



# Retiree Benefits Program Summary

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EFFECTIVE JULY 1, 2018—JUNE 30, 2019

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Important Resources	Member Services Telephone Number	Web or Claims Mailing Address	
CareFirst BlueCross BlueShield Medical Claims	800-628-8549	carefirst.com	Mailroom Administrator PO Box 14651 Lexington, KY 40512
Mental Health	800-972-0716		
CVS Caremark	800-241-3371		
CVS Mail Order Pharmacy	800-241-3371	carefirst.com/rx	
Delta Dental	800-932-0783	deltadentalins.com	PO Box 2105 Mechanicsburg, PA 17055-2105
State Retirement Agency	800-492-5909	sra.state.md.us	
Harford County Public Schools Benefits Office	410-588-5275		

# What's New for this Plan Year

*Changes for 2018–2019*

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Here is a look at what's changing for 2018:

## **New insurance premiums**

New 2018 insurance premiums are detailed on pages 2–3 of this guide. New premiums are effective July 1, 2018.

## **Reminder: Social Security Number required**

Due to new reporting requirement under the Affordable Care Act we are required to provide reports to the IRS. The IRS requires that the reports include each covered person's, including dependents, social security number (SSN), which is the primary identifier used by the IRS. Therefore we must have the SSN for all enrollees in an HCPS health plan.



# Medical and Dental Deductions— Retired Employees

Plan	Total Annual Premium	Retiree Monthly Premium at 100%	BOE % of Annual Cost	Retiree % of Annual Cost	Retiree Monthly Premium
<b>Medical Insurance Rates</b>					
<b>Medicare Supplemental</b>			<b>90%</b>	<b>10%</b>	
Supplemental 65	\$6,701.76	\$558.48	\$6,031.58	\$670.18	\$55.85
<b>HMO</b>			<b>95%</b>	<b>5%</b>	
Individual	\$10,378.68	\$864.89	\$9,859.75	\$518.93	\$43.24
Parent & Child	\$20,347.20	\$1,695.60	\$19,329.84	\$1,017.36	\$84.78
Employee & Spouse	\$24,298.44	\$2,024.87	\$23,083.52	\$1,214.92	\$101.24
Family	\$29,901.72	\$2,491.81	\$28,406.63	\$1,495.09	\$124.59
Supplemental 65	\$5,778.48	\$481.54	\$5,489.56	\$288.92	\$24.08
<b>Preferred Provider Core Plan</b>			<b>90%</b>	<b>10%</b>	
Individual	\$11,608.68	\$967.39	\$10,447.81	\$1,160.87	\$96.74
Parent & Child	\$25,089.00	\$2,090.75	\$22,580.10	\$2,508.90	\$209.08
Employee & Spouse	\$29,654.04	\$2,471.17	\$26,688.64	\$2,965.40	\$247.12
Family	\$32,143.80	\$2,678.65	\$28,929.42	\$3,214.38	\$267.87
<b>Triple Option</b>			<b>85%</b>	<b>15%</b>	
Individual	\$12,195.96	\$1,016.33	\$10,366.57	\$1,829.39	\$152.45
Parent & Child	\$26,357.40	\$2,196.45	\$22,403.79	\$3,953.61	\$329.47
Employee & Spouse	\$31,153.32	\$2,596.11	\$26,480.32	\$4,673.00	\$389.42
Family	\$33,769.20	\$2,814.10	\$28,703.82	\$5,065.38	\$422.12
<b>Dental Insurance Rates</b>					
<b>Delta Premier</b>			<b>90%</b>	<b>10%</b>	
Individual	\$259.92	\$21.66	\$233.93	\$25.99	\$2.17
Parent & Child	\$427.32	\$35.61	\$384.59	\$42.73	\$3.56
Employee & Spouse	\$547.44	\$45.62	\$492.70	\$54.74	\$4.56
Family	\$798.36	\$66.53	\$718.52	\$79.84	\$6.65
<b>Delta PPO</b>			<b>90%</b>	<b>10%</b>	
Individual	\$354.48	\$29.54	\$319.03	\$35.45	\$2.95
Parent & Child	\$581.88	\$48.49	\$523.69	\$58.19	\$4.85
Employee & Spouse	\$746.16	\$62.18	\$671.54	\$74.62	\$6.22
Family	\$1,087.80	\$90.65	\$979.02	\$108.78	\$9.07

Premium deductions will begin in July and coverage will be effective July 1, 2018.

# Medical and Dental Deductions— Retired Employees

Rates for 7/1/06 hires that retire on or after 8/1/16 with 10 years of service

Plan	Total Annual Premium	Retiree Monthly Premium at 100%	BOE % of Annual Cost	Retiree % of Annual Cost	Retiree Monthly Premium
<b>Medical Insurance Rates</b>					
<b>Medicare Supplemental</b>			<b>1/3</b>	<b>2/3</b>	
			<b>90%</b>	<b>10%</b>	
Supplemental 65	\$6,701.76	\$558.48	\$2,010.53	\$4,691.23	\$390.94
<b>HMO</b>			<b>95%</b>	<b>5%</b>	
Individual	\$10,378.68	\$864.89	\$3,286.58	\$7,092.10	\$591.01
Parent & Child	\$20,347.20	\$1,695.60	\$6,443.28	\$13,903.92	\$1,158.66
Employee & Spouse	\$24,298.44	\$2,024.87	\$7,694.51	\$16,603.93	\$1,383.66
Family	\$29,901.72	\$2,491.81	\$9,468.88	\$20,432.84	\$1,702.74
Supplemental 65	\$5,778.48	\$481.54	\$1,829.85	\$3,948.63	\$329.05
<b>Preferred Provider Core Plan</b>			<b>90%</b>	<b>10%</b>	
Individual	\$11,608.68	\$967.39	\$3,482.60	\$8,126.08	\$677.17
Parent & Child	\$25,089.00	\$2,090.75	\$7,526.70	\$17,562.30	\$1,463.53
Employee & Spouse	\$29,654.04	\$2,471.17	\$8,896.21	\$20,757.83	\$1,729.82
Family	\$32,143.80	\$2,678.65	\$9,643.14	\$22,500.66	\$1,875.06
<b>Triple Option</b>			<b>85%</b>	<b>15%</b>	
Individual	\$12,195.96	\$1,016.33	\$3,455.52	\$8,740.44	\$728.37
Parent & Child	\$26,357.40	\$2,196.45	\$7,467.93	\$18,889.47	\$1,574.12
Employee & Spouse	\$31,153.32	\$2,596.11	\$8,826.77	\$22,326.55	\$1,860.55
Family	\$33,769.20	\$2,814.10	\$9,567.94	\$24,201.26	\$2,016.77
<b>Dental Insurance Rates</b>					
<b>Delta Premier</b>			<b>90%</b>	<b>10%</b>	
Individual	\$259.92	\$21.66	\$77.98	\$181.94	\$15.16
Parent & Child	\$427.32	\$35.61	\$128.20	\$299.12	\$24.93
Employee & Spouse	\$547.44	\$45.62	\$164.23	\$383.21	\$31.93
Family	\$798.36	\$66.53	\$239.51	\$558.85	\$46.57
<b>Delta PPO</b>			<b>90%</b>	<b>10%</b>	
Individual	\$354.48	\$29.54	\$106.34	\$248.14	\$20.68
Parent & Child	\$581.88	\$48.49	\$174.56	\$407.32	\$33.94
Employee & Spouse	\$746.16	\$62.18	\$223.85	\$522.31	\$43.53
Family	\$1,087.80	\$90.65	\$326.34	\$761.46	\$63.46

Premium deductions will begin in July and coverage will be effective July 1, 2018.



# Be an Informed Health Care Consumer

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Most people are not accustomed to questioning their doctors about the insurance plans they accept, or the cost and medical necessity of a treatment. Knowing what questions to ask and when to ask them makes the process much easier and less stressful! Asking questions of your health care providers helps maintain both the cost and quality of your health care. So it's important for everyone, regardless of the health care option elected, to ask about the medical necessity of any treatment and if there are alternatives to consider.

## Here are some tips to help you become a good health care consumer

- Ask your provider or his/her business office if they accept your HCPS health care plan. If they do, evaluate what plan is best for you.
- Make notes in advance of your office visit about the things you want to ask your doctor. Keep a list of any symptoms you have had or are currently experiencing. Keep a list of the medications you take, whether prescriptions or over the counter. Share the list with all health care providers.
- Bring a spouse or friend along with you... chances are if you don't recall something that was said, he or she will!
- Bring a pad and pencil to the doctor's office; don't rely on your memory for everything!
- If your doctor uses a term that you do not understand, ask what it means and ask that it be spelled. Then, write it down and do some more research once you leave the office.
- Get a copy of any test results.
- If your doctor writes a prescription for you, ask your doctor and pharmacist about interactions with other drugs you may be taking or about side effects that you may experience. Remember, if you are taking any maintenance medications, request one prescription for a 30-day supply from a retail pharmacy and another prescription for mail-order. (for up to a 90-day supply, plus up to three refills).

- If you have access to the Internet, use it to learn about your medications or illnesses. The Internet has excellent information on many health-related subjects. One respected resource is [www.webmd.com](http://www.webmd.com). Ask your physician which web-sites they believe are valuable. Be sure to let your physician know your findings.
- Visit <https://share.hcps.org> or <https://hcp.benelogic.com> to link to our health care vendors' websites for more resources.
- Check the vendor websites for details on providers and other useful information.

## Help control the cost of health care and promote your well-being

On an almost-daily basis, the rising cost of health care is in the news. Advances in medical technology, expensive prescription drugs, consumer demand, and an aging population are just a few factors that impact health care costs. While some factors are beyond the control of the consumer, there are some things you can do to help keep health care costs down—both for you and for HCPS. Below are a few tips to help you become a wiser consumer of health care.

## Be an Informed Health Care Consumer

### Maintain a healthy lifestyle

Maintaining your own health can help to minimize your health care costs. The healthier you are, the less likely you are to need costly health care services—which means you spend less on copays, deductibles, and other medical costs. Eat right and get plenty of exercise.

### Get regular checkups

Get a regular annual checkup and/or physical exam, which can uncover early warning signs of potential health problems, and can also help you build a good relationship with your doctor.

### Save the emergency room for emergencies

Emergency room visits are two to three times more expensive than a visit to the doctor's office or an urgent care center. These ER visits are not only costly, but they can be unnecessarily stressful and time-consuming for you and your family if what you need is routine care. Urgent care facilities are available in the area and may be used for a variety of urgent health problems for a lower copay than the ER.

### Get regular screenings

Get regular screenings (e.g., mammograms) as recommended by your carrier and national organizations, such as the American Cancer Society.

### Visit a primary care provider before going to see a specialist

Primary care providers are usually family practitioners, general practitioners, internists or pediatricians. A primary care provider can treat many illnesses and injuries at a lower fee—in many cases at half the cost of a specialist's fee. For example, you don't necessarily need to see an orthopedic specialist for back pain. Primary care providers consider your overall health. They can advise you about disease prevention and how to stay healthy. They are also familiar with your personal health history and needs and have your medical records on file.

