BlueChoice Advantage HSA/HRA Minimum Value Summary of Benefits

Integrated Deductible

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Visit www.carefirst.com/doctor to locate providers and facilities	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
WELLBEING PROGRAM & BLUE REWARDS		
Visit **www.carefirst.com/wellbeing** for more information.	You have access to a comprehensive wellbeing program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$3,400	$6,800
Family	$6,800	$13,600
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$6,800 Individual/$13,600 Family	$13,600 Individual/$27,200 Family
Prescription Drug[6]	Combined with in-network medical out-of-pocket maximum	All drug costs are subject to in-network out-of-pocket maximum
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*	No charge* after deductible
Breast Cancer Screening	No charge*	No charge*
Pap Test	No charge*	No charge* after deductible
Prostate Cancer Screening	No charge*	No charge* after deductible
Colorectal Cancer Screening	No charge*	No charge* after deductible
PCP AND SPECIALIST SERVICES		
FACILITY CHARGE[7]—In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Office Visits for Illness—PCP[7,8]	Virtual Connect Plus through selected providers, including CloseKnit[9] - No charge* after deductible (**www.carefirst.com/virtualconnect**) All other providers - No charge* after deductible	Deductible, then 40% of Allowed Benefit
Convenience Care (retail health clinics such as CVS MinuteClinic)	No charge* after deductible	Deductible, then 40% of Allowed Benefit
Office Visits for Illness—Specialist[7,8]	Deductible, then $20 per visit	Deductible, then 40% of Allowed Benefit
Allergy Testing[7]	Deductible, then $20 per visit	Deductible, then 40% of Allowed Benefit
Allergy Shots[7]	Deductible, then $20 per visit	Deductible, then 40% of Allowed Benefit
Physical, Speech, and Occupational Therapy[7,10] (limited to 30 visits/injury/benefit period)	Deductible, then $20 per visit	Deductible, then 40% of Allowed Benefit
Chiropractic Services[7] (limited to 20 visits/benefit period)	Deductible, then $20 per visit	Deductible, then 40% of Allowed Benefit
Acupuncture[7] (limited to 20 visits/benefit period)	Deductible, then $20 per visit	Deductible, then 40% of Allowed Benefit

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Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
EMERGENCY SERVICES		
Urgent Care Center[11] (such as Patient First or Express Care)	Deductible, then 20% of Allowed Benefit	In-network deductible, then 40% of Allowed Benefit
Hospital Emergency Room Services[11]		
■ Facility	Deductible, then 20% of Allowed Benefit	In-network deductible, then 20% of Allowed Benefit
■ Physician	Deductible, then 20% of Allowed Benefit	In-network deductible, then 20% of Allowed Benefit
Ambulance[11] (if medically necessary)	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
DIAGNOSTIC SERVICES		
Labs[12]		
■ Non-Hospital/Freestanding Facility	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
■ Hospital	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
X-ray[12]		
■ Non-Hospital/Freestanding Facility	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
■ Hospital	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Imaging[12]		
■ Non-Hospital/Freestanding Facility	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
■ Hospital	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
HOSPITALIZATION—(Members are responsible for both physician and facility fees)		
Outpatient Surgical Center Services		
■ Facility	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
■ Physician	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Hospital Surgical Services		
■ Facility	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
■ Physician	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Hospital Services		
■ Facility	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
■ Physician	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Hospice (Inpatient—limited to 30 days; Outpatient—unlimited during Hospice eligibility period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 40% of Allowed Benefit
Delivery and Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Artificial and Intrauterine Insemination[7,13]	Not covered	Not covered
In Vitro Fertilization Procedures[7,13]	Not covered	Not covered

BlueChoice Advantage HSA/HRA Minimum Value Summary of Benefits

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)		
Office Visits	Virtual Connect Plus through selected providers, including CloseKnit[9] - No charge* after deductible (**www.carefirst.com/virtualconnect**) All other providers - No charge* after deductible	Deductible, then 40% of Allowed Benefit
Outpatient Services		
■ Facility	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
■ Physician	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Services		
■ Facility	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
■ Physician	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing-impaired ear, up to $1,500, every 24 months	No charge* after deductible	Deductible, then 40% of Allowed Benefit
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Total charge minus $33 Allowed Benefit
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

BlueChoice Advantage HSA/HRA Minimum Value Summary of Benefits

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

* No copayment or coinsurance.

