
<td><strong>MISCELLANEOUS</strong></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100% AB</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Covered under Prescription Drug plan</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>$15 copay (limited to 24 visits/benefit period)</td>
</tr>
<tr>
<td>Hearing Aids for Children and Adults (limited to one hearing aid/per ear every 36 months)</td>
<td>100% AB per aid/per ear; member may be balanced billed up to the total charge</td>
</tr>
<tr>
<td>Outpatient Surgery (office)</td>
<td>$10 PCP / $15 Specialist copay</td>
</tr>
<tr>
<td>Chemotherapy/Radiation Therapy (office)</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>No charge</td>
</tr>
<tr>
<td>Cardiac Rehab (subject to Medical Policy review)</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUGS</strong></td>
<td>Covered through the CVS Caremark SilverScript Program. Refer to the 2022 Retirees’ Healthcare Enrollment Guide.</td>
</tr>
<tr>
<td><strong>DEPENDENT AGE LIMIT</strong></td>
<td>To age 26, end of month</td>
</tr>
</tbody>
</table>
## Medical Benefits Options

### BlueChoice Triple Option Plan—Open Access—3 Health Care Plans in 1

#### BlueChoice Triple Option Open Access

<table>
<thead>
<tr>
<th>Level 1 No Referrals Required</th>
<th>Level 2 No Referrals Required</th>
<th>Level 3 No Referrals Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge</td>
<td>90% AB after deductible</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>90% AB after deductible</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>90% AB after deductible</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>$15 copay</td>
<td>$20 copay</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>100% AB</td>
<td>100% AB</td>
</tr>
<tr>
<td>No charge</td>
<td>100% AB</td>
<td>100% AB</td>
</tr>
<tr>
<td>No charge</td>
<td>90% AB after deductible</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>Not covered under Level 1</td>
<td>90% AB after deductible (OP Facility)</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td></td>
<td>$20 copay (OP Facility Practitioner or Office)</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td>Not covered under Level 1</td>
<td>90% AB after deductible (OP Facility)</td>
<td>80% AB after deductible</td>
</tr>
<tr>
<td></td>
<td>$20 copay (OP Facility Practitioner or Office)</td>
<td>80% AB after deductible</td>
</tr>
</tbody>
</table>

#### BLUECHOICE NETWORK

<table>
<thead>
<tr>
<th>PREFERRED PROVIDER NETWORK</th>
<th>PARTICIPATING/ NON-PARTICIPATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge</td>
<td>90% AB after deductible</td>
</tr>
<tr>
<td>No charge</td>
<td>90% AB after deductible</td>
</tr>
<tr>
<td>$15 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td>No charge</td>
<td>100% AB</td>
</tr>
<tr>
<td>$15 copay</td>
<td>$15 copay</td>
</tr>
</tbody>
</table>

| 100% AB                    | 90% AB after deductible          | 80% AB after deductible       |
| Covered under Prescription Drug plan |
| $15 copay (limited to 24 visits/benefit period) | $20 copay | 80% AB after deductible |

100% AB per aid/per ear; member may be balanced billed up to the total charge

$15 copay | $20 copay | 80% AB after deductible
$15 copay | $20 copay | 80% AB after deductible
No charge | $20 copay | 80% AB after deductible
No charge | 100% AB | 80% AB after deductible

Covered through the CVS Caremark SilverScript Program. Refer to the 2022 Retirees' Healthcare Enrollment Guide.

To age 26, end of month

AB=Allowed Benefit
<table>
<thead>
<tr>
<th>Product Line</th>
<th>Medicare Covers</th>
<th>Medi-Comp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A Hospital Deductible</td>
<td>60 days of inpatient hospital care, except for a $1,484 deductible.</td>
<td>After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary</td>
</tr>
<tr>
<td>Inpatient Days 61–90</td>
<td>30 additional days of hospital inpatient care, except for a $371 per day copayment.</td>
<td>After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary</td>
</tr>
<tr>
<td>Lifetime Reserve Days</td>
<td>60 additional “lifetime reserve” days of inpatient hospital care, except for a $742 per day copayment.</td>
<td>After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>100 days of inpatient care in a skilled nursing facility, except for the $185.50 per day copayment for days 21–100.</td>
<td>After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary</td>
</tr>
<tr>
<td>Inpatient Medical/Surgery</td>
<td>80% of the Medicare-approved amount for in-hospital surgery and medical care, after the annual $203 deductible has been met.</td>
<td>After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>80% of the Medicare-approved amount for outpatient hospital visits and surgery, for medical conditions after the annual $203 deductible has been met.</td>
<td>After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>80% of the Medicare-approved amount for minor surgery and emergency first aid provided in a physician's office or hospital outpatient department, after the annual $203 deductible has been met.</td>
<td>After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>Covers clinical laboratory services at 100% of the Medicare-approved amount. 80% of the Medicare-approved amount for diagnostic X-rays or pathology examinations provided in a physician's office or hospital outpatient department, after the $203 deductible has been met.</td>
<td>Medicare covers in full For outpatient minor surgery or accidental injury: After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary For all other cases: After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary</td>
</tr>
<tr>
<td>Radiation/Chemotherapy Services</td>
<td>80% of the Medicare-approved amount for radiation/chemotherapy services provided in an office or hospital outpatient department, after the $203 deductible has been met.</td>
<td>After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary</td>
</tr>
<tr>
<td>Diabetic Self-Management</td>
<td>80% of the Medicare-approved amount for blood glucose monitors, testing strips, lancet devices, after the $203 annual deductible has been met.</td>
<td>After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary</td>
</tr>
</tbody>
</table>
# Medi-Comp Plan