### Ask for Generic

When you need a prescription, ask your doctor to prescribe a generic, if one is available. Generics have the same chemical equivalency as brand-name drugs, and are held to the same standards by the Food and Drug Administration, but they cost less than brand-name drugs.

### Review your bills

Reviewing your health care bills can help you identify and prevent unnecessary health care costs. Here's what to look for to determine if a bill is correct:

- Does the date of service on the bill match the date you went to the doctor or the hospital?
- Did you receive all the services or procedures listed on the bill?
- Are you charged for more x-rays or lab work than you received? Call your provider to report any errors you spot on your bills or Explanation of Benefits forms (EOB's).
- Is your share of the cost correct? If not, call the insurance provider to discuss. If there is a referral involved, was the referral processed prior to the claim?

# Eligibility Guidelines for Medical & Dental

## Dependent children

Dependents are covered to the end of the month in which he or she reaches age 26.

## Ineligibility

Any ineligible dependents should be removed from your coverage as soon as they become ineligible. As a reminder we have included a few examples of ineligible dependents:

- Anyone who is not your legal spouse (ex-spouse, fiancé, common-law spouse, etc.)
- Dependents no longer covered by a court order
- Children of live-in partners
- Stepchildren following divorce from natural parent

## Dependent eligibility documentation requirements

Relationship to Employee	Eligibility Definition	Documentation for Verification of Relationship
Spouse	A person to whom you are legally married	Copy of Marriage certificate, copy of Social Security card and most recent Federal Tax Form (1040 or 1040A)* that identifies employee-spouse relationship (attach 1st page only & black out financial information) *If marriage occurred in current year, tax form is not needed
Dependent Child(ren)	Dependent children until the end of the month in which they reach age 26	<p><b>Natural Child—Provide a copy of Social Security card and one of the following:</b></p> <ul style="list-style-type: none"> <li>■ Copy of birth certificate showing employee’s name or</li> <li>■ Hospital verification of birth (must include child’s name, date of birth and parents’ names) or</li> <li>■ Certificate of live birth</li> </ul> <p><b>Step Child—Provide a copy of Social Security card and one of the above</b> showing employee’s spouse name; and a copy of marriage certificate showing the employee and parent’s name</p> <p><b>Legal Guardian, Adoption, Grandchild(ren), or Foster Child(ren)—</b>Copy of Final Court Ordered Custody with presiding judge’s signature and seal, or Adoption Final Decree with presiding judge’s signature and seal and a copy of Social Security card</p> <p><b>Child for whom the court has issued a QMSCO—</b>A copy of the Qualified Medical Child Support Order and a copy of Social Security card</p>
Disabled Dependents	Unmarried dependent children over the age limit if: <ol style="list-style-type: none"> <li>1. They are dependent on you for primary financial support and maintenance due to a physical or mental disability,</li> <li>2. They are incapable of self-support, and</li> <li>3. The disability existed before reaching age 26 or while covered under the plan.</li> </ol>	Copy of Social Security disability award (if a disability ruling by Social Security is pending, include a current copy of the application for disability) <b>and</b> Federal Tax Return for year just filed <b>and</b> copy of Social Security card <b>and</b> Completed Disability Form (Request from Benefits Office)



# BlueChoice HMO Open Access

*An HMO plan with no referrals required*

With a BlueChoice HMO Open Access plan, your primary care provider (PCP) provides preventive care and works with you to find specialty care using a large network of CareFirst BlueChoice specialists. However, unique to this plan is its Open Access feature which allows you to visit specialists directly without needing a referral from your PCP.

## Benefits of BlueChoice HMO Open Access

- Choose from more than 37,000 providers, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- HMO plans encourage you to establish a relationship with your PCP for consistent, quality care.
- No PCP referral required to see a specialist.
- Receive comprehensive coverage for preventive health care visits at no cost.
- Avoid the unwelcome surprise of high medical costs with predictable copays and deductibles (if applicable).
- Save time—you don't have to file a claim when you receive care from a CareFirst BlueChoice provider.
- Avoid balance billing when you receive care from a CareFirst BlueChoice provider.
- Access the Away from Home Care® program to enjoy plan benefits if you're out of the area for at least 90 days.

## How your plan works

Establishing a relationship with one provider is the best way for you to receive consistent, quality health care. When you enroll in a BlueChoice HMO Open Access plan, you will select a PCP to manage your primary medical care. Make sure you select a PCP for not only yourself but each of your family members as well. Your PCP must participate in the CareFirst BlueChoice provider network and must specialize in either family practice, general practice, pediatrics or internal medicine.



To ensure you receive the highest level of benefits (and pay the lowest out-of-pocket cost), you should first call your PCP when you need care.

Your PCP will:

- Provide basic medical care.
- Prescribe any medications you need.
- Maintain your medical history.
- Work with you to determine when you should see a specialist.
- Assist you in the selection of a specialist, if needed.

While traditional HMO plans require you to obtain a written referral from your PCP before seeing a specialist, this plan has an Open Access feature, so you have direct access to CareFirst BlueChoice specialists without needing a written referral from your PCP. Make sure you only receive care from a CareFirst BlueChoice provider or you will not be covered, with the exception of emergency services and follow-up care after emergency surgery.

### Your benefits

#### Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the entire cost of services up to the amount of your deductible. Once your deductible is satisfied, your BlueChoice HMO Open Access coverage will become available to you. Some services do not require you to meet a deductible first.

If more than one person is covered under your plan, once the total deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements can vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Evidence of Coverage for detailed deductible information.

#### Step 2: Your plan will start to pay for services

After you satisfy your deductible (if applicable), your plan will start to pay for covered services, as long as you visit participating CareFirst BlueChoice providers and facilities. Please remember, depending on your particular plan, you may have to pay a copay or coinsurance when you receive care.

#### Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you pay during your benefit period. Should you ever reach your out-of-pocket maximum, CareFirst BlueChoice, Inc. will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Any amount you pay toward your deductible (if applicable) and most copays and/or coinsurance will count toward your out-of-pocket maximum.

If more than one person is covered under your BlueChoice HMO Open Access plan, once the total out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family). Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

### Laboratory services

To receive the maximum laboratory benefit from your BlueChoice HMO Open Access plan, you must use a LabCorp® facility for any laboratory services. Services performed at a facility that is not part of the LabCorp network may not be covered under your plan. Also, any lab work performed in an outpatient hospital setting will require a prior authorization from your PCP.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call 888-LAB-CORP (522-2677) or visit [www.labcorp.com](http://www.labcorp.com).

### Out-of-area coverage

Out-of-area coverage is limited to emergency or urgent care only. However, members and their covered dependents planning to be out of the CareFirst BlueChoice, Inc. service area for at least 90 consecutive days may be able to take advantage of a special program, Away from Home Care®.

This program allows temporary benefits through another Blue Cross and Blue Shield affiliated HMO. It provides coverage for routine services and is perfect for extended out-of-town business or travel, semesters at school or families living apart. For more information on Away from Home Care, please call Member Services at the phone number listed on your identification card.

# Away From Home Care<sup>®</sup>

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.
- 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.

# Triple Option

## Open Access

Triple Option Open Access offers you the freedom to visit any provider you wish. You have the flexibility to choose from both in- and out-of-network providers with your out-of-pocket costs determined by your choice. There is no need to choose a primary care provider (PCP) or to obtain a referral before visiting a specialist.

### Benefits of the Triple Option Open Access plan

- The ability to visit providers from either our BlueChoice Network, CareFirst PPO Network, National PPO Network or out-of-area providers
- No PCP referral required to see a specialist
- Receive coverage for preventive health care services at no cost
- Take your health care benefits with you—across the country and around the world

### How your plan works

With the Triple Option Open Access plan, you can visit any provider of your choosing. Your out-of-pocket costs are determined by who you decide to see.

**In-network benefits** provide a higher level of coverage, meaning you have lower out-of-pocket costs. **Out-of-network benefits** provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose.

Your in- and out-of-network benefits are organized into three levels of coverage.

**Level 1:** For your lowest and most predictable in-network out-of-pocket costs, choose a BlueChoice provider. You can visit any of the 37,000 BlueChoice providers within Maryland, Washington, D.C. and Northern Virginia. Visit our online provider directory at [carefirst.com/doctor](https://carefirst.com/doctor) to locate in-network providers.

Remember, you have direct access to CareFirst BlueChoice specialists without needing to obtain a referral from your PCP.

**Level 2:** To receive level 2 in-network benefits, visit a provider who participates in either:

- The CareFirst PPO Network (MD, DC and Northern Virginia), or
- The national BlueCard® PPO network of over 600,000 doctors and 61,000 hospitals.

To locate a PPO provider, visit [carefirst.com/doctor](https://carefirst.com/doctor).

**Level 3:** This level of coverage is out-of-network and offers you the most flexibility. In exchange for a lower level of coverage, you have the freedom to seek care from any provider you choose.

If you receive services from a provider who does not participate in any of the networks listed above, you may have to:

- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a higher deductible and/or coinsurance amount

In general, out-of-network providers do not have an agreement with CareFirst to accept the allowed benefit as payment in full for their services. Therefore, if you receive services from a non-participating provider, you may be balance billed based on the provider's actual charge.

Certain services under this level of coverage require you to meet a deductible. Check your benefits enrollment guide for details. When applicable, you are responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied,

## Triple Option

your coverage will become available. Depending on the service, you may have to pay a copay or coinsurance when you receive care.

### Laboratory services

To receive the maximum laboratory benefit from your Triple Option plan, you must use a LabCorp® facility for any laboratory services. Lab services at any other independent lab will be processed at Level 2 or Level 3 based on the laboratory's network status. Also, any lab work performed in an outpatient hospital setting will require a prior authorization.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call 888-LAB-CORP (522-2677) or visit [www.labcorp.com](http://www.labcorp.com).

### Hospital authorization

In-network providers will obtain any necessary admission authorizations for in-area (Maryland, Washington, D.C. and Northern VA). You will be responsible for obtaining authorization for services provided by out-of-network and out-of-area admissions. Call toll-free 888-PRE-AUTH (773-2884).