1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

2 In-network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst service area, by a provider in the CareFirst BlueChoice network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst Allowed Benefit. The CareFirst Allowed Benefit is generally the contracted rates or fee schedules that CareFirst providers have agreed to accept as payment for covered services. These payments are established by CareFirst, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level.These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

3 Out-of-network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

4 For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.

5 For family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum includes deductibles, copays and coinsurance.

6 Plan has integrated medical and prescription drug out-of-pocket maximum.

7 If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.

8 "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service. Providers will use their professional judgment to determine if a telemedicine visit is appropriate or if an in-person visit is required.

9 CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross Blue Shield products or services and is providing in person and telehealth services to CareFirst members. Atlas Health, LLC is a corporate affiliate within the CareFirst, Inc. corporate umbrella of companies.

10 Visit Limitation does not apply to children ages 2-10 when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.

11 If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.

12 Members accessing laboratory tests, x-rays, and specialty imaging services inside the CareFirst Service Area (Maryland, D.C., Northern Virginia) must use a designated Contracting Provider and/or Contracting Facility which may include a non-hospital/freestanding facility for In-Network benefits. Services performed by any other provider while inside the CareFirst Service Area will be considered Out-of-Network. Members accessing laboratory tests, x-rays, and specialty imaging services outside the CareFirst Service Area may use any participating BlueCard PPO facility and receive In-Network benefits.

13 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

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

CareFirst

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Coverage is not provided for:

A. Any services, tests, procedures, or supplies which CareFirst BlueChoice determines are not necessary for the prevention, diagnosis, or treatment of the Member's illness, injury, or condition. Although a service or supply may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in CareFirst BlueChoice's judgment, is Experimental/ Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for clinical trials.
C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under this Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that do not meet all other conditions and criteria for coverage as determined by CareFirst BlueChoice.
E. Routine, palliative or Cosmetic foot care (except for conditions determined by CareFirst BlueChoice to be Medically Necessary) including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
F. Any type of dental care (except treatment of accidental bodily injuries or oral surgery, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess and periodontal disease, removal of teeth, orthodontics, replacement of teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. All other procedures involving the teeth or areas and structures surrounding and/or supporting the teeth, including surgically altering the mandible or maxillae (orthognathic surgery) for Cosmetic purposes or for correction of malocclusion unrelated to a documented functional impairment are excluded.
G. Benefits will not be provided for Cosmetic surgery (except as specifically provided for Reconstructive Breast Surgery and Reconstructive Surgery and services for cleft lip or cleft palate or both, as listed above) or other services primarily intended to correct, change or improve appearances.
H. Treatment rendered by a health care provider who is a member of the Member's family (parents, Spouse, domestic partner, brothers, sisters, and children).
I. Any Prescription Drugs obtained and self-administered by the Member for outpatient use unless the Prescription Drug is specifically covered under the Evidence of Coverage. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility except as otherwise provided in this Description of Covered Services. Benefits for Prescription Drugs may be available through a rider attached to the Evidence of Coverage.
J. All non-Prescription Drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services or the Prescription Drug Benefits Rider attached to this Evidence of Coverage. Over-the-Counter means any item or supply, as determined by CareFirst BlueChoice, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".
K. Voluntary sterilization of male Members and services to reverse voluntary, surgically induced infertility, such as a reversal of sterilization, for all Members.
L. All assisted reproductive technologies, including artificial insemination and intrauterine insemination, in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.
M. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; exercise programs; and use of passive or patient-activated exercise equipment other than Medically Necessary and approved Cardiac Rehabilitation and pulmonary rehabilitation programs.
N. Treatment for obesity, weight reduction, dietary control or commercial weight loss programs. This exclusion does not apply to:
    1. Surgical treatment for morbid obesity;
    2. Well child care visits for obesity evaluation and management;
    3. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
    4. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
    5. Office visits for the treatment of childhood obesity; and
    6. Professional Nutritional Counseling and Medical Nutrition Therapy.
O. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy or any other form of refractive keratoplasty.
P. Services furnished as a result of a referral prohibited by law.
Q. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst BlueChoice.
R. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
S. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.
T. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.
U. Coverage under this Evidence of Coverage does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:
    1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
    2. From any federal, state, county or municipal facility or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that Benefits are payable by the federal, state, county or municipal facility or other government agency and provided at no charge to the Member, but excluding Medicare benefits and Medicaid benefits.

    Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.
V. Private duty nursing.
W. Non-medical, health care provider services, including, but not limited to:
    1. Telephone consultations, except as provided for telemedicine services in Section 1.1.AA, failure to keep a scheduled visit, completion of forms (except for forms that may be required by CareFirst BlueChoice), copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.
    2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a health care provider.
X. Educational therapies intended to improve academic performance.
Y. Vocational rehabilitation and employment counseling.
Z. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact lenses may be available through a rider purchased by the group and attached to the Evidence of Coverage. This exclusion does not apply to evidence-informed preventive care and screenings, including oral and vision care, provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents.
AA. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).
BB. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
CC. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, drug therapy, and psychiatric treatment.
DD. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in Section 1.3,Organ and Tissue Transplants.
EE. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
FF. Services required solely for administrative purposes, for example: employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

Autism Spectrum Disorder. Coverage is not provided for:

A. Services delivered through school services.

Organ and Tissue Transplants. Coverage is not provided for:

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary, non-experimental skin grafts that are covered under the Evidence of Coverage.

B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice that are not for the recipient Member and a companion (or two (2) companions if the Member is under age eighteen (18)).
D. Services for a Member who is an organ donor when the recipient is not a Member.
E. Benefits will not be provided for donor search services.
F. Any service, supply or device related to a transplant that is not listed as a benefit in the Evidence of Coverage.

Inpatient Hospital Services. Coverage is not provided for:
A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
B. Non-medical items and convenience items, such as television and phone rentals, guest trays and laundry charges.
C. Except for covered Emergency Services and Maternity Care (including interhospital transfers for mothers and newborns as stated in Section 2), a hospital admission or any portion of a hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage. See Utilization Management Non-Compliance provision in the Schedule of Benefits for exclusion of services or limitation of benefits, if any, for failure to comply with Utilization Management requirements.
D. Private duty nursing.
E. Admissions to a facility that is a convalescent home, convalescent rest or nursing facilities, facilities primarily affording custodial, educational or rehabilitative care.

Home Health Services. Coverage is not provided for:
A. Private duty nursing.
B. Custodial Care.

Hospice Benefits. Coverage is not provided for:
A. Services, visits, medical equipment or supplies that are not included in CareFirst BlueChoice approved plan of treatment.
B. Financial and legal counseling.
C. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
D. Chemotherapy or radiation therapy, unless used for symptom control.
E. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.
F. Reimbursement for volunteer services.
G. Custodial Care, domestic or housekeeping services.
H. Meals on Wheels or similar food service arrangements.
I. Rental or purchase of renal dialysis equipment and supplies.
J. Private duty nursing.

Emergency Services and Urgent Care. Benefits for Emergency Services and Urgent Care will not be provided for:
A. Charges for services when the claims filing and notice procedures stated in Section 7 of the Evidence of Coverage have not been followed by the Member.
B. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by the Member's treating physician.