<table>
<thead>
<tr>
<th>Product Line</th>
<th>Medicare Covers</th>
<th>Medi-Comp</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTIVE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Physical</td>
<td>One Annual Wellness visit every 12 months. There is no coinsurance, copayment or deductible.</td>
<td>Covered by Medicare</td>
</tr>
<tr>
<td>Routine GYN</td>
<td>No coinsurance, copayment or deductible for Pap Smears, Pelvic and clinical breast exams. Covered once every 2 years. Covered once a year for women at high risk.</td>
<td>100% of the Allowed Benefit the year Medicare does not pay</td>
</tr>
<tr>
<td>Prostate Cancer Screening Exam</td>
<td>80% of the Medicare-approved amount for digital rectal exam for men age 50 and older after the $203 annual deductible has been met. 100% for the PSA test; 80% for other related services. Covered once a year.</td>
<td>Pays 100% of Medicare Part B deductible and coinsurance.</td>
</tr>
<tr>
<td>Colorectal Cancer Screening Procedures</td>
<td>No coinsurance, copayment or deductible for screening colonoscopy or screening flexible sigmoidoscopy.</td>
<td>Covered by Medicare</td>
</tr>
<tr>
<td>Mammography Screening</td>
<td>No coinsurance, copayment or deductible. One baseline between ages 35–39. Once every 12 months for age 40 and older.</td>
<td>Covered by Medicare</td>
</tr>
<tr>
<td>Bone Mass Measurement</td>
<td>No coinsurance, copayment or deductible. Once every 24 months for persons at high risk for osteoporosis.</td>
<td>Covered by Medicare</td>
</tr>
</tbody>
</table>

**Examples:**

<table>
<thead>
<tr>
<th>Medicare Claim</th>
<th>$5,000.00 Medicare Allowed Amount</th>
<th>CareFirst Claim</th>
<th>$5,000.00 Allowed Amount</th>
<th>Member Liability $500</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000.00 Facility Charge</td>
<td>$1,484.00 Part A Deductible</td>
<td>$5,000.00 Allowed Amount</td>
<td>$4,500.00 90% of Allowed Benefit</td>
<td>$984.00 CareFirst Payment Amount</td>
</tr>
<tr>
<td>$3,516.00 Medicare Paid</td>
<td></td>
<td></td>
<td>-$3,516.00 Medicare Paid Amount</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Claim</th>
<th>$500.00 Provider Charge</th>
<th>CareFirst Claim</th>
<th>$500 Provider Charge</th>
<th>Member Liability $25</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250.00 Medicare Allowed Amount</td>
<td>$203.00 Part B Deductible</td>
<td>$250.00 Allowed Amount</td>
<td>$225.00 90% of Allowed Benefit</td>
<td>$78.00 CareFirst Payment Amount</td>
</tr>
<tr>
<td>$ 47.00 Medicare Paid</td>
<td></td>
<td></td>
<td>-$47.00 Medicare Paid Amount</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Claim</th>
<th>$500 Provider Charge</th>
<th>CareFirst Claim</th>
<th>$500 Provider Charge</th>
<th>Member Liability $203</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250.00 Medicare Allowed Amount</td>
<td>$203.00 Part B Deductible</td>
<td>$30.00 Allowed Amount</td>
<td>$27.00 90% of Allowed Benefit</td>
<td>$47.00 CareFirst Payment Amount</td>
</tr>
<tr>
<td>$ 47.00 Medicare Paid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Out-of-pocket

After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if we were primary, up to a $750 out-of-pocket. Reimbursement is then 100% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if we were primary for the remaining calendar year.

### Prescription drugs

Covered through the CVS Caremark SilverScript Program. Refer to the 2022 Retirees' Healthcare Enrollment Guide.

Note: Medicare's deductibles and/or coinsurance amounts are subject to change effective 1/1/2022. As of the print date, we do not have the information from Medicare for 2022. Should Medicare's deductibles and/or coinsurance change 1/1/2022, CareFirst will increase the amount covered to reflect the change in the deductibles and/or coinsurance.
Preferred Dental
Includes access to a National Provider Network

CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice) offer Preferred (PPO) Dental coverage, which allows you the freedom to see any dentist you choose.

Advantages of the plan

- Freedom of choice, freedom to save—With Preferred Dental coverage, you can see any dentist you choose. However, this plan also gives you the option to reduce your out-of-pocket expenses by visiting a dentist who participates in our Preferred Provider network. It's your choice!
- Comprehensive coverage—Benefits include regular preventive care, X-rays, dental surgery and more. A summary of your benefits is available on the following page. (Additional coverage for orthodontia is included for children and adults.)
- Nationwide access to participating dentists—You have access to one of the nation's largest dental networks, with more than 95,000 participating dentists throughout the United States. Preferred Dental gives you coverage for the dental services you need, whenever and wherever you need them.

Three options for care

- Option 1—By choosing a dentist in the Preferred Provider Network, you incur the lowest out-of-pocket costs. These dentists accept CareFirst’s allowed benefit as payment in full, which means no balance billing for you. You are just responsible for deductibles and coinsurance.
- Option 2—You can receive out-of-network coverage from a dentist who participates with CareFirst, but not through the Preferred Provider Network. Similar to Option 1, there is no balance billing. You are responsible for deductibles and coinsurance, and also have the convenience of your provider being reimbursed directly.
- Option 3—You can receive out-of-network coverage from a dentist who has no relationship with CareFirst. With this option, you may experience higher out-of-pocket costs since you pay your provider directly. You can be balance billed and must pay your deductible and coinsurance as well.

Frequently asked questions

How do I find a preferred dentist?
You can access an online directory 24 hours a day at carefirst.com/aacps. Click on the Dental tab, followed by Preferred Dental (PPO).

How much will I have to pay for dental services?
The chart on the following page gives you an overview of many of the covered services along with the percentage of what you will pay for each class of services, both in and out-of-network.

Is there a lot of paperwork?
There is no paperwork when you see a participating dentist, you are free from filing claims. However, if you use a non-participating dentist, you may be required to pay all costs at the time of care, and then submit a claim form in order to be reimbursed for covered services.

Who can I call with questions about my dental plan?
Call Dental Customer Service toll free at: (866) 891-2802 between 8:30 am and 5:00 pm ET, Monday–Friday.

1 The CareFirst BlueChoice Dental Plan is offered in conjunction with Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield, which contracts with participating dentists and provides claims processing and administrative services under the Dental Plan.
Traditional Dental

Includes access to a National Provider Network

CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice) offer Traditional Dental coverage, which allows you the freedom to see any dentist you choose.