### Examples:

Inpatient Hospital Stay Claim					
Provider Status/ Benefit Level	Amount Charged	Allowed Benefit	CareFirst BlueCross BlueShield Pays	Member Pays	
BlueChoice/Level 1	\$14,800	\$8,160	\$8,160	\$0	
PPO/Level 2	\$14,800	\$9,180	\$9,180	\$0	
Participating*/Level 3	\$14,800	\$10,200	\$8,000	\$2,200	\$200 deductible then 20% AB (\$2,000)
Non-participating*/ Level 3	\$14,800	\$10,200	\$8,000	\$6,800	\$200 deductible then 20% AB (\$2,000 + balance to charge \$4,600)
Primary Care Provider Office Visit					
Provider Status/ Benefit Level	Amount Charged	Allowed Benefit	CareFirst BlueCross BlueShield Pays	Member Pays	
BlueChoice/Level 1	\$150	\$64	\$54	\$10	Office Visit copay
PPO/Level 2	\$150	\$72	\$57	\$15	Office Visit copay
Participating*/Level 3	\$150	\$80	\$0	\$80	Deductible applied
Non-participating*/ Level 3	\$150	\$80	\$0	\$150	\$80 deductible plus balance to charge \$70
Maternity Provider Delivery Charge					
Provider Status/ Benefit Level	Amount Charged	Allowed Benefit	CareFirst BlueCross BlueShield Pays	Member Pays	
BlueChoice/Level 1	\$5,864	\$3,616	\$3,616 (100% AB)	\$0	
PPO/Level 2	\$5,864	\$4,068	\$4,068 (100% AB)	\$0	
Participating*/Level 3	\$5,864	\$4,520	\$3,616	\$904	Deductible was already met 20% AB
Non-participating*/ Level 3	\$5,864	\$4,520	\$3,616	\$2,248	Deductible was met 20% AB \$904 + difference to charge \$1344

\* Participating Provider—A physician or other provider who has signed an agreement with CareFirst BlueCross BlueShield to accept the Allowed Benefit as payment in full.

# Preferred Provider Organization

*A referral-free go anywhere health plan*

Designed for today's health conscious and busy families, the Preferred Provider Organization (PPO) plan offers one less thing to worry about during your busy day. Your PPO plan gives you the freedom to visit any provider you wish—any time you wish. This means you can receive care from the provider of your choice without ever needing to select a primary care provider (PCP) or obtaining a PCP referral for specialist care.

## Benefits of PPO

- Access to our network of more than 43,000 doctors, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- No primary care provider required, and no referrals to see a specialist.
- Take your health care benefits with you—across the country and around the world.
- Receive coverage for preventive health care visits at no cost.
- Avoid balance billing when you receive care from a preferred provider.
- Enjoy the freedom to visit providers outside of the PPO network and still be covered but with a higher out-of-pocket cost.

## How your plan works

### In-network vs. out-of-network coverage

The amount of coverage your PPO plan offers depends on whether you see a provider in the PPO network (preferred provider). You will always receive a higher level of benefits when you visit a preferred provider. However, the choice is entirely yours. That's the advantage of a PPO plan.

**In-network benefits** provide a higher level of coverage. This means you have lower out-of-pocket costs when you choose a preferred provider. If you are out of the CareFirst BlueCross BlueShield (CareFirst) service area, you have the freedom to select any provider that participates with a Blue Cross and Blue Shield PPO plan across the country and receive benefits at the in-network level.



No referrals. No PCPs.  
Coverage everywhere.



## Preferred Provider Organization

**Out-of-network benefits** provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose. If you receive services from a provider outside of the PPO network (non-preferred provider), you may have to:

- Pay the provider's actual charge at the time you receive care.
- File a claim for reimbursement.
- Satisfy a higher deductible and/or coinsurance amount.

### Hospital authorization/ Utilization management

Preferred providers will obtain any necessary admission authorizations for in-area covered services. You will be responsible for obtaining authorization for services provided by non-preferred providers and out-of-area admissions. Call toll-free 888-PRE-AUTH (773-2884).

### Your benefits

#### Step 1: Meet your deductible

You will be responsible for the entire cost of your medical care up to the amount of your deductible for services where the deductible applies. Once your deductible is satisfied, your PPO coverage will become available to you.

Following is a list of services for which the deductible does NOT apply in-network:

- Preventive care, including well child care, routine physical exam, routine gynecological exam and routine mammography
- Office Visits for Illness
- Physical, Speech and Occupational Therapy
- Chiropractic Care
- Office Visits for Mental Health and Substance Abuse

PPO CORE members will have a different deductible amount for in-network vs. out-of-network benefits. However, any amount applied to your in-network deductible will also count towards your out-of-network deductible and vice versa.

If more than one person is covered under your PPO plan, once the family deductible amount is satisfied, the plan will start to make payments for

everyone covered. Deductible requirements vary based on your coverage level (e.g. individual, family). Members should refer to their Evidence of Coverage for detailed deductible information.

#### Step 2: Your PPO plan will start to pay for services

After you satisfy your deductible, your PPO plan will start to pay for covered services. The level of those benefits will depend on whether you see preferred or non-preferred providers.

#### Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Should you reach your out-of-pocket maximum, CareFirst will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Any amount you pay toward your deductible and most copays and/or coinsurance will count toward your out-of-pocket maximum.

You will have a different out-of-pocket maximum for in-network vs. out-of-network benefits. However, deductible amounts applied to your in-network out-of-pocket maximum will also count toward your out-of-network out-of-pocket maximum and vice versa.

If more than one person is covered under your PPO plan, once the total out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family) as well as the specific PPO plan selected. Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

#### Out-of-area coverage

You have the freedom to take your health care benefits with you—across the country and around the world. BlueCard® PPO, a program from the Blue Cross and Blue Shield Association, allows you to receive the same health care benefits when receiving care from a BlueCard® preferred provider while living or traveling outside of the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia). The BlueCard® program includes more than 6,100 hospitals and 600,000 other health care providers nationally.

# 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.



As always, go directly to the nearest hospital in an emergency.

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](http://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.

### Around the world

Like your passport, you should always carry your ID card when you travel or live outside the U.S. The BlueCard Worldwide program 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 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 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 Global Core Service Center. The claim form is available online at [bcbs.globalcore.com](https://bcbs.globalcore.com).
- To find a BlueCard provider outside of the U.S. visit [bcbs.com](https://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](https://bcbs.com) to find providers within the U.S. and around the world.

# Find a Doctor, Hospital or Urgent Care

*carefirst.com/doctor*

It's easy to find the most up-to-date information on health care providers and facilities who participate with CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively CareFirst).

Whether you need a doctor, nurse practitioner or health care facility, **carefirst.com/doctor** can help you find what you're looking for based on your specific needs.

You can search and filter results by:






- Provider name
- Gender
- Provider specialty
- Accepting new patients
- Distance
- Language
- Zip code
- Group affiliations
- City and state



To view personalized information on which doctors are in your network, log in to *My Account* on your computer, tablet or smartphone and click *Find a Doctor* from the Doctors tab or the Quick Links.

## Find a Doctor

What type of care are you looking for?

 <p><b>Medical</b></p> <p>Search for a doctor or facility by name or provider type</p>	 <p><b>Mental Health</b></p> <p>Search for a behavioral health/substance abuse provider or facility</p>	 <p><b>Dental</b></p> <p>Search for a dentist or facility for dental care</p>	 <p><b>Vision</b></p> <p>Search for a provider or facility for vision care</p>	 <p><b>Pharmacy</b></p> <p>Locate a pharmacy near you home or office</p>
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# CareFirst Prescription Drug Program

*For BlueChoice HMO, Triple Option and PPO Plans*

Your pharmacy benefit program is now administered by CVS Caremark. This program is based on the CareFirst Preferred Drug List, formerly formulary, that encourages the use of Generic drugs and certain Brand drugs. You pay a different copay depending on whether you choose a Generic drug, a Brand drug on the Preferred Drug List, or a Non-preferred Brand drug. Always remember to talk to your doctor about using Preferred drugs that can save you money. You and your doctor should check your Preferred Drug List before you receive a prescription.

## Retail program

The retail program provides a 34-day or less supply of medication when purchased at a participating retail pharmacy. Present your prescription drug identification card at any participating pharmacy and pay the appropriate copayment for your medication. Maintenance medication when purchased at a participating pharmacy is dispensed up to a 90-day supply for one copay for Triple Option members, two copays for PPO CORE Plan members and three copays for HMO Plan members.

## Mail order service prescription program

Your mail order prescription drug program is administered by CVS Caremark. The Mail Order Service Prescription Program is a special added feature to your CareFirst Plan. For those who regularly take one or more types of maintenance medication, this service provides a convenient, inexpensive way for you to order these medications and have them delivered at home.

For Triple Option, you can order up to a 90-day supply of maintenance medication for the \$20 copayment. For PPO CORE, you can order up to a 90-day supply of maintenance medication for 1 times the required copayment (\$10/25/40). For HMO, you can order a 90-day supply of maintenance medication for 2 times the copayment (\$5/15/35). The copayment cannot be reimbursed through your Medical Benefits Plan.



## CareFirst Prescription Drug Program

Medications are delivered to your home postage paid via UPS or First Class U.S. Mail.

If you have any questions regarding this prescription service, call the CareFirst Pharmacy Services toll-free telephone number Monday through Friday 8 a.m. – 8 p.m. and Saturday 8 a.m. – 12 p.m. at 800-241-3371.

### Refill guidelines

Refills will not be authorized on any prescriptions until 25% or less of the original quantity is remaining in your possession (75% has been used).

### Vacation supply

Since your program has a nationwide network, in most cases there are several area participating pharmacies available when on vacation. You may obtain a written prescription from the physician prior to leaving and obtain a list of pharmacies in the area in which you will be traveling.

- If you are traveling out of the country for less than one month, call CareFirst Pharmacy Services at 800-241-3371 to receive authorization for an additional short-term supply.
- For additional quantities greater than one month, please contact CareFirst Member Services using the number on your ID card.

Please call no less than 10 days in advance of your departure date to request the additional supply.

### Non-participating pharmacy

If a pharmacy is non-participating you will be required to pay the full cost of the prescription at the time of purchase. Claims for these prescriptions should be submitted on the appropriate claim form.

CVS Caremark claim forms are available on the CareFirst website at [carefirst.com](http://carefirst.com) or you can contact CareFirst Pharmacy Services at 800-241-3371.

### Generic drug appeal process when medically necessary

1. When members cannot take the Generic medication due to medical reasons, the member's physician would be required to supply medical justification for prescribing the Brand medication.
2. The member's physician must initiate the request process.
3. Requests will be forwarded directly to CVS Caremark. Requests will be reviewed and turned around within 2 business days when submitted during business hours.
4. Once the appeal is received and approval is given by CVS Caremark, the prescribing physician and the pharmacy are provided notification of the appeal, and the pharmacy will be requested to reprocess the claim.
5. The approval of a Brand medication will be valid for 12 months from the original fill date of the medication.