Medical Devices and Supplies. Coverage is not provided for:
A. Convenience items.
B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g., chair or dresser.
C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, e.g., exercycle or other physical fitness equipment.
D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g., parallel bars.
E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids, except for Hearing Aids for minors, as described in Section N, Hearing Aids for Minors, of this amendment. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.
H. Medical equipment/supplies of an expendable nature, except those specifically listed as Covered Medical Supplies in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.
I. Tinnitus maskers; purchase, examination, or fitting of hearing aids, except as described in the Hearing Aids for Minors section.
J. Related charges for handling, delivery, mailing and shipping, and taxes for Durable Medical Equipment.

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 4/15/2025)

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 14858 Lexington, KY 40512
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**.

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SUM7384-1P (09/25) ■ VA ■ Option MV6-S (Level Funding)

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 identification card. All others may call 1-855-258-6518 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.

ማሳሰቢያ (Amharic)፦ ይህ ማሳወቂያ ስለ ኢንሹራንስ ሽፋንዎ መረጃ ይዟል። ቁልፍ ቀኖችን ሊይዝ ይችላል እና በተወሰኑ የግዜ ገደቦች እርምጃ መውሰድ ሊኖርብዎ ይችላል። ይህን መረጃ እና እገዛ ያለ ምንም ወጪ በቋንቋዎ የማግኘት መብት አለዎት። አባላት በአባላት መታወቂያ ካርዳቸው ጀርባ ወዳለው ስልክ ቁጥር መደወል አለባቸው። ሌሎች በሙሉ ወደ 855-258-6518 በመደወል 0ን እንዲጫኑ እስኪጠየቁ ድረስ ምልልሱን መጠበቅ ይችላሉ። አንድ ወኪል ሲመልስ፣ የሚፈልጉትን ቋንቋ ይግለጹ እና ከአስተርጓሚ ጋር ይገናኛሉ።

انتبه (Arabic): يحتوي هذا الإشعار على معلومات حول تغطيتك التأمينية. قد يحتوي على تواريخ رئيسية وقد تحتاج إلى اتخاذ إجراء بحلول مو اعيد نهائية معينة. لديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. يجب ع ل ى الأعض اء الا ت ص ال بر قم الهـ ات ف الموجود ع لى ظهر ب طاقة هو ية العض و ية الخ ا ص ة بهم. يجب على الأعضاء الاتصال برقم الهاتف الموجود على ظهر بطاقة هو ية العضو ية الخاصة بهم. يمكن للآخرين الاتصال بالرقم 855-258-5618 والانتظار طوال الحوار حتى يُطلب منهم الضغط على الرقم 0. عندما يجيبك أحد الوكلاء، حدد اللغة التي تحتاجها وسيتم توصيلك بمترجم فوري.

মনোযোগ দিন (Bengali): এই বিজ্ঞপ্তিতে আপনার বীমা কভারেজ সম্পর্কে তথ্য রয়েছে। এতে গুরুত্বপূর্ণ তারিখগুলি থাকতে পারে এবং আপনাকে হয়ত নির্দিষ্ট সময়সীমার মধ্যে পদক্ষেপ নিতে হতে পারে। আপনার ভাষায় বিনামূল্যে এই তথ্য এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদের তাদের সদস্য পরিচয়পত্রের পিছনে দেওয়া ফোন নম্বরে কল করা উচিত। অন্যরা 855-258-6518 নম্বরে কল করতে পারেন এবং 0 চাপ দেওয়ার জন্য অনুরোধ না করা পর্যন্ত সংলাপের জন্য অপেক্ষা করতে পারেন। যখন একজন এজেন্ট উত্তর দেবেন, তখন আপনার প্রয়োজনীয় ভাষাটি বলুন এবং আপনাকে একজন দোভাষীর সাথে সংযুক্ত করা হবে।

注意（Chinese）：此通知包含有關您的保險範圍的資訊。它可能包含關鍵日期，您可能需要在特定截止日期之前採取行動。您有權免費以您的語言獲取此資訊和協助。會員應撥打會員證背面的電話號碼。其他所有人可以撥打 855-258-6518 並等待對話框，直到提示按 0。當代理商接聽時，請說明您需要的語言，然後您將會與翻譯人員聯繫。

توجه (Farsi): این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه ای شما است. ممکن است شامل تاریخ های مهم باشد و لازم باشد تا مهلت‌های مشخصی اقدام کنید. شما حق دارید این اطلاعات و کمک را به زبان خود و به صورت رایگان دریافت کنید. اعضا باید با شماره تلفنی درج شده در پشت کارت شناسایی عضویت خود تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس بگیرند و منتظر بمانند تا دس تور د اده شود که عدد 0 را فشار دهند. ه نگ امی که یک نم اینده پاسخ د اد، زبان مورد نیاز خود را اعلام کنید تا به یک مترجم متصل شوید.