Advantages of the plan

- **Freedom of choice, freedom to save**—With Traditional Dental coverage, you can see any dentist you choose. However, this plan also gives you the option to reduce your out-of-pocket expenses by visiting a dentist who participates in our Traditional Provider network. It’s your choice!

- **Comprehensive coverage**—Benefits include regular preventive care, X-rays, dental surgery and more. A summary of your benefits is available on the following page. (Additional coverage for orthodontia is included for children and adults.)

- **Nationwide access to participating dentists**—You have access to one of the nation’s largest dental networks, with more than 95,000 participating dentists throughout the United States. Traditional Dental gives you coverage for the dental services you need, whenever and wherever you need them.

- **Opportunity to reduce costs**—If you see a participating dentist, you will incur lower out-of-pocket costs for all dental services and you will have no claim forms to file. Participating dentists have agreed to accept CareFirst’s allowed benefit as payment in full for covered services. Once you meet your deductible and coinsurance, you won’t have any additional expenses. You will not be balance billed!

- **Out-of-network benefit**—You can receive care from a non-participating dentist and have the same level of coverage; however, you may be subject to higher out-of-pocket costs and balance billing.

Frequently asked questions

**How do I find a traditional dentist?**

You can access an online directory 24 hours a day at carefirst.com/aacps. Click on the Dental tab, followed by Traditional Dental (PPO).

**How much will I have to pay for dental services?**

The chart on the following page gives you an overview of many of the covered services along with the percentage of what you will pay for each class of services, both in and out-of-network.

**Is there a lot of paperwork?**

There is no paperwork when you see a participating dentist, you are free from filing claims. However, if you use a non-participating dentist, you may be required to pay all costs at the time of care, and then submit a claim form in order to be reimbursed for covered services.

**Who can I call with questions about my dental plan?**

Call Dental Customer Service toll free at: (866) 891-2802 between 8:30 am and 5:00 pm ET, Monday–Friday.
## Dental Options

**Retirees 65+ and Medicare-Eligibles**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>CareFirst Traditional</th>
<th>CareFirst PPO</th>
<th>Concordia Plus DHMO MD/DC2260*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td>Plan Pays</td>
<td>Plan Pays</td>
<td>Plan Pays</td>
</tr>
<tr>
<td>Oral Examination</td>
<td>100% of AB</td>
<td>100% of AB</td>
<td>80% of AB</td>
</tr>
<tr>
<td>Routine Cleaning</td>
<td>100% of AB</td>
<td>80% of AB</td>
<td>80% of AB</td>
</tr>
<tr>
<td>Sealants (limited to permanent molars—until end of year in which a member turns 19)</td>
<td>100% of AB</td>
<td>100% of AB</td>
<td>80% of AB</td>
</tr>
<tr>
<td>Bitewing X-ray</td>
<td>100% of AB</td>
<td>100% of AB</td>
<td>80% of AB</td>
</tr>
<tr>
<td>Palliative Treatment</td>
<td>100% of AB</td>
<td>80% of AB</td>
<td>80% of AB</td>
</tr>
<tr>
<td>Other X-rays as required</td>
<td>100% of AB</td>
<td>100% of AB</td>
<td>80% of AB</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>100% of AB</td>
<td>100% of AB</td>
<td>80% of AB</td>
</tr>
<tr>
<td>Fillings</td>
<td>100% of AB</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>100% of AB</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Pulpotomy</td>
<td>100% of AB</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Direct Pulp Caps</td>
<td>100% of AB</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Root Canals</td>
<td>100% of AB</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Apicoectomy</td>
<td>80% of AB**</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Oral Surgical Services</td>
<td>80% of AB**</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Surgical Extractions</td>
<td>80% of AB**</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>80% of AB**</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>General Anesthesia</td>
<td>80% of AB**</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Periodontics</td>
<td>50% of AB**</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Crown</td>
<td>80% of AB**</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Prosthetic Appliances (including implants)</td>
<td>50% of AB**</td>
<td>80% of AB</td>
<td>60% of AB**</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>50% of AB</td>
<td>50% of AB</td>
<td>35% of AB</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$25 Ind./$50 Family</td>
<td>None</td>
<td>$50 Ind./$150 Family</td>
</tr>
<tr>
<td>Annual Benefit Maximum</td>
<td>$1,500</td>
<td>$1,500</td>
<td>None/See note 2</td>
</tr>
<tr>
<td>Ortho Lifetime Maximum</td>
<td>$1,500</td>
<td>$1,500</td>
<td>None/See note 2</td>
</tr>
</tbody>
</table>

(AB Allowed Benefit)

Under the Concordia Plus DHMO (MD/DC 2260*) Plan, out-of-network services are reimbursed up to a maximum amount, based on the fee schedule provided by United Concordia.

* The above DHMO Plan percentages are approximate and used for comparison purposes only. Please refer to the United Concordia (UCCI) Schedule of Benefits for actual copayment amounts. All coverage is subject to the Plan’s exclusions and limitations.

** After Deductible

Note 1—General Anesthesia is considered integral to other procedures under this plan and is not covered separately.

Note 2—No annual maximum for in-network services. United Concordia will reimburse up to a maximum of $1,000 per family member per contract year for out-of-network services.

Note 3—After $2,900 member copayment satisfied, benefits applicable to in-network services; provider should submit pre-treatment estimate. United Concordia will not reimburse covered members for any orthodontic services performed out-of-network.

This is to be used as a guide. Actual benefits will be governed by the terms and conditions of the contract between CareFirst BlueCross BlueShield and Anne Arundel County Public Schools. Some limits may apply.
Vision Program
Making vision care more affordable

Vision is one of our most valued assets. Everyone should take precautions to protect this priceless gift. Some vision problems, such as glaucoma, can only be detected through regular, professional vision exams. Without proper care, these problems can gradually grow worse.

An important asset
The CareFirst BlueCross BlueShield Vision plan can make a difference. It makes vision care more affordable, and it encourages people to follow a routine of preventive care for their eyes.

An affordable option
Vision care is one of the least expensive health care benefits you can purchase. It is also one of the first optional benefits chosen by employees when it is offered.