# CareFirst Drug Program Summary of Benefits

Plan Feature	BlueChoice HMO Open Access	Triple Option	PPO CORE	Description
<b>Deductible</b>	None	None	None	Your benefit does not have a deductible.
<b>Family Deductible Maximum</b>	None	None	None	Your benefit does not have a family deductible maximum.
<b>Preventive Drugs</b> (up to a 34-day supply)	\$0 (not subject to deductible)	\$0 (not subject to deductible)	\$0 (not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List.*
<b>Oral Chemotherapy &amp; Diabetic Supplies</b> (up to a 34-day supply)	\$0	\$0	\$0	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
<b>Generic Drugs (Tier 1)</b> (up to a 34-day supply)	\$5	\$10	\$10	Generic drugs are covered at this copay level.
<b>Preferred Brand Drugs (Tier 2)</b> (up to a 34-day supply)	\$15	\$25	\$25	All preferred brand drugs are covered at this copay level.
<b>Non-Preferred Brand Drugs (Tier 3)</b> (up to a 34-day supply)	\$35	\$40	\$40	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
<b>Maintenance Copays</b> (up to a 90-day supply)				Maintenance drugs of up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or retail pharmacy.
Mail Order:				
Generic	\$10	\$20	\$10	
Preferred	\$30	\$20	\$25	
Non-preferred	\$70	\$20	\$40	
Retail:				
Generic	\$15	\$10	\$20	
Preferred	\$45	\$25	\$50	
Non-preferred	\$105	\$40	\$80	
<b>Prior Authorization</b>	Some prescription drugs require Prior Authorization. Prior Authorization is a tool used to ensure that you will achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call (800) 294-5979 to begin the prior authorization process. For the most up-to-date prior authorization list, visit the prescription drug website at <a href="http://carefirst.com/rx">carefirst.com/rx</a> .			
<b>Mandatory Generic Substitution</b>	If you choose a Non-preferred Brand drug (Tier 3) instead of its Generic equivalent, you will pay the highest copay plus, the difference in cost between the Non-preferred Brand drug and the Generic. If a Generic version is not available, you will only pay the copay.			

# Prescription Drug Program

*A total prescription for health*

Prescription drugs are an integral part of high-quality health care. The prescription benefits your employer is offering give you an affordable and convenient way to make the best decisions when it comes to your prescriptions.

## Your prescription benefits

As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (CareFirst) member, you'll have access to:

- A nationwide network of more than 69,000 participating pharmacies
- Nearly 5,000 covered drugs
- Mail Service Pharmacy, a convenient and fast option to refill your prescriptions through home delivery
- Coordinated medical and pharmacy programs to help improve your overall health and reduce costs

## Keeping you informed

Together with our pharmacy benefit manager, CVS Caremark<sup>®,\*</sup> we keep you informed about your prescription drug coverage and provide you with periodic updates about your plan through targeted mailings and phone calls. Take the call and/or review your mailed notices to learn about lower-cost drug alternatives, possible safety concerns, drug tier changes and more.

## Online tools and resources

To get the most from your prescription drug plan, you need to stay informed. Our easy-to-use, interactive tools and resources are available 24/7. Visit [carefirst.com/rx](https://carefirst.com/rx) to see if a drug is covered, find a pharmacy, learn how drugs interact with each other and get more information about medications. You can access even more tools and resources once you're a member through *My Account* by selecting *Drug and Pharmacy Resources* under *Quick Links*.



\* CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst members.

### Understanding your formulary

A formulary is a list of covered prescription drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals who make sure the drugs on the formulary are safe and clinically effective. The prescription drugs found on the CareFirst Formulary (drug list) are divided into tiers. These tiers include zero-dollar cost share, generics, preferred brand and non-preferred brand drugs. Your cost share is determined by the tier the drug falls into.

Drug tier	Description
<b>Tier 0: \$0 Drugs</b>	<ul style="list-style-type: none"> <li>Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor.</li> </ul>
<b>Tier 1: Generic Drugs</b> \$	<ul style="list-style-type: none"> <li>Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.</li> <li>Generic drugs generally cost less than brand-name drugs.</li> </ul>
<b>Tier 2: Preferred Brand Drugs</b> \$\$	<ul style="list-style-type: none"> <li>Preferred brand drugs are brand-name medications that do not have a generic equivalent.</li> <li>They are chosen for their cost-effectiveness to alternatives.</li> <li>Your cost share will be more than generic drugs but less than non-preferred brand drugs.</li> <li>If a generic drug becomes available, the preferred brand drug will be moved to the non-preferred brand tier.</li> </ul>
<b>Tier 3: Non-Preferred Brand Drugs</b> \$\$\$	<ul style="list-style-type: none"> <li>Non-preferred brand drugs often have a generic or preferred brand drug option where your cost share will be lower.</li> </ul>

Note: If the cost of your drug is less than your copay or coinsurance, you only pay the cost of the drug. Once you meet your deductible (if applicable to your plan), you may pay a different copay or coinsurance for drugs depending on the drug tier. Some drugs may not be covered based on your plan. There is an exception process if you need an excluded drug to be covered for medical necessity reasons. Check your benefit summary or enrollment materials for specific plan information. Once you are a member, you can view specific cost-share information in *My Account*.

### Preferred Drug List

CareFirst's Preferred Drug List includes generic and preferred brand drugs selected for their quality, effectiveness and safety by the CVS Caremark national Pharmacy and Therapeutics (P&T) committee. By using the CareFirst Preferred Drug List, you can work with your doctor or pharmacist to make safe and cost-effective decisions to better manage your health care and out-of-pocket costs.

Non-preferred drugs aren't included on the Preferred Drug List; they are still covered but at the highest cost share. Also, some drugs on the Preferred Drug List may not be covered based on your plan. To see your full formulary, go to [carefirst.com/rx](http://carefirst.com/rx).

## Prescription Drug Program

### Prescription guidelines

Some medications are only intended to be used in limited quantities; others require that your doctor obtain prior authorization through CareFirst before they can be filled. These drug guidelines are indicated on the formulary found at [carefirst.com/rx](https://www.carefirst.com/rx).

- **Quantity limits** have been placed on the use of selected drugs for quality or safety reasons. Limits may be placed on the amount of the drug covered per prescription or for a defined period of time.
- **Prior authorization** is required before you fill prescriptions for certain drugs. Your doctor must obtain approval from CareFirst before these drugs are covered.
- **Step therapy** asks that you try lower-cost, equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Prior to getting the higher-cost alternative, your doctor must receive approval from CareFirst.

### Two ways to fill

#### Retail pharmacies

With access to more than 69,000 pharmacies across the country, you can visit [carefirst.com/rx](https://www.carefirst.com/rx) and use our *Find a Pharmacy* tool to locate a convenient participating pharmacy. Be sure to take your prescription and member ID card with you when filling prescriptions.

#### Mail Service Pharmacy

Mail Service Pharmacy is a convenient way to fill your prescriptions, especially for refilling drugs taken frequently. You can register three ways—online through *My Account*, by phone or by mail. Once you register for Mail Service Pharmacy you'll be able to:

- Refill prescriptions online, by phone or by email
- Choose your delivery location
- Consult with pharmacists by phone 24/7
- Schedule automatic refills
- Receive email notification of order status
- Choose from multiple payment options

### Ways to save

Here are some ways to help you save on your prescription drug costs.

- **Use generic drugs**—generic drugs can cost up to 80 percent less than their brand-name counterparts. Made with the same active ingredients as their brand-name counterparts, generics are also equivalent in dosage, safety, strength, quality, performance and intended use.
- **Use drugs on the Preferred Drug List**—the Preferred Drug List identifies generic and preferred brand drugs that may save you money.
- **Use maintenance medications**—maintenance medications are drugs you take regularly for ongoing conditions such as diabetes, high blood pressure or asthma. You can get up to a three-month supply of your maintenance medications for the cost of two copays through any pharmacy in the network, including through mail order.
- **Use mail order**—by using our Mail Service Pharmacy you get the added convenience of having your prescriptions delivered right to your home. Plus, if you pay a coinsurance for your maintenance drugs, the overall cost of the drug may be less expensive through mail order, reducing your out-of-pocket costs.

## Prescription Drug Program

### Care management programs

Together with CVS Caremark, our pharmacy benefit manager, we offer care management programs and tools designed to improve your health while lowering your overall health care costs.

### Specialty Pharmacy Coordination Program

The Specialty Pharmacy Coordination Program provides personalized care for our members with certain chronic conditions, like rheumatoid arthritis or cancer, requiring the use of specialty drugs. For certain chronic conditions, you will receive enhanced one-on-one support with a registered nurse and dedicated clinical team who will coordinate care with your doctor.

The program provides:

- 24-hour pharmacist assistance
- Injection training coordination
- Educational materials for your specific condition
- Drug interaction monitoring and review
- Drugs mailed to your home or office, or available for pick up at any CVS retail pharmacy
- Refill reminders

### Comprehensive Medication Review

When you are taking multiple drugs to treat a medical condition, it can be overwhelming. The Comprehensive Medication Review program can connect you with a CVS Caremark pharmacist who will review your drugs and talk to your doctor about dosages, duration and any other pertinent issues. The pharmacist will work with your doctor to evaluate opportunities to:

- Identify possible drug interactions
- Improve drug adherence
- Reduce gaps in care
- Eliminate duplications in drug therapy

The program works with your doctor to ensure that you are not only taking the best drugs to manage your conditions, but you are also able to take your drugs as prescribed.

### Medication Therapy Management Program

Taking medications as prescribed not only helps improve your health but can also reduce your health care costs. CareFirst's Medication Therapy Management program is designed to help you get the best results from your drug therapy.

We review pharmacy claims for opportunities to:

- Save you money
- Support compliance with medications
- Improve your care
- Ensure safe use of high-risk medications

When opportunities are identified, "Drug Advisories" will be communicated to either you and/or your doctor regarding your drug therapy. Through our Pharmacy Advisor program, you may also have the opportunity to speak one-to-one with a pharmacist, who can answer questions and help you manage your prescription drugs.

Should you have any questions about your prescription benefits, please contact CareFirst Pharmacy Services at 800-241-3371.

# BlueVision

*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](http://carefirst.com) 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, the benefit covers one pair of eyeglasses or a supply of contact lenses per benefit period at a discounted price<sup>1</sup>.

### Mail order replacement contact lenses

[DavisVisionContacts.com](http://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?  
Visit [carefirst.com](http://carefirst.com) or call  
800-783-5602.

<sup>1</sup> As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.