Attention (French): Le présent avis contient des informations essentielles relatives à votre couverture d’assurance. Il peut inclure des échéances importantes nécessitant une action de votre part dans un délai déterminé. Vous avez le droit d’obtenir ces informations ainsi qu’une assistance dans votre langue, et ce, sans frais. Les assurés sont invités à contacter le numéro figurant au verso de leur carte d’adhérent. Toute autre personne peut appeler le 855-258-6518 et patienter jusqu’à l’invitation à composer le 0. Lorsque votre appel sera pris en charge, indiquez la langue souhaitée afin d’être mis en relation avec un interprète.

Achtung (German): Dieser Hinweis enthält Informationen zu Ihrem Versicherungsschutz. Darin sind möglicherweise wichtige Termine aufgeführt und Sie müssen möglicherweise bis zu bestimmten Fristen Maßnahmen ergreifen. Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Mitglieder sollten die Telefonnummer auf der Rückseite ihres Mitgliedsausweises anrufen. Alle anderen können 855-258-6518 anrufen und den Dialog abwarten, bis sie aufgefordert werden, die 0 zu drücken. Wenn ein Agent antwortet, geben Sie die gewünschte Sprache an und Sie werden mit einem Dolmetscher verbunden.

ध्यान दें (Hindi): इस नोटिस में आपके बीमा कवरेज के बारे में जानकारी है। इसमें महत्वपूर्ण तिथियां हो सकती हैं और आपको निश्चित समय सीमा तक कार्रवाई करनी पड़ सकती है। आपको यह जानकारी और सहायता अपनी भाषा में निःशुल्क प्राप्त करने का अधिकार है। सदस्यों को अपने सदस्य पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और 0 दबाने का संकेत मिलने तक संवाद की प्रतीक्षा कर सकते हैं। जब कोई एजेंट उत्तर दे, तो वह भाषा बताएं जिसकी आपको आवश्यकता है और आपको दुभाषिया से जोड़ा जाएगा।

Leruoanya (Igbo): ọ́ kwà a nwere ozi bànyéré mkpuchi megide ihe mberede gị. Ọ nwere ike inwe ụbọchị ndi dị óké ḿkpà ma o nwekwara ike idị mkpa ka imee ihe tupu oge ụfọdụ agafee. Inwere ikike inweta ozi a ya na enyemaka na asụsụ gị n'akwụghị ụgwọ ọbụla. Ndi òtù ga akpọ ọnụọgụgụ ekwenti dị na àzú ́káàdị njirimara ndi òtù ha. Ndi ọ̀zọ́ nile nwere íke ịkpọ 855-258-6518 ma chere geruo mkpariịta ụka ruo mgbe asi ha pịa 0. Mgbe onye ozi zara,kwuo asụsụ ichọrọ, a ga ejikota gi na onye ntughari asụsụ.

Attenzione (Italian): Questa informativa contiene informazioni sulla copertura assicurativa. Potrebbe contenere date importanti e potrebbe essere necessario intraprendere azioni entro determinate scadenze. È possibile ottenere queste informazioni e assistenza nella propria lingua gratuitamente. I membri sono pregati di chiamare il numero di telefono riportato sul retro del proprio tesserino di riconoscimento. Tutti gli altri possono chiamare il numero 855-258-6518 e rimanere in linea fino a quando non viene richiesto di premere 0. Quando un operatore risponde, è necessario indicare la lingua desiderata per essere messi in contatto con un interprete.