Your Vision plan helps you commit to routine eye exams and preventive care that help detect small problems before they become serious and costly.

Your Vision plan provides benefits for:
- Comprehensive vision examinations
- Lenses and frames or contact lenses

A name you can trust
CareFirst BlueCross BlueShield is one of the largest health insurers in Maryland. You will be pleased that you have chosen CareFirst BlueCross BlueShield to provide such an important and valuable benefit program.

Freedom of choice
You can choose any licensed vision care provider within the Davis Vision network along with the Select Vision network—in Maryland or out of state. You have complete freedom to choose your own ophthalmologists, optometrists, and opticians. You may choose to see your current provider, a provider convenient to work or home, or take the recommendations of others.

Need more information?
Please visit carefirst.com/aacps or call 800-783-5602.
Vision Program

Easy to use

Our Vision plan is as easy to use as it is effective. You simply show your CareFirst BlueCross BlueShield membership card to participating providers at the time of service. The participating provider will bill us and we pay them directly for their services. You don’t have any paperwork or claims to file.

If you choose a non-participating provider for your care, you must pay the provider. We will reimburse you up to the limits of your vision plan.

Visit carefirst.com/aacps to find participating Davis Vision and Select Vision providers. To find a Davis Vision provider, click on the drop down box and select BlueVision, BlueVision Plus, Pediatric Vision (Davis Vision). To find a Select Vision provider, choose Select Vision.

What is not covered under Select Vision

- Sunglasses (lenses darker than tint 2), even if prescribed.
- Replacement, within the same benefit period, of lost or damaged frames or lenses (including contacts) for which benefits were provided.
- Exams or materials furnished after the member’s coverage is terminated (unless lenses and frames or contact lenses are ordered prior to the termination date and received within 30 days after the date of the order).
- Separate exam for contact lens fitting.
## Summary of Benefits: Select Vision/BlueVision Plus

<table>
<thead>
<tr>
<th>Network</th>
<th>Select Vision (includes in- &amp; out-of-network benefits)</th>
<th>BlueVision Plus You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Eye Exam</td>
<td>100% of Allowed Benefit</td>
<td>No Copay</td>
</tr>
<tr>
<td>Frames</td>
<td>$45.00</td>
<td>Plan pays up to $45 or up to $95 at Visionworks (plus 20% discount on balance with all Davis Vision Providers)</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>$52.00</td>
<td>No Copay</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>$82.00</td>
<td>No Copay for lined bifocals</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>$101.00</td>
<td>No Copay for lined trifocals</td>
</tr>
<tr>
<td>Contact Lenses instead of glasses (Cosmetic)</td>
<td>$97.00</td>
<td>Plan pays up to $97</td>
</tr>
<tr>
<td>Contact Lenses(Medically Indicated**)</td>
<td>$352.00</td>
<td>Plan pays up to $352</td>
</tr>
</tbody>
</table>

### ADDITIONAL LENS OPTIONS

| Tinting of Plastic Lenses (Solid/Gradient) | N/A | $15 |
| Scratch-Resistant Coating Polycarbonate Lenses (Children****Adults) | N/A | Covered $0/$35 |
| Ultraviolet Coating | N/A | $15 |
| Blue Light Filtering | N/A | $15 |
| Anti-Reflective Coating (Standard/Premium/Ultima/ Ultimate) | N/A | $40/$55/$69/$85 |
| Progressive Lenses (Standard/Premium/Ultima/ Ultimate) | N/A | $65/$105/$140/$175 |
| High-Index Lenses (1.67/1.74) | N/A | $60/$120 |
| Polarized Lenses | N/A | $75 |
| Plastic Photochromic Lenses | N/A | $70 |
| Scratch Protection Plan: (Single Vision, Multifocal Lenses) | N/A | $20 | $40 |
| Blended Segment Lenses | N/A | $20 |
| Photochromic Lenses | N/A | $20 |
| Oversized Lenses | N/A | Covered |

*The Davis Vision Network has 94,000+ providers nationwide including Retailers (Walmart, Sam's Club, Costco, Vision Works, Target, JCPenney, My Eye Dr., Pearle Vision and America's Best), 1-800-CONTACTS and glasses.com.

**Following cataract surgery or when visual acuity is correctable to at least 20/70 in the better eye only by use of contact lenses.

These services or supplies are not considered covered benefits under the Plan. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.

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### BlueVision Plus Exclusions

The following services are excluded from coverage:

1. Diagnostic services, except as listed in What's Covered under the Evidence of Coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
4. Services or supplies not specifically approved by the Vision Care Designee where required in What's Covered under the Evidence of Coverage.
5. Orthoptics, vision training and low vision aids.
6. Replacement, within the same benefit period of frames, lenses or contact lenses that were lost.
7. Non-prescription glasses, sunglasses or contact lenses.
8. Vision Care services for cosmetic use.

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Please note: Not all services 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. All benefits are subject to the provisions stipulated in the CareFirst BlueCross BlueShield Vision contract. CareFirst BlueCross BlueShield does not warrant the quality of vision services or materials.
BlueVision (Davis Vision)
A plan for healthy eyes, healthy lives

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueChoice, through the Davis Vision, Inc. national network of providers.

How the plan works

How do I find a provider?
To find a provider, go to carefirst.com/aacps and utilize the Find a Provider feature or call Davis Vision at 800-783-5602 for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

How do I receive care from a network provider?
Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

Can I get contacts and eyeglasses in the same benefit period?
With BlueVision, you receive one pair of eyeglasses or a supply of contact lenses per benefit period at a discounted price.¹

Mail order replacement contact lenses
DavisVisionContacts.com offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses, easy, convenient purchasing online and quick shipping direct to your door.