# BlueVision Summary of Benefits

(12-month benefit period)

In-network	You Pay
<b>EYE EXAMINATIONS<sup>1</sup></b>	
Routine Eye Examination with dilation (per benefit period)	\$10
<b>FRAMES<sup>1,2</sup></b>	
Priced up to \$70 retail	\$40
Priced above \$70 retail	\$40, plus 90% of the amount over \$70
<b>SPECTACLE LENSES<sup>2</sup></b>	
Single Vision	\$35
Bifocal	\$55
Trifocal	\$65
Lenticular	\$110
<b>LENS OPTIONS<sup>2,3</sup> (add to spectacle lens prices above)</b>	
Standard Progressive Lenses	\$75
Premium Progressive Lenses (Varilux®, etc.)	\$125
Ultra Progressive Lenses (digital)	\$140
Polarized Lenses	\$75
High Index Lenses	\$55
Glass Lenses	\$18
Polycarbonate Lenses	\$30
Blended invisible bifocals	\$20
Intermediate Vision Lenses	\$30
Photochromic Lenses	\$35
Scratch-Resistant Coating	\$20
Standard Anti-Reflective (AR) Coating	\$45
Ultraviolet (UV) Coating	\$15
Solid Tint	\$10
Gradient Tint	\$12
Plastic Photosensitive Lenses	\$65
<b>CONTACT LENSES<sup>1,3</sup></b>	
Contact Lens Evaluation and Fitting	85% of retail price
Conventional	80% of retail price
Disposable/Planned Replacement	90% of retail price
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices
<b>LASER VISION CORRECTION<sup>3</sup></b>	
Up to 25% off allowed amount or 5% off any advertised special <sup>4</sup>	

- <sup>1</sup> At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.
- <sup>2</sup> 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.
- <sup>3</sup> Special lens designs, materials, powers and frames may require additional cost.
- <sup>4</sup> 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. Benefits issued under policy form numbers: MD/BC-OOP/VISION (R. 6/04) • DC/BC-OOP/VISION (R. 6/04) • VA/BC-OOP/VISION (R. 6/04)

# Medical Benefits Options

Effective for plan year July 1, 2018–June 30, 2019

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
	<b>DEDUCTIBLE—CONTRACT YEAR JULY 1–JUNE 30</b>	\$100 Individual / \$200 Family aggregate (does not apply to Rx benefits)
<b>MEDICAL OUT-OF-POCKET MAXIMUM</b>	None	\$1,200 Individual /\$2,400 Family (combined in- and out-of-network)
<b>LIFETIME MAXIMUM</b>	Unlimited	Unlimited
<b>HOSPITAL</b>		
Hospital Room/Semi-Private*	100% AB	365 days at 100% AB
Skilled Nursing Facility*	100% AB (limited to 60 days/contract year)	100% AB
Inpatient Rehabilitation*	100% AB (limited to 60 days/contract year)	100% AB
Outpatient Surgery	100% AB	100% AB
Emergency Care**	Emergency Room—\$50 copay, (waived if admitted) Urgent Care Center—\$30 copay	Emergency Room—\$50 copay, (waived if admitted) Urgent Care Center—\$15 copay
<b>PHYSICIAN SERVICES</b>		
Surgeon	100% AB	100% AB
Assistant Surgeon	100% AB	100% AB
Anesthesiologist	100% AB	100% AB
In-Hospital Medical	100% AB	100% AB
<b>MEDICAL SERVICES</b>		
Office Visits	\$10 PCP/\$15 Specialist copay	\$10 PCP/\$15 Specialist copay
Outpatient Facility	100% AB	100% AB
Outpatient Physician	\$10 PCP/\$15 Specialist copay	\$10 PCP/\$15 Specialist copay
Diagnostic X-rays	100% AB	100% AB
Radiation Therapy	\$15 Specialist copay	100% AB
Chemotherapy	\$15 Specialist copay	100% AB
Laboratory Tests	100% AB (LabCorp only)	100% AB (LabCorp only)
Allergy Testing	\$10 PCP/\$15 Specialist copay	100% AB
Allergy Treatment/Injections	\$10 PCP/\$15 Specialist copay	100% AB

AB = Allowed Benefit

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.

## Medical Benefits Options

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	Level 3 Participating and Non-participating Providers	In-network BlueCross BlueShield PPO Providers	Out-of-network Participating and Non-participating Providers
None	\$200 Individual \$400 Family aggregate (Deductible applies to all services unless otherwise noted.)	\$100 Individual / \$200 Family aggregate (Deductible applies to all services unless otherwise noted.)	\$300 Individual / \$600 Family aggregate (Deductible applies to all services unless otherwise noted.)
\$1,200 Individual / \$2,400 Family (combined in- and out-of-network)		\$2,400 Individual / \$4,800 Family (combined in- and out-of-network)	
		Unlimited	
365 days at 100% AB	365 days at 80% AB	365 days at 90% AB	365 days at 70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
Emergency Room—\$50 copay, (waived if admitted); Urgent Care Center—\$20 copay	Emergency Room—\$50 copay, (waived if admitted); Urgent Care Center—80% AB	Emergency Room—\$75 copay (waived if admitted) Urgent Care Center—\$20 copay	Emergency Room—\$75 copay (waived if admitted) Urgent Care Center—70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	100% AB (no deductible)	90% AB	90% AB
100% AB	100% AB (no deductible)	90% AB	90% AB
100% AB	80% AB	90% AB	70% AB
\$15 PCP/\$20 Specialist copay	80% AB	\$15 PCP / \$20 Specialist copay (no deductible)	70% AB
100% AB	80% AB	100% AB	70% AB
\$25 copay	80% AB	\$25 copay	70% AB
100% AB	100% AB inpatient, waive deductible 80% AB outpatient	90% AB	90% AB inpatient / 70% AB office
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	100% AB inpatient (no deductible) 80% AB outpatient	90% AB	90% AB inpatient / 70% AB office
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB

\* Precertification required or penalties may apply.

\*\* Overnight stays for observation are not considered an inpatient admission.

## Medical Benefits Options

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
	<b>MEDICAL SERVICES (CONTINUED)</b>	
Physical, Speech and Occupational Therapy (combined visits)	\$15 Specialist copay; 60 visit maximum per condition per contract year combined with speech and occupational therapy	\$15 Specialist copay; 100 visit maximum per contract year combined with speech and occupational therapy
Chiropractic Care (Spinal Manipulation)	\$15 Specialist copay	\$15 Specialist copay
Acupuncture	Not covered	\$15 Specialist copay
<b>PREVENTIVE CARE</b>		
Well Child Care/Immunization	100% AB (no deductible)	100% AB
Routine Physical Exam	100% AB (no deductible)	100% AB
Breast Cancer Screening/ Routine Mammography	100% AB (no deductible)	100% AB
Prostate Cancer Screening	100% AB (no deductible)	100% AB
Routine Gynecological Exam (one per contract year)	100% AB (no deductible)	100% AB
Eye Exams	\$10 copay per annual visit no-referral (Davis Vision provider)	\$10 copay per annual visit no-referral (Davis Vision provider)
Eye Glasses/Lenses/Contact Lenses	Discounts available; See pages 24–27	Discounts available; See pages 24–27
<b>SPECIAL SERVICES</b>		
Durable Medical Equipment	100% AB	100% AB
Home Health Care Visits*	100% AB	100% AB
Hospice*	100% AB	100% AB
Maternity Care (Pre/Post/ Delivery)	100% AB	100% AB
Nursery Care (Must be enrolled within 30 days)	100% AB	100% AB
Infertility Services	Pre-approval required Artificial Insemination—50% copayment of charges; In Vitro Fertilization—50% copayment of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)	Pre-approval required Artificial Insemination—100% copayment of charges; In Vitro Fertilization—100% copayment of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)
Lapband Benefits	100% AB	100% AB
Surgical Treatment for Morbid Obesity (Gastric Bypass)	Not Covered	Not Covered

AB = Allowed Benefit

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.

## Medical Benefits Options

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	Level 3 Participating and Non-participating Providers	In-network BlueCross BlueShield PPO Providers	Out-of-network Participating and Non-participating Providers
\$20 Specialist office; \$25 OP Facility; \$25 OP Professional; 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)	80% AB; 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)	\$20 Specialist copay; \$25 OP Facility, \$25 OP Professional (no deductible); 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)	70% AB; 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)
\$20 Specialist copay	80% AB	\$20 Specialist copay	70% AB
\$20 Specialist copay	80% AB	\$20 Specialist copay	70% AB
100% AB	80% AB	100% AB (no deductible)	70% AB
100% AB	80% AB	100% AB (no deductible)	70% AB
100% AB	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
100% AB	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
100% AB	80% AB	100% AB (no deductible)	70% AB
\$10 copay per annual visit no-referral (Davis Vision provider)		No Benefit	No Benefit
Discounts available; See pages 24–27		No Benefit	No Benefit
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	100% AB (no deductible)	90% AB	70% AB
100% AB	80% AB	100% AB (no deductible)	70% AB
100% AB	80% AB	90% AB	70% AB
Artificial Insemination—100% AB, pre-approval required; In Vitro Fertilization—100% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)	Artificial Insemination—80% AB, pre-approval required; In Vitro Fertilization—80% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)	Artificial Insemination – 90% AB, pre-approval required; In Vitro Fertilization – 90% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)	Artificial Insemination – 70% AB, pre-approval required; In Vitro Fertilization – 70% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)
100% AB	80% AB	90% AB	70% AB
Not Covered	Not Covered	Not Covered	Not Covered

\* Precertification required or penalties may apply.

\*\* Mandatory generic substitution—see the CareFirst Drug Program section on page 19.

## Medical Benefits Options

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
	<b>SPECIAL SERVICES (CONTINUED)</b>	
Ambulance When Medically Necessary (surface, air, private, and public)	100% AB	100% AB
Hearing Exam	\$15 copay	\$15 copay
Hearing Aids (one per hearing impaired ear every 36 months)	100% AB	100% AB
<b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</b>	(administered by Magellan Behavioral Health)	(administered by Magellan Behavioral Health)
Inpatient Care*	100% AB	100% AB
Outpatient Facility	100% AB	100% AB
Office Visits	\$10 copay	\$10 copay
<b>PRESCRIPTION DRUGS</b>		
Prescription Drug Out-of-Pocket Max.	\$6,600 Individual / \$13,200 Family	\$5,400 Individual / \$10,800 Family
Retail Prescription Drug**	\$5 copay – Generic drug (Tier 1) \$15 copay – Preferred Brand (Tier 2) \$35 copay – Non-preferred Brand (Tier 3) Maintenance drugs: 90 day supply, 3 times retail copay: \$15 copay – Generic drug (Tier 1) \$45 copay – Preferred Brand (Tier 2) \$105 copay – Non-preferred Brand (Tier 3)	\$10 copay Generic drug (Tier 1) \$25 copay Preferred Brand (Tier 2) \$40 copay Non-preferred Brand (Tier 3) (Maintenance medication up to 90 day supply 1X copay)
Mail Order Drug**	CVS Caremark Mail Order – 2X retail copay – up to 90 day supply \$10 copay – Generic drug (Tier 1) \$30 copay – Preferred Brand (Tier 2) \$70 copay – Non-preferred Brand (Tier 3)	CVS Caremark Mail Order Prescription Program for maintenance medication \$20 copay — Up to 90 day supply
Oral Contraceptives**	100% AB	100% AB
Diabetic supplies	100% AB	100% AB

AB = Allowed Benefit

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.