주의 (Korean): 이 고지에는 귀하의 보험 적용 범위에 대한 정보가 포함되어 있습니다. 여기에는 주요 날짜가 포함되어 있을 수 있으며, 특정 마감일까지 조치를 취해야 할 수도 있습니다. 귀하는 비용 없이 귀하의 언어로 이러한 정보와 지원을 받을 권리가 있습니다. 회원은 회원증 뒷면에 있는 전화번호로 전화하시기 바랍니다. 회원이 아닌 모든 분들은 855-258-6518로 전화하여 안내 메시지가 끝날 때까지 기다렸다가 0을 눌러 주세요. 상담원이 통화에 응답했을 때, 필요한 언어를 말씀하시면 통역사와 연결됩니다.

Baa'ákonínízin (Navajo) Díí bee ił hane'í béeso nich'ą́ąh naa'nil bee nik'é'asti'í bódahólníihgo bee baa dahane'í biyi'. Dayoołkáłí dóó bee ida'ii'aahí háídíí shíį t'áá bich'į'jį' ha'át'íishíį ádadiiliiłígíí biyi'. Díí bee baa dahane'í dóó t'áá jiik'eh nizaad bee nika'e'eyeedgo bee ná'ahoot'i'. Bił hada'dít'éhí binaaltsoos nitł'izhí bee béédahóziní bąąh béésh bee hane'í námboo biká'ígíí yee dahalne' dooleeł. Nááná ła' 855-258-6518 yee dahalne' dóó yáłti'í biba' asdáago niléí ó bił adílchíid hodoo'niidjį'. Naalnishí haadzíį'go, saad nínízinígíí bee bił hodíilnih dóó ata' yáłti'í bich'į' ni'doolnih.

ध्यान दिनुहोस् (Nepali): यस सूचनामा तपाईंको बीमा कभरेजका बारेमा जानकारी समावेश छ। यसमा प्रमुख मितिहरू हुन सक्छन् र तपाईंले निश्चित समयसीमा भित्र कारबाही गर्नुपर्ने हुन सक्छ। तपाईंलाई यो जानकारी र सहयोग तपाईंको भाषामा निःशुल्क प्राप्त गर्ने अधिकार छ। सदस्यहरूले आफ्नो सदस्य परिचयपत्रको पछाडि रहेको फोन नम्बरमा कल गर्नुपर्छ। अरू सबैले 855-258-6518 मा कल गर्न सक्छन् र ० पुश गर्न प्रेरित नभएसम्म संवादको प्रतीक्षा गर्न सक्छन्। एजेन्टले जवाफ दिँदा, तपाईंलाई चाहिने भाषा बताउनुहोस् र तपाईंलाई दोभाषेसँग जोडिने छ।

Atenção (Portuguese): Este aviso contém informações sobre a cobertura do seu seguro. Ele pode conter datas importantes e você pode precisar tomar medidas dentro de determinados prazos. Você tem o direito de obter essas informações e assistência em seu idioma, sem nenhum custo. Os associados deverão ligar para o número de telefone indicado no verso do seu cartão de identificação de associado. Todos os outros podem ligar para 855-258-6518 e aguardar a mensagem até que seja solicitado a pressionar 0. Quando um agente atender, indique o idioma que você precisa e você será conectado a um intérprete.

Внимание (Russian): В настоящем уведомлении содержится информация о вашем страховом покрытии. Оно может содержать ключевые даты, и вам может потребоваться предпринять действия к определенным срокам. Вы имеете право получить эту информацию и помощь на своем языке бесплатно. Членам профсоюза следует звонить по номеру телефону, указанному на обратной стороне их удостоверения личности. Все остальные могут звонить по номеру 855-258-6518 и дождаться диалога, пока не появится предложение нажать 0. Когда агент ответит, назовите нужный вам язык, и вас соединят с переводчиком.