Need more information?
Please visit carefirst.com/aacps or call 800-783-5602.
BlueVision (Davis Vision)

Summary of Benefits
(12-month benefit period)

<table>
<thead>
<tr>
<th>In-Network</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EYE EXAMINATIONS</strong></td>
<td></td>
</tr>
<tr>
<td>Routine Eye Examination with</td>
<td></td>
</tr>
<tr>
<td>dilation (per benefit period)</td>
<td>$10</td>
</tr>
<tr>
<td><strong>FRAMES</strong></td>
<td></td>
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<tr>
<td>Priced up to $70 retail</td>
<td>$40</td>
</tr>
<tr>
<td>Priced above $70 retail</td>
<td>$40, plus 90% of the amount</td>
</tr>
<tr>
<td></td>
<td>over $70</td>
</tr>
<tr>
<td><strong>SPECTACLE LENSES</strong></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$35</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$55</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$65</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$110</td>
</tr>
<tr>
<td><strong>LENS OPTIONS</strong></td>
<td>(add to spectacle lens prices</td>
</tr>
<tr>
<td></td>
<td>above)</td>
</tr>
<tr>
<td>Standard Progressive Lenses</td>
<td>$75</td>
</tr>
<tr>
<td>Premium Progressive Lenses</td>
<td>$125</td>
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<tr>
<td>(Varilux®, etc.)</td>
<td></td>
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<tr>
<td>Ultra Progressive Lenses (digital)</td>
<td>$140</td>
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<tr>
<td>Polarized Lenses</td>
<td>$75</td>
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<tr>
<td>High Index Lenses</td>
<td>$55</td>
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<tr>
<td>Glass Lenses</td>
<td>$18</td>
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<tr>
<td>Polycarbonate Lenses</td>
<td>$30</td>
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<tr>
<td>Blended Invisible Bifocals</td>
<td>$20</td>
</tr>
<tr>
<td>Intermediate Vision Lenses</td>
<td>$30</td>
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<tr>
<td>Photochromic Lenses</td>
<td>$35</td>
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<tr>
<td>Scratch-Resistant Coating</td>
<td>$20</td>
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<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$45</td>
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<tr>
<td>Ultraviolet (UV) Coating</td>
<td>$15</td>
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<tr>
<td>Solid Tint</td>
<td>$10</td>
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<tr>
<td>Gradient Tint</td>
<td>$12</td>
</tr>
<tr>
<td>Plastic Photosensitive Lenses</td>
<td>$65</td>
</tr>
<tr>
<td><strong>CONTACT LENSES</strong></td>
<td></td>
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<tr>
<td>Contact Lens Evaluation and</td>
<td>85% of retail price</td>
</tr>
<tr>
<td>Fitting</td>
<td></td>
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<tr>
<td>Conventional</td>
<td>80% of retail price</td>
</tr>
<tr>
<td>Disposable/Planned Replacement</td>
<td>90% of retail price</td>
</tr>
<tr>
<td>DavisVisionContacts.com Mail</td>
<td>Discounted prices</td>
</tr>
<tr>
<td>Order Contact Lens Replacement</td>
<td></td>
</tr>
<tr>
<td>Online</td>
<td></td>
</tr>
<tr>
<td><strong>LASER VISION CORRECTION</strong></td>
<td>Up to 25% off allowed amount</td>
</tr>
<tr>
<td></td>
<td>or 5% off any advertised</td>
</tr>
<tr>
<td></td>
<td>special</td>
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</tbody>
</table>

1. At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.
2. CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.
3. Special lens designs, materials, powers and frames may require additional cost.
4. Some providers have flat fees that are equivalent to these discounts.

**Exclusions**

The following services are excluded from coverage:

1. Diagnostic services, except as listed in What’s Covered under the Evidence of Coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
4. Services or supplies not specifically approved by the Vision Care Designee where required in What’s Covered under the Evidence of Coverage.
5. Orthoptics, vision training and low vision aids.
6. Glasses, sunglasses or contact lenses.
7. Vision Care services for cosmetic use.
8. Services obtained from Non-Contracting Providers.

For BlueChoice Opt-Out Plus members, Vision Care benefits are not available under the Out-of-Network Evidence of Coverage.

Exclusions apply to the Routine Eye Examination portion of your vision coverage. Discounts on materials such as glasses and contacts may still apply.

My Account
Online access to your health care information

My Account makes it easier than ever to understand and manage personalized information about your health plan and benefits. Set up an account today! Go to carefirst.com/aacps to create a username and password.

My Account at a glance

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

2. Coverage
   - Access your plan information—plus, see who is covered
   - Update your other health insurance information, if applicable
   - View, order or print member ID cards
   - Review the status of your health expense account (HSA or FSA)
   - Order and refill prescriptions
   - View prescription drug claims

Signing up is easy
Information included on your member ID card will be needed to set up your account.
- Visit carefirst.com/aacps
- Select Register Now
- Create your username and password

1 Only if offered by your plan.
My Account

1. **Home**
2. **Coverage**
3. **Claims**
4. **Doctors**
5. **My Health**
6. **Document**
7. **Tools**
8. **Help**

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

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

### 5 My Health
- Access health and wellness discounts through Blue365
- Learn about your wellness program options

### 6 Documents
- Look up plan forms and documentation
- Download Vitality, your annual member resource guide

### 7 Tools
- Access the Treatment Cost Estimator to calculate costs for services and procedures
- Use the drug pricing tool to determine prescription costs

### 8 Help
- Find answers to many frequently asked questions
- Send a secure message or locate important phone numbers

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1. Only if offered by your plan.
2. Only available when using a computer.
3. The doctors accessed via this website are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.
Health & Wellness
*Putting the power of health in your hands*

Improving your health just got easier! Brought to you in partnership with Sharecare, Inc., the highly personalized CareFirst BlueCross BlueShield (CareFirst) wellness program can help you live a healthier life. Catering to your unique health and wellness goals, our program offers motivating digital resources accessible anytime, plus specialized programs for extra support.

**Ready to take charge of your health?**

Find out if your healthy habits are truly making an impact by taking the RealAge® health assessment! In just a few minutes, RealAge will help you determine the physical age of your body compared to your calendar age. You’ll discover the lifestyle behaviors helping you stay younger or making you age faster and receive insightful recommendations based on your results.