## Medical Benefits Options

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	Level 3 Participating and Non-participating Providers	In-network BlueCross BlueShield PPO Providers	Out-of-network Participating and Non-participating Providers
100% AB	100% AB (no deductible)	90% AB	90% AB
\$20 copay	80% AB	\$20 copay (no deductible)	70% AB
100% AB	80% AB	90% AB	70% AB
(administered by Magellan Behavioral Health)		(administered by Magellan Behavioral Health)	
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
\$15 copay	80% AB	\$15 copay (no deductible)	70% AB
\$5,400 Individual / \$10,800 Family		\$4,200 Individual / \$8,400 Family	
\$10 copay Generic drug (Tier 1) \$25 copay Preferred Brand (Tier 2) \$40 copay Non-preferred Brand (Tier 3) (Maintenance medication up to 90 day supply 1X copay)		\$10 copay Generic drug (Tier 1) \$25 copay Preferred Brand (Tier 2) \$40 copay Non-preferred Brand (Tier 3) Maintenance medication up to 90 day supply 2X copay: \$20 copay – Generic drug (Tier 1) \$50 copay – Preferred Brand (Tier 2) \$80 copay – Non-preferred Brand (Tier 3)	
CVS Caremark Mail Order Prescription Program for maintenance medication \$20 copay — Up to 90 day supply		CVS Caremark Mail Order Prescription Program for maintenance medication 1X copay – Up to 90 day supply \$10 copay – Generic drug (Tier 1) \$25 copay – Preferred Brand (Tier 2) \$40 copay – Non-preferred Brand (Tier 3)	
100% AB		100% AB	
100% AB		100% AB	

\* Precertification required or penalties may apply.

\*\* Mandatory generic substitution—see the CareFirst Drug Program section on page 19.

# Patient-Centered Medical Home

*Supporting the relationship between you and your doctor*

Whether you're trying to get healthy or stay healthy, you need the best care. That's why CareFirst<sup>1</sup> created the Patient-Centered Medical Home (PCMH) program to focus on the relationship between you and your primary care provider (PCP).

The program is designed to provide your PCP with a more complete view of your health needs. Your PCP will be able to use information to better manage and coordinate your care with all your health care providers including specialists, labs, pharmacies and others to ensure you get access to, and receive the most appropriate care in the most affordable settings.

## Extra care for certain health conditions

If you have certain health conditions, your PCMH PCP will partner with a care coordinator, a registered nurse, to:

- Create a care plan based on your health needs with specific follow up activities
- Review your medications and possible drug interactions
- Check in with you to make sure you're following your treatment plan
- Assist you in obtaining services and equipment necessary to manage your health condition(s)



### A PCP is important to your health

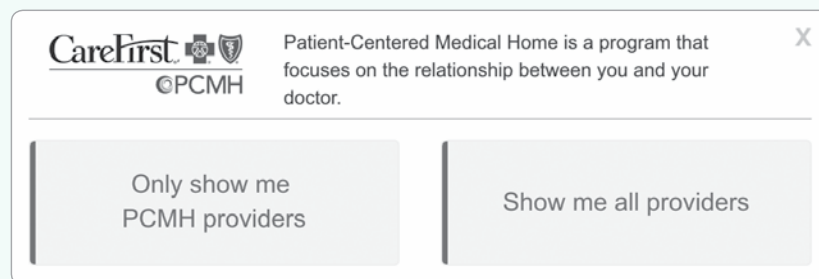
By visiting your PCP for routine visits, you build a relationship, and your PCP will get to know you and your medical history.

If you have an urgent health issue, having a PCP who knows your history often makes it easier and faster to get the care you need.

Even if you are young and healthy, or don't visit the doctor often, choosing a PCP is key to maintaining good health.

PCPs play a huge role in keeping you healthy for the long run. If you don't already have a relationship with a doctor, you can begin researching one today!

- To find a PCMH PCP, look for the PCMH logo when searching for primary care providers in our Provider Directory or log in to *My Account* and click *Select/Change PCP* under *Quick Links*.



<sup>1</sup> All references to CareFirst refer to CareFirst BlueCross BlueShield and CareFirst, BlueChoice, Inc., collectively.

# Take the Call

You know that CareFirst BlueCross BlueShield (CareFirst) provides your health benefits and processes claims, but that's not all we do. We're there for you at every step of care—and every stage, even when life throws you a curveball.

Whether you are faced with an unexpected medical emergency, managing a chronic condition like diabetes, or looking for help with a health goal such as losing weight, we offer one-on-one coaching and support programs. You may receive a letter or postcard in the mail, or a call from a nurse, health coach or pharmacy technician explaining the programs and inviting you to participate.

These programs are confidential and part of your medical benefit. They can also play a huge role in helping you through an illness or keeping you healthy. Once you decide to participate, you can choose how involved you want to be. We encourage you to connect with the CareFirst team so you can take advantage of this personal support.







CareFirst may call you to offer one-on-one support programs concerning Health & Wellness, Care Coordination, Pharmacy or Behavioral Health

[carefirst.com/takethecall](https://carefirst.com/takethecall)

## Take the Call

Here are a few examples of when we may contact you about these programs. Visit [carefirst.com/takethecall](https://carefirst.com/takethecall) to learn more.

	Program name	Overview	Why it's important	Communication
	<b>Health &amp; Wellness</b>	Personal coaching support to help you achieve your health goals	Health coaching can help you manage stress, eat healthier, quit smoking, lose weight and much more	Letter or phone call from a <b>Healthways coach</b>
	<b>Complex Case Management</b>	Managing treatment for a serious illness or injury	Specialized nurses help navigate the health care system by talking with your doctors, setting up appointments, identifying resources and helping you better understand your health	Phone call from a <b>CareFirst case manager (nurse)</b>
	<b>Chronic Care Coordination</b>	Managing multiple chronic conditions (e.g., diabetes, congestive heart failure)	Connecting you with a nurse who works closely with your primary care physician (PCP) to help you understand your doctor's recommendations, medications and treatment regimens	Introduction by your PCP or a phone call from a <b>CareFirst care coordinator (nurse)</b>
	<b>Hospital Transition of Care</b>	Supporting transition from hospital to home	Help plan for your recovery after you leave the hospital, answer your questions and, based on your needs, connect you to additional services	Onsite visit or phone call from a <b>CareFirst nurse</b>
	<b>Pharmacy Advisor</b>	Managing medications for specific conditions	Understanding your condition and staying on track with appropriate medications is crucial to successfully managing your health	Letter or a phone call from a <b>CVS Caremark pharmacy specialist</b>
	<b>Comprehensive Medication Review</b>	Managing multiple medications	Talking to a pharmacist who understands your medication history can help identify any possible side effects or harmful interactions	Phone call from a <b>CVS Caremark pharmacist</b>
	<b>Specialty Pharmacy Coordination</b>	Managing specialty medications for chronic conditions	Connecting with a nurse who specializes in your condition provides additional support so you can adhere to your treatment plan for better health	Letter or phone call from a <b>CVS Caremark specialty nurse</b>
	<b>Behavioral Health and Substance Use Disorder</b>	Support for mental health and/or addiction issues.	Confidential, one-on-one support to help schedule appointments, explain treatment options, collaborate with doctors and identify additional resources	Phone call from a <b>CareFirst behavioral health care coordinator</b>

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

CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst members.

# 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)

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

## FirstHelp—free 24-hour nurse advice line

Call 800-535-9700 anytime to speak with a registered nurse. Nurses can provide you with medical advice and recommend the most appropriate care.

## CareFirst Video Visit

See a doctor 24/7 without an appointment! You can consult with a board-certified doctor on your smartphone, tablet or computer. Doctors can treat a number of common health issues like flu and pinkeye. Visit [carefirst.com/needcare](https://www.carefirst.com/needcare) for more information.

## 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 accessible care with extended hours. Visit a convenience care center for help with minor concerns like cold symptoms and ear infections.

## Urgent care centers

Urgent care centers (such as Patient First or ExpressCare) have a doctor on staff and are another option when you need care on weekends or after hours.

## Emergency room (ER)

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



For more information, visit [carefirst.com/needcare](https://www.carefirst.com/needcare).

\*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.

### 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.

	Sample cost	Sample symptoms	Available 24/7	Prescriptions?
Video Visit	\$20	<ul style="list-style-type: none"> <li>▪ Cough, cold and flu</li> <li>▪ Pink eye</li> <li>▪ Ear infection</li> </ul>	✓	✓
Convenience Care (e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)	\$20	<ul style="list-style-type: none"> <li>▪ Cough, cold and flu</li> <li>▪ Pink eye</li> <li>▪ Ear infection</li> </ul>	✗	✓
Urgent Care (e.g., Patient First or ExpressCare)	\$60	<ul style="list-style-type: none"> <li>▪ Sprains</li> <li>▪ Cut requiring stitches</li> <li>▪ Minor burns</li> </ul>	✗	✓
Emergency Room	\$200	<ul style="list-style-type: none"> <li>▪ Chest pain</li> <li>▪ Difficulty breathing</li> <li>▪ Abdominal pain</li> </ul>	✓	✓

\* 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/myaccount](https://carefirst.com/myaccount)
- 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/needcare](https://carefirst.com/needcare).



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.

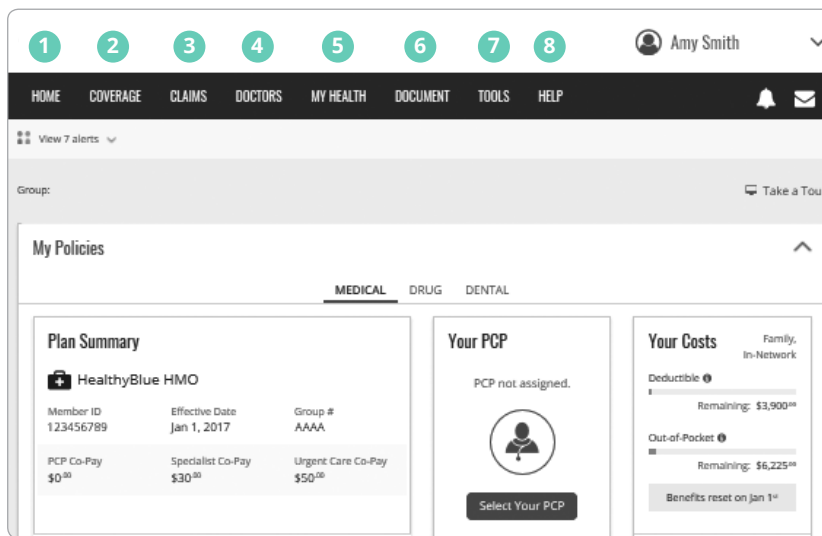
PLEASE READ: The information provided in this document regarding various care options is meant to be helpful when you are seeking care and is not intended as medical advice. Only a medical provider can offer medical advice. The choice of provider or place to seek medical treatment belongs entirely to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



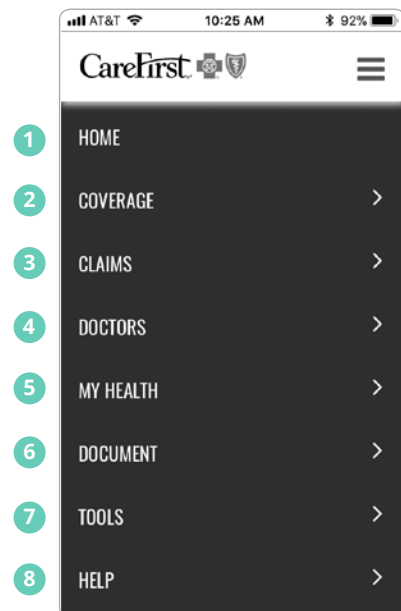
# My Account

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/myaccount** to create a username and password.