Fa'alogo (Samoan): O lenei fa'aaliga o lo'o iai fa'amatalaga i vaega e kava e lau inisiua. E ono aofia ai aso taua ma atonu e te mana‘omia ai le faia o se gaioiga i nisi taimi fa‘agata. E iai lau aia tatau e maua ai nei fa'amatalaga ma fesoasoani i lau gagana e aunoa ma se totogi. E tatau i sui auai ona vili le numera o le telefoni i tua o le latou pepa faamaonia. O isi uma e mafai ona vala'au i le 855-258-6518 ma fa'atali i le talanoaga se'ia fa'atonuina e oomi le 0. A tali mai se so'o upu, fa'ailoa atu le gagana e te mana'omia ona fa'afeso'ota'i lea o oe i se tagata fa'aliliu.

Pažnja (Serbian): Ovo obaveštenje sadrži informacije o vašem osiguranju. Može sadržati ključne datume i možda ćete morati da preduzmete akciju do određenih rokova. Imate prava da dobijete ove informacije i pomoć na vašem jeziku besplatno. Trebalo bi da članovi nazovu telefonski broj na poleđini svoje članske legitimacije. Svi ostali mogu pozvati 855-258-6518 i sačekati automat dok ne dobiju obaveštenje da pritisnu taster "0". Kada se agent javi, navedite jezik koji vam je potreban i bićete povezani s prevodiocem

Atención (Spanish): Este aviso contiene información sobre su cobertura de seguro. Puede contener fechas clave y es posible que deba tomar medidas antes de determinadas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin coste alguno. Los afiliados deben llamar al número de teléfono que figura en el reverso de su tarjeta de identificación del afiliado. Todos los demás pueden llamar al 855-258-6518 y esperar el diálogo hasta que se les solicite presionar 0. Cuando un agente responda, indique el idioma que necesita y se conectará con un intérprete.

Atensyon (Tagalog): Ang abisong ito ay naglalaman ng impormasyon tungkol sa saklaw ng iyong insurance. Maaaring naglalaman ito ng mga mahahalagang petsa at maaaring kailanganin mong kumilos ayon sa ilang partikular na mga deadline. May karapatan kang makuha ang impormasyong ito at tulong sa iyong wika nang walang bayad. Ang mga miyembro ay dapat tumawag sa numero ng telepono sa likod ng kanilang member identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa masabihan na pindutin ang 0. Kapag sumagot ang isang ahente, sabihin ang wikang kailangan mo at ikaw ay ikokonek sa isang tagapagsalin.

توجہ (Urdu): اس نو ٹس میں آپ کی انشور نس کور یج کے بارے میں معلومات شامل ہیں- اس میں کلیدی تاریخیں شامل ہو سکتی ہیں اور آپ کو کچھ آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑ سکتی ہے- آپ کو یہ معلومات اور مدد اپنی زبان میں، بغ یر کسی قیمت کے حاصل کرنے کا حق ہے- ممبر ان کو اپنے رکنیتی کار ڈ کی پشت پر دئے گئے فون نمبر پر کال کر نی چاہیے- باقی تمام لو گ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کا اشار ہ ملنے تک ڈائیلاگ پر انتظار کر نا چاہئیے- جب کو ئی ایجنٹ جو اب دتیا ہے تو اپنی مطلوبہ ز بان بتائیں اور آپ کا ر ابطہ ایک مترجم سے کر دیا جائے گا-

Lưu ý (Vietnamese): Thông báo này có chứa thông tin về phạm vi bảo hiểm của bạn. Nó có thể chứa các ngày quan trọng và bạn có thể cần phải hành động theo thời hạn nhất định. Bạn có quyền nhận thông tin và hỗ trợ này bằng ngôn ngữ của mình mà không mất phí. Các thành viên nên gọi đến số điện thoại ở mặt sau thẻ thành viên của mình. Những người khác có thể gọi đến số 855-258-6518 và chờ qua hội thoại cho đến khi được nhắc nhấn số 0. Khi có nhân viên trả lời, hãy nêu ngôn ngữ bạn cần và bạn sẽ được kết nối với phiên dịch viên.