**Exclusive features**

Our wellness program is full of resources and tools that reflect your own preferences and interests. You get:

- **Trackers:** Connect your wearable devices or enter your own data to monitor daily habits like sleep, steps, nutrition and more.
- **A personalized health timeline:** Receive content and programs tailored to you.
- **Challenges:** Stay motivated by joining a challenge to make achieving your health goals more entertaining.
- **Inspirations and Relax 360°:** Break free from stress, unwind at the end of the day or ease into a restful night of sleep with meditation, streaming music and videos.

*Sharecare, Inc. is an independent company that provides health improvement management services to CareFirst members.*
Health & Wellness

Specialized programs
The following programs can help you focus on specific wellness goals. For more information about any of these programs, please call Sharecare support at 877-260-3253.

Health coaching
Coaches are registered nurses and trained professionals who provide one-on-one support to help you reach your wellness goals. If you are interested in health coaching or are contacted, we encourage you to take advantage of this voluntary and confidential program that can help you achieve your best possible health.

Weight management program
Improve your overall health, reach a healthier weight and reduce your risk for pre-diabetes and associated chronic diseases.

Tobacco cessation program
Quitting smoking and other forms of tobacco can lower your risk for many serious conditions from heart disease and stroke to lung cancer. Our program’s expert guidance, support and online tools make quitting easier than you might think.

Financial well-being program
Learn how to take small steps toward big improvements in your financial situation. Whether you want to stop living paycheck to paycheck, get out of debt, or send a child to college, our financial well-being program can help.

Additional offerings
- **Wellness discount program**—Sign up for Blue365 at carefirst.com/wellnessdiscounts to receive special offers from top national and local retailers on fitness gear, gym memberships, healthy eating options and more.
- **Vitality magazine**—Read our member magazine which includes important plan information at carefirst.com/vitality.
- **Health education**—View our health library for more health and well-being information at carefirst.com/livinghealthy.

Log in today. If you don’t already have a Sharecare account, visit carefirst.com/sharecare. You’ll need to enter your CareFirst My Account username and password and complete the one-time registration with Sharecare to link your CareFirst account information. This will help personalize your experience.

This wellness program is administered by Sharecare, Inc., an independent company that provides health improvement management services to CareFirst members. Sharecare, Inc. does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the health improvement management services it provides.
Preventive Service Guidelines for Adults

To stay healthy, adults need preventive check-ups. These guidelines* describe recommended preventive services that most adults need. Depending on your personal health care needs or risk factors, your doctor may give you a different schedule. If you think you may be at risk for a particular condition, talk to your doctor.

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

Counseling and education

Depending on the patient's age, health care providers will discuss one or more of these topics or provide screenings during exams:

- Drug and alcohol use
- Tobacco use
- Harmful effects of smoking on children's health
- Physical activity and diet, including recommended changes
- Injury prevention
- Dental health
- Hepatitis A, B and C
- Sexual behavior
- Sexually transmitted diseases
- Use of alternative medicines and therapies
- Tuberculosis (TB)
- Domestic violence
- Aspirin therapy
- Sleep patterns
- Sun safety/skin cancer prevention

Screenings for men and women ages 21 & older

- Medical history and physical exam: At the advice of the doctor
- Height: At least once with follow-up as needed
- Weight: Screen all adults for obesity; body mass index (BMI) recommended at least every two years
- Blood pressure:
  - At least every 2 years if blood pressure is less than 120/80
  - Every year if systolic measure (top number) is 120–139 or diastolic measure (bottom number) is 80–90
- Cholesterol: Every 5 years
- Diabetes: Every 3 years for patients with any of these risk factors:
  - Overweight (BMI greater than or equal to 25)
  - Family history of diabetes
  - High blood pressure
  - High cholesterol
  - High blood sugar
  - History of vascular disease
  - Inactivity
  - African American, Latino, Native American, Asian American or Pacific Islander race/ethnicity
- COPD: Spirometry for patients with dyspnea, chronic cough/sputum production and history of risk factors
- Colorectal cancer: Ages 45-75 with average risk. The decision to screen before or after this age range should be between you and your doctor. Discuss the possible benefits and harm of screening and treatment with your doctor. The options for colorectal cancer screening are:
  - Fecal immunochemical test annually
  - High-sensitivity, guaiac-based fecal occult blood test annually
  - Multitarget stool DNA test every 3 years
  - Colonoscopy every 10 years
  - Computed tomography colonography every 5 years
  - Flexible sigmoidoscopy every 5 years

* Guidelines are adapted from a variety of sources including: United States Preventive Services Task Force; American Diabetes Association; American Cancer Society, and National Comprehensive Cancer Network.
Preventive Service Guidelines for Adults

- **Depression**: Screen men and women every year
- **Hepatitis B**: For men and women at increased risk for infection
- **Hepatitis C**: At least once for those born between 1945 and 1965
- **Human immunodeficiency virus (HIV)**: For men and women at increased risk for HIV infection
- **Syphilis**: For men and women at increased risk for syphilis infection

**Screenings for women only**

- **Breast cancer**: Routine screening every 2 years for women aged 50 to 74 years. The decision to start screening before the age of 50 should be between you and your doctor. Discuss the possible benefits and harm of screening and treatment with your doctor.
- **Hereditary breast and ovarian cancer screening**: Women who carry the genes associated with increased risk (a strong family history of breast, ovarian, tubal or peritoneal cancer) should be referred for genetic counseling and evaluation for testing
- **Cervical cancer**:
  - Pap smear every 3 years for ages 21–29
  - For women ages 30 and older, Pap smear alone every 3 years or a combination of Pap smear and HPV testing every 5 years
  - Screening is not recommended for women older than 65 who have had adequate prior screening
  - Screening is not suggested for women who have had a hysterectomy with removal of the cervix

- **Chlamydia**: For sexually active women ages 25 and younger who are not pregnant; the doctor may advise the test for women older than age 25
- **Cystic Fibrosis carrier screening**: For women of child-bearing age, preferably before conception
- **Osteoporosis**:  
  - Begin at age 65 or older for women at average risk. Women at greater risk should be screened at an earlier age.
  - Counseling for women ages 21 and older to get enough calcium
- **Menopause counseling**: Women who are of menopausal age should be counseled about menopause, risks and benefits of estrogen replacement, treatment and lifestyle changes
- **Screening pelvic exam**: Is not recommended for women with no symptoms and who are not pregnant. The decision not to have this exam should be between you and your doctor. Discuss the benefits and harm with your doctor.