As viewed on a computer.



As viewed on a smartphone.

## 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)<sup>1</sup>
- Order and refill prescriptions
- View prescription drug claims

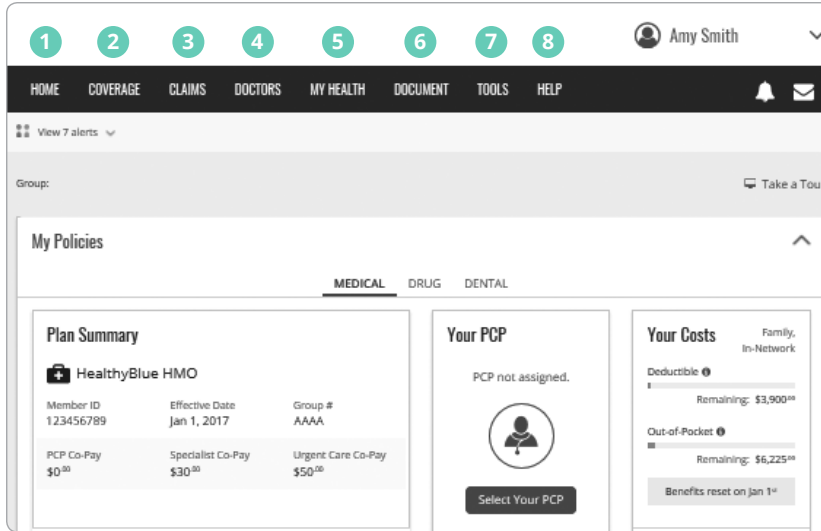


### Signing up is easy

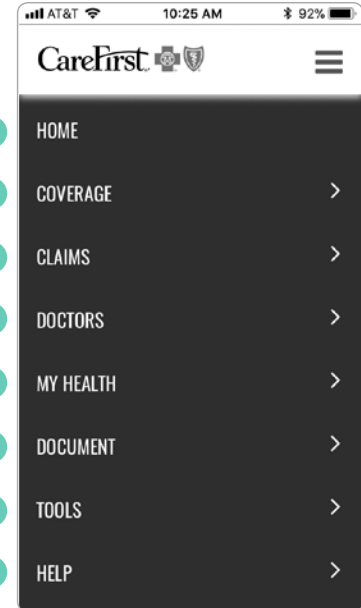
Information included on your member ID card will be needed to set up your account.

- Visit [carefirst.com/myaccount](https://carefirst.com/myaccount)
- Select *Register Now*
- Create your username and password

<sup>1</sup> Only if offered by your plan.



As viewed on a computer.



As viewed on a smartphone.

### 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<sup>1</sup>
- Track your Blue Rewards progress<sup>1</sup>

### 6 Documents

- Look up plan forms and documentation<sup>2</sup>
- Download *Vitality*, your annual member resource guide

### 7 Tools

- Access the Treatment Cost Estimator to calculate costs for services and procedures<sup>3</sup>
- 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

<sup>1</sup> Only if offered by your plan.

<sup>2</sup> Only available when using a computer.

<sup>3</sup> 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

## Take charge

Whether you're looking for health and wellness tips, support to manage a health condition, or discounts on health-related services, we have the resources to help you get on the path to better well-being.

### With our Health & Wellness program you can:

- Become aware of unhealthy habits.
- Improve your health with programs that address your specific goals or concerns.
- Access online tools to help you get and stay healthy.

### 15 minutes can help improve your well-being

When it comes to your health, it's important to know where you stand. You can get an accurate picture of your health status with our confidential, online assessment.

After you complete your health assessment, you'll unlock access to additional health and wellness support. Whether you want to eat healthier, lose weight, or stop using tobacco, you will have the tools needed to meet your personal health goals. These resources and the health assessment are available by logging into *My Account* at [carefirst.com/myaccount](https://carefirst.com/myaccount) and selecting *Health Assessment and Online Coaching* under *Quick Links*.

### Health coaching

As part of your health coverage, you may receive a call from an engagement specialist inviting you to participate in health coaching. We encourage you to take advantage of this voluntary and confidential phone-based program that can help you achieve your best possible health. Coaches are registered nurses and trained professionals who provide motivating support to help you reach your wellness goals. You can also choose to participate in health coaching by calling 800-783-4582 and pressing option 6.



“ One thing that attracted me to the program was the individual counseling. I like the one-on-one attention. ”

—Lucia, Innergy® Healthier Weight participant

**To access these wellness programs, log in to *My Account* at [carefirst.com/myaccount](https://carefirst.com/myaccount)**

### **Innergy® Healthier Weight program**

If you are age 18 or older, have a BMI of 30 or greater and are looking to lose weight, the Innergy program can help. Innergy offers a personalized solution for long-term weight loss and helps participants reach a healthier weight. To get started, select the Innergy icon and complete the registration process.

### **QuitNet® 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. QuitNet's expert guidance, support and wealth of tools make quitting easier than you might think. To get started, simply click on the QuitNet icon and complete the registration process.

### **Financial Well-Being™, powered by Dave Ramsey**

Financial expert Dave Ramsey will show you 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, the Financial Well-Being program can help. To get started, select the Financial Well-Being icon and complete the registration process.

### **Additional wellness offerings**

- **Wellness discount program**—Sign up for Blue365 at [carefirst.com/wellnessdiscounts](https://carefirst.com/wellnessdiscounts) to receive discounts from top national and local retailers on fitness gear, gym memberships, healthy eating options and more.
- **Health news**—Register for our seasonal newsletter at [carefirst.com/healthnews](https://carefirst.com/healthnews) and receive healthy recipes, videos and articles delivered to your email box.
- **Vitality magazine**—Read our member magazine which includes important plan information at [carefirst.com/vitality](https://carefirst.com/vitality).
- **Health education**—View our health library for more health and well-being information at [carefirst.com/livinghealthy](https://carefirst.com/livinghealthy).

To learn more about any of these wellness programs, log in to *My Account* at [carefirst.com/myaccount](https://carefirst.com/myaccount) or call 800-783-4582 between 8:30 a.m.–8:30 p.m., Monday–Friday, or Saturday from 8:30 a.m.–5:30 p.m. Eastern time.

# Mental Health Support

*Well-being for mind and body*

Living your best life involves good physical and mental health. Emotional well-being is important at every stage in life, from adolescence through adulthood.

It's common to face some form of mental health challenge during your life, caused by a variety of reasons, many of which are beyond your control. Some of the contributing factors include:

- Biology, such as genes, brain chemistry, physical illness or injury
- Life experiences, such as trauma, tragedy or abuse
- Family history

When mental health difficulties arise for you or a loved one, remember you are not alone. Help is available and feeling better is possible.

Through CareFirst BlueCross BlueShield, CareFirst BlueChoice Inc. (CareFirst), you have access to specialized services and programs to help you get well, if and when you need assistance related to:

- Depression
- Drug or alcohol dependence
- Stress
- Work-life balance
- Eating disorders



*One in five American adults has experienced a mental health issue.<sup>1</sup>*

If you or someone close to you needs support or help making an appointment, call 800-972-0716 or visit [carefirst.com/mentalhealth](http://carefirst.com/mentalhealth).

<sup>1</sup> United States Department of Health and Human Services. Mental Health Myths and Facts. Accessed August 21, 2015 at: <http://www.mentalhealth.gov/basics/myths-facts/index.html>.

# Your Medicare Supplemental Plan

## Your protection against illness and high medical costs

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

## Using your benefit summary

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

## This benefit summary will also tell you the following:

- What the Medicare Supplemental Plan is and how it works
- What Medicare does and doesn't cover
- When you'll need to file claims, and how to file them
- How to get the most from your health care plans
- What your Medicare Supplemental benefits are

If you have any questions, just call CareFirst BlueCross BlueShield's Customer Service Department at 800-628-8549. You can call between 8 a.m. and 10 p.m., Monday through Friday and 8 a.m. and 1 p.m., Saturday. A customer service representative will be happy to help you.



## What your plan is and how it works

### What does the Medicare Supplemental Plan cover?

First, it covers your inpatient Medicare deductible and coinsurance, costs associated with emergency care, outpatient surgery and diagnostic services. Second, CareFirst BlueCross BlueShield will pay 80% of the difference between what Medicare pays and the Medicare approved amount (when you visit Medicare participating providers) or limiting charge (when you visit Medicare non-participating providers) for Major Medical services such as office visits and durable medical equipment.



## Your Medicare Supplemental Plan

### How does the Medicare Supplemental Plan work?

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

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

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

Sometimes Medicare non-participating providers will agree to accept the Medicare approved amount for some services. Whenever they do, you will have less to pay for covered services. Please refer to questions 4 & 5 for examples.

### How can I save money with my Medicare Supplemental Plan?

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

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

### Why is it better to use Medicare participating providers?

When you use Medicare participating providers for Medicare and Major Medical covered services, you save money. Here’s an example of a Major Medical service:

### How much will I pay if I use Medicare non-participating providers?

Medicare non-participating providers can charge you the difference between the Medicare approved amount and the Medicare limiting balance. The difference is usually 15% more than the approved amount.

Here’s an example of a Major Medical service:

Provider’s charge	\$50.00
Medicare approved amount	\$28.00
Medicare pays 80% of \$28 approved amount (after Part B deductible)	\$22.40
Balance	\$5.60
CareFirst pays 80% of \$5.60 balance	\$4.48
<b>You pay remaining 20% coinsurance</b>	<b>\$1.12</b>

CareFirst’s allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge.

Provider’s charge	\$50.00
Medicare approved amount	\$28.00
Medicare limiting charge (15% greater than Medicare approved amount)	\$32.20
Medicare pays 80% of \$28 approved amount (after Part B deductible)	\$22.40
Balance	\$9.80
CareFirst pays 80% of \$5.60 balance	\$4.48
<b>You pay remaining balance up to Medicare limiting charge</b>	<b>\$5.32</b>

### How can I find out if a doctor is participating with Medicare?

There are two ways you can check on a doctor’s participation with Medicare:

- Check the Medicare MedPar Directory (you can receive your own copy by calling Medicare)
- Call the provider directly

### What Medicare does and doesn't cover

#### What does Medicare cover?

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

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

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

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

#### What isn't covered by Medicare?

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

### What you'll need to file claims

You never have to submit a claim to Medicare. By law all providers must file these claims for you. And that applies to non-participating providers as well as participating providers.

#### If I receive care in Maryland, will I have to file any claims to CareFirst?

You will not have to file any claims with CareFirst for covered services if you receive the services in Maryland, Washington D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. While you may be asked to fill out claim forms for the provider, you will not have to submit the claims yourself.

CareFirst electronically receives claims from Medicare for covered services received in Maryland, Washington D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. That means that your claims automatically come to us from Medicare when you give your CareFirst membership number to your provider at the time you receive care.

Make sure that you always give your CareFirst membership number to your provider when you give your Medicare membership number. Without your CareFirst number, Medicare won't know to forward your claim information to us. You will then have to file your own claim.