**Screenings for men only**

- **Prostate cancer**: Discuss the possible benefits and harm of screening and treatment with your doctor
- **Aortic abdominal aneurysm**: One-time ultrasonography for men ages 65 to 75 who smoke or have smoked
- **Osteoporosis**: Periodic screenings for older men with risk factors

Find more information about adult immunizations, visit carefirst.com/prevention and click on the Adults link under Shots.
Preventive Service Guidelines for Children

To stay healthy, children need routine shots and preventive check-ups. These guidelines* describe recommended preventive services that most children need. Depending on your child's personal health care needs or risk factors, your doctor may give you a different schedule. If you think your child may be at risk for a particular condition, talk to your doctor.

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

Counseling and screenings

Your health care provider should discuss these topics at every exam, depending on your child's age:

- Injury prevention
- Diet and exercise
- Substance use
- Smoking
- Dental health: Check-ups twice a year, beginning at 12 months
- Sexual behavior
- Depression
- Domestic violence
- Use of alternative medicine and therapies
- Sun safety/skin cancer prevention
- Fluoride supplementation

Birth to 24 months

- Medical history and exam: At birth to 1 month and at 2, 4, 6, 9, 12, 15, 18 and 24 months
- Height, weight, hearing, vision, head measurement, body mass index (BMI) percentile, and assessment of growth, development and behavior: Each visit
- Congenital heart disease: After 24 hours of age before discharge from the hospital
- Congenital hypothyroidism: 2–4 days of age
- Tests required by state law: By 1 month
- Tuberculosis: Assess risk at 1, 6, 12 and 24 months. Testing should be performed on recognition of high risk factors
- Bilirubin screening: First newborn visit
- Lead poisoning: Assess risk at 6, 9, 12, 18 and 24 months. Perform blood test at 12 and 24 months in high prevalence areas
- Anemia: Assess risk at 4, 12, 15, 18 and 24 months. Perform blood test at 12 months
- Autism screening: At 18 month visit and 24 month visit
- Sexually transmitted disease: HIV test for infants born to mothers whose HIV status is unknown
- Sickle Cell Disease: Once between 9–12 months
- Nutrition counseling: From birth to 21 months, check the baby's eating habits

Remember to use firm bedding and place healthy babies on their backs to sleep.

Find out when your child's shots are due at: carefirst.com/prevention.
For more information about health and wellness, visit carefirst.com/livinghealthy.

* Guidelines are adapted from a variety of sources including: American Academy of Pediatrics; American Academy of Family Physicians; Centers for Disease Control and Prevention, and United States Preventive Services Task Force.
Preventive Service Guidelines for Children

Ages 2 to 10
- Medical history and exam: Ages 2, 2½, 3, 4, 5, 6, 7, 8, 9 and 10
- Height, weight, hearing, vision, and assessment of growth, development and behavior: Each visit; BMI percentile once a year, starting at age 2
- Head measurement: Until age 2
- Blood pressure: Each visit, beginning at age 3
- Urinalysis: Age 5
- Cholesterol: Test one time between 9–11 years
- Rubella: Vaccination history or blood test for girls of child-bearing age, beginning at age 10
- Tuberculosis: Assess risk annually from 2–10 years. Testing should be performed on recognition of high-risk factors
- Anemia: Assess risk at 24 months, 30 months, 3 years and annually thereafter
- Lead poisoning: Assess risk annually between 2–6 years
- Body Mass Index (BMI): Screen at 24 months, 30 months, 3 years and annually thereafter
- Diabetes: Testing every 3 years, beginning at age 10 or at onset of puberty, whichever comes first, if these conditions apply:
  □ Overweight (body mass index > 85th percentile or weight > 120% of ideal for height)
  □ Family history of type 2 diabetes
  □ Native American, African American, Latino, Asian American or Pacific Islander race/ethnicity

Ages 11 to 21
- Medical history and exam: Once a year
- Height, weight, hearing, vision, and assessment of growth, development and behavior: Each well visit; BMI percentile once a year
- Blood pressure: Each visit
- Cholesterol: Test one time between 17–21 years
- Rubella: Vaccination history or blood test for females of childbearing age
- Anemia: Assess risk annually. Screen females once a year after periods begin
- Urinalysis: Beginning at age 11, screen annually if sexually active
- Tuberculosis: Assess risk annually from 11–21 years. Testing should be performed on recognition of high-risk factors
- Depression: Screen annually between 12–21 years of age
- Sexually transmitted diseases: Screen if sexually active or at high risk beginning at age 11
- Screen for HIV once between 15–18 and test annually if at high risk
- Pelvic exam: Most women under age 21 should not be screened for cervical cancer regardless of sexual activity or other factors
- Calcium counseling: Beginning at age 11
- Body Mass Index (BMI): Screen annually between 11–21 years

Depending on your child's age and history, your doctor may screen for other high-risk conditions, including hepatitis A, B and C, chlamydia, gonorrhea and HIV.

CareFirst Preventive Service Guidelines are for physician practice and patient care and do not define member benefits. These guidelines are general recommendations for members with no special risk factors. Variations are appropriate based on individual circumstances. Approved by CareFirst's Quality Improvement Council—April 2018.
Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

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

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

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

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

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

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

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

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

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.

Notice of Nondiscrimination and Availability of Language Assistance Services

Foreign Language Assistance

注意（中文）：此通知包含有关您保险覆盖的信息。它可能包含关键日期，您可能需要采取某些行动。在日期之后，您有权获取此信息和帮助。成员应拨打背面的成员身份证号码上的电话号码。其他人可拨打855-258-6518并等待电话引导，直到被提示按0。当接线员接通时，声明您需要的语言，您将被连接到一名翻译。

외국어 지원

주의 (영어) : 이 안내서에는 건강 보험에 대한 정보가 포함되어 있습니다. 주요 날짜가 포함되어 있을 수 있으며, 특정 기한 내에 행동할 필요가 있을 수 있습니다. 참가자는 그의 참가자 식별 카드에 있는 전화 번호로 부를 때, 통화 시어바를 요구할 수 있습니다. 이 번호는 855-258-6518이며, 대화를 진행하여 0을 누르게 됩니다. 한계를 넘어서 도와드리기 위한 언어를 말씀하시면 연결될 수 있습니다.

Notice of Nondiscrimination and Availability of Language Assistance Services

Foreign Language Assistance

Notícia de no discriminación e disponibilidade de assistência de idiomas

Atenção (Português): Esta notificação contém informações sobre sua cobertura de seguro. Pode conter datas-chave e você pode precisar agir antes de certas datas finais. Você tem o direito de obter esta informação e assistência em seu idioma sem custo. Todos podem ligar para 855-258-6518 e esperar que o diálogo finalize até ser solicitado para pressionar 0. Quando o agente responder, informe o idioma que precisa e ele irá comunicar-se com um intérprete.

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 a la reversa 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.

Russian (Russian) Внимание! Это 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. Весь прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.
Notice of Nondiscrimination and Availability of Language Assistance Services

Anne Arundel County Public Schools—Health Benefit Options

Notice of Nondiscrimination and Availability of Language Assistance Services

Bàc-ci-wúdú (Bassa) Tô Dòu Cá! Bô ni ka bà nyc bë ke rî m goho kpà bò ni fùu-xàa-ti-in nye jë dyi. Bô ni ka bèdè wè jë bè bë rè m ke dë wa mò m ke nyeue nyu wëv bë wë bëa kë zi. S mò ni kpe bë rè m bô ni ka kè bë-gpà kpâ m muèc dyë dë ni bëd-wúdû mú bë rè m se wîja dô pé. Kpoo nyc bë me dâ fûn-nôdà nîa dë waaw I.D. kàà ñèn nyc. Nyc tò se dâ mà nôdà nîa kë: 855-258-6518, kë m fe tò bë wa kë rè m goho cë bè bë rè m nôdà mòd 0 kë dyì paddìn wëv. J jû kë nyc dò dyi m gô jùn, po wuñ m mò poë dyie, kë nyc dô mu nôl mè cë kë ni wuñd mú zà.

বাংলা (Bengali) নোট: এই লিঙ্গে আমাদের বিভিন্ন ক্ষেত্রে প্রস্তুত করা হয়েছে এবং আমাদের সহায়তা সম্বন্ধে আরও তথ্য পাওয়া যেতে পারে।

हिंदी (Hindi) ध्यान दें: इस सुचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य विषयों का उल्लेख होंगे और आपके लिए किसी नियम का बदलाव करना जरूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में लिखा हुआ कालिफोर्निया के अधिकारी है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए प्रेमनंबर पर कॉल कर सकते हैं और जब तक 0 दिनों के लिए न कहा जाए, तब तक संबंध की प्रतिक्रिया करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बनाएँ और आपको व्यापारपत्र से कनेक्ट कर दिया जाएगा।

اردو (Urdu) یہ نیویورک کے ایشیاریوبی کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخی ہوے ہو سکتی ہیں۔ اور ممکن

فارسی (Persian) یہ اعلامیہ حاوی اطلاعاتی دریوا دریوا پیشہ ورہے اس کے استعمال کے لئے سہولی کردیا گیا ہے۔

اللغة العربية (Arabic) تذيب: يجوح هذا الإخطار على معلومات بشأن تغطية الأمية، وقد يكون على تواضع مهمة. وقد تحتاج إلى اتخاذ إجراءات على مواتية إلى جانب أتعزية محددة. تجربة لك الحصول على هذه المساعدة والمعلومات بلغة أخرى تفضل أي تكلفة. ينبغي أن تتم على الأخصب الأتصال على رقم الهاتف المذكور في طلب تقريبة بمجرد أن تكون للمتاح على رقم 855-258-6518 والإبلاغ عن المحتال حتى تطلب منهم الضغط على رقم 0 عند إجابة أحد الوقالين، اذكر اللغة التي تحتاج إلى التواصل بها.

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時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鈕 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繫。
Igbo (Igbo) Nrubama: Ọkwa a nwere ozi gbasara mkpuchi nehekwa onwe gi. O nwere ike inwe ọbochị ndị dị mkpa, i nwere ike ime ihe tupu ụfo dị ọbochị ijedibe. I nwere ikike inweta ozi na enyemaka a n’asụṣụ gi na akwụghị ugwọ ọ bua. Ndị otu kwesịrị ikpọ akara ekwenti dị n’azụ nke kaadi njirimara ha. Ndị ozọ niile nwere ike ikpọ 855-258-6518 wee chere ubuṣi ahu ruo mgbe amanyere ipi 0. Mgbe onye nnọchite anya zara, kwuo asụṣụ i chọrọ, a ga-eji̊kọ gi na onye ọkwụa okwu.


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 정보의 지원을 받을 권리가 있습니다. 회원이 아닌 경우 855-258-6518 번으로 통화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad (Navajo) Ge’: Díí bee il hane’íigíí biiʼ dahóló bee éédahózín béeso ách’ááh naanil nik’ísí’tíigíí bá. Biiʼ dahólóqí doo íiyisií yoolkááiligíí dóó t’àáadoo leʼe áddadoolyííligíí da yókeedgo t’àá doo bee e’e’aaahí ájíil’ííií. Bee ná ahóó̈t’íí̈ díí bee il hane’ dóó nik’áádoowol t’àá ninizadae bee t’àá jik’í. Atah danilííigíí béesh bee haneʼe bee wólta’íigíí nítt’izgo bee nee hódołzinííigíí bikéédéq’ bikáa’ bich’í̊’ hodoohińíí’í. Aáddóo naáánaa’ éí koji’ dahódoolníí 855-258-6518 dóó yíi diílt’s’ííál’íigíí t’àá nílééjíí ááddóó éí bikéédóó naásbaqás bíl addíiíchí. Áák’aándaalwó’íigíí neidílt’áágo, saad bee yánilt’íigíí yíi diikíí dóó ata’ halné’e lá niikááadoowol.