#### Will I have to file any claims to CareFirst if I receive care outside of the states listed above?

Yes, your providers will file your Medicare claims for you. That's the law. But you will have to file claims with CareFirst to get benefits from your Traditional Medicare Supplemental Plan.

Here's what you should do. After Medicare has paid its share, you will receive an "Explanation of Medicare Benefits" (EOMB). Make copies of this form and of your bills for each claim. Do not send the original EOMB and medical bills. Keep the originals in your files. Claims rarely get lost, but if that should happen, you can resubmit your claim if you have kept the originals.

Send a copy of the EOMB, your bills and a completed claim form to the following address:

**CareFirst Blue Cross Blue Shield**  
**Mail Administrator**  
**P.O. Box 14114**  
**Lexington, KY 40512**

## Your Medicare Supplemental Plan

### What if I need a claim form or help submitting a claim?

Just call your CareFirst customer service representative. The numbers to call are 410-581-3539 or 800-342-7287. You can also call these numbers if you want to find out if your claim has been received.

### Is there a deadline for filing claims?

Yes, we must receive your claims by December 31 following the year in which you receive medical care.

For example, if you received care in January of 2018, you should file your claim no later than December 31, 2019.

### What happens if my claim arrives after the deadline?

Your claim will not be covered, and you will not receive payment. So be sure to file your claim right away.

### Getting the most from your health care plan

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

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

### Your retail prescription drug plan

Your medical ID card is also your Rx card and should be given to the pharmacy each time you fill a prescription. You will pay a 20% copayment up front for your prescriptions. We encourage you to shop around for the best price to reduce your out-of-pocket expense. Pharmacy claims cannot be submitted on a Major Medical claim form for reimbursement.

### Mail Service prescription drug program sponsored by CVS Caremark

A mail service prescription drug program is a special added feature to your Traditional Medicare Supplemental Plan. For those who regularly take maintenance medications, this service provides a convenient and inexpensive way for you to order these medications and have them delivered to your home.

You can order up to a 90-day supply of medication for the required copayment of \$20. You must send the \$20 copayment with your prescription to CVS Caremark. The copayment will not be reimbursed through your medical benefits.

Medications are delivered to your home postage paid via UPS or First Class U.S. Mail.

If you have any questions regarding this prescription service, call the CareFirst Pharmacy Services telephone number, Monday through Friday at (800) 241-3371.

# Medicare Supplemental Plan Summary of Benefits

Benefits	Other Payments Made		Member Payment	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment	Provider Accepting Medicare Assignment	Provider Not Accepting Medicare Assignment
<b>DEDUCTIBLE</b>			\$183 Major Medical Deductible	
<b>FACILITY</b>				
Inpatient Hospital ■ Days 1–60 ■ Days 61–90 ■ Lifetime reserve	Part A initial deductible \$1,340 \$335 per day \$670 per day	\$1,340 \$335 per day \$670 per day	No member payment No member payment No member payment	No member payment No member payment No member payment
Skilled Nursing Facility ■ Days 1–20 ■ Days 21–100	None \$167.50 per day	None \$167.50 per day	No member payment No member payment	No member payment No member payment
Home Health	None	None		
Hospice Care	Medicare pays most charges. Remaining costs include drug copayment and limited cost for respite care.	Remaining cost	No member payment	No member payment
<b>PHYSICIAN SERVICES</b>				
Inpatient	20% of Medicare's approved amount and Part B deductible if accepting assignment	100% up to CareFirst allowed benefit	No member payment	No member payment
Emergency	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Surgery	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Laboratory Services	100%	None	No member payment	No member payment
Radiology Services (Inpatient)	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Radiology Services (Outpatient or Office)	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Office Visit	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
<b>OFFICE THERAPY</b>				
Radiation/Chemotherapy	20% of Medicare's approved amount	100% up to CareFirst allowed benefit	No member payment	No member payment
Physical Therapy	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount

## Medicare Supplemental Plan Summary of Benefits

Benefits	Other Payments Made		Member Payment	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment	Provider Accepting Medicare Assignment	Provider Not Accepting Medicare Assignment
<b>OTHER SERVICES</b>				
Ambulance Services	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Durable Medical Equipment	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Prosthetic Appliances	20% of Medicare's approved amount deductible	80% up to allowed benefit	No member payment	No member payment
Whole Blood (In full—Part A, 3 pint deductible—Part B)	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Medical Supplies	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Hearing Exam (once every 36 months)	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Hearing Aid	20% of Medicare's approved amount and Part A/B deductible	100% up to allowed benefit	No member payment	No member payment
Physical Exam		100% of allowed benefit	No member payment	No member payment
Mammograms	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare	No member payment	No member payment when Medicare approved. Difference between CareFirst allowed benefit and provider's charge when not Medicare approved.
Prostate Cancer Screening	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare	No member payment	No member payment when Medicare approved. Difference between CareFirst allowed benefit and provider's charge when not Medicare approved.
<b>PRESCRIPTION DRUGS</b>				
Retail Prescription Drug			20% Coinsurance of Average Wholesale Price	
Mail Order Drug			CVS/Caremark Mail Order Prescription Program for maintenance supply medication \$20 copay—up to 90 day supply	

The Medicare deductibles and coinsurance amounts shown are based on 2017 figures. Your benefits will automatically adjust to meet any amounts that change in 2018.

CareFirst's allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge. Medicare does not place a limiting charge on durable medical equipment, therefore the CareFirst allowed benefit will prevail. If Medicare benefits are exhausted, or service is not covered by Medicare, CareFirst Medicare Supplemental Plan benefits may be provided.

Blue Cross and Blue Shield benefits for inpatient hospital services are provided for 90 days per inpatient stay with a 60-day renewal interval. That is, an inpatient stay will be one stay if discharge date and readmission date are not separated by at least 60 days.

Reimbursement under Major Medical is subject to an annual deductible of \$200 per individual. After your deductible is met, payment is made at 80% of allowed benefit and you pay the coinsurance of 20%.

# Words You Need to Know

## *Medicare Supplemental*

### **Approved amount**

The amount that Medicare allows participating providers to be paid for Medicare—covered services. Payments are made according to the Medicare fee schedule (see following pages).

Participating providers agree to accept the approved amount as payment in full for covered services. Non-participating providers can charge you more than this amount for your care (see limiting charge). The “approved amount” also may be called the “allowed amount” or “assignment”.

### **Coinsurance**

Some services require that you pay a percentage of the costs for your medical care. For example, under Medicare Part B, you pay 20% and Medicare pays 80%.

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

Your Traditional Medicare Supplemental Plan pays the Part A coinsurance for you.

### **Deductibles**

Some services require that you pay a deductible before Medicare begins to pay. For example, under Medicare Part A, you must pay the first \$1,100 of your hospital bill. And under Medicare Part B, you must pay the \$200 deductible for services. Then Medicare begins to pay its share.

### **Limiting charge**

Some providers do not accept the Medicare approved amount as payment in full for Medicare—covered services. To protect you from high charges for these services, Medicare limits the amount that these non-participating providers can bill you.

The limiting charge does not apply to any of the Traditional Medicare. Supplemental Plan benefits that Medicare does not cover.

### **Medicare fee schedule**

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

### **Medicare participating providers**

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

### **Medicare non-participating providers**

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

### **Provider**

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



# Keep Smiling

## Delta Dental PPO<sup>SM</sup>



### Save with PPO

Visit a dentist in the PPO network to maximize your savings.<sup>1</sup> These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.<sup>2</sup> Find a PPO dentist at [deltadentalins.com](http://deltadentalins.com).<sup>3</sup>

### Set up an online account

Get information about your plan anytime, anywhere by signing up for an Online Services account at [deltadentalins.com](http://deltadentalins.com). This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

### Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply sign in to Online Services, where you can view or print your card with the click of a button.

### Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

### Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.<sup>4</sup> You can find this date by logging in to Online Services.

### Newly covered?

Visit [deltadentalins.com/welcome](http://deltadentalins.com/welcome).

## Save with a PPO dentist



PPO



NON-PPO

Maryland law requires we make the following statement:

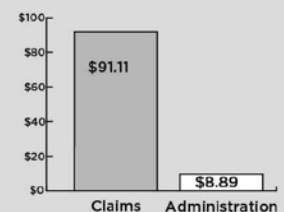
*Our compensation to physicians who offer health care services to our insured members of enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary or capitation. Bounties may be used with these various types of payment methods. If you desire method(s) apply to your physician, please call additional information about our methods of paying physicians, or if you want to know which Delta Dental at 800-932-0783 or write to: Delta Dental of Pennsylvania, One Delta Drive, Mechanicsburg, PA 17055.*

Please note that the benefit payments made by Delta Dental to dentists, other dental care providers or enrollees are based on fee-for-service payment mechanisms and do not include salary, capitation or bonuses.

In Maryland, Delta Dental PPO<sup>SM</sup> and Delta Dental Premier<sup>®</sup> are underwritten by Delta Dental of Pennsylvania, a not-for-profit dental service company.

### Where your dental benefits premium goes

Amount of every \$100 in premiums used to pay for claims and administration\*



\* for the year ending December 31, 2016

FFS #103459D (rev. 1/17)

<sup>1</sup> You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

<sup>2</sup> You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

<sup>3</sup> We recommend verifying before each appointment that your dentist is a PPO dentist.

<sup>4</sup> Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

**LEGAL NOTICES:** Access federal and state legal notices related to your plan at [deltadentalins.com/about/legal/index-enrollee.html](http://deltadentalins.com/about/legal/index-enrollee.html).

**Plan Benefit Highlights for:** Harford County Public Schools

**Group No:** 00528 - PPO - Comprehensive

<b>Eligibility</b>	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
<b>Deductibles</b>	Delta Dental PPO dentists: \$25 per person / \$50 per family each plan year Non-Delta Dental PPO dentists: \$50 per person / \$150 per family each plan year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
<b>Maximums</b>	\$1,500 per person each plan year			
D & P counts toward maximum?	No			
<b>Waiting Period(s)</b>	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None
<b>Benefits and Covered Services*</b>	<b>Delta Dental PPO dentists**</b>		<b>Non-Delta Dental PPO dentists**</b>	
<b>Diagnostic &amp; Preventive Services</b> Exams, cleanings, x-rays and sealants	100 %		65 %	
<b>Surgical Removal of Impacted Teeth</b>	100 %		65 %	
<b>Basic Services</b> Fillings, denture repair/relining, stainless steel crowns, bridges, bridge recementation/repair and posterior composite restorations	80 %		50 %	
<b>Endodontics</b> (root canals) Covered Under Basic Services	80 %		50 %	
<b>Periodontics</b> (gum treatment) Covered Under Basic Services	80 %		50 %	
<b>Oral Surgery</b> Covered Under Basic Services	80 %		50 %	
<b>Major Services</b> Crowns, inlays, onlays and cast restorations	50 %		30 %	
<b>Prosthodontics</b> Dentures	50 %		30 %	
<b>Implants</b> Covered <i>only</i> as an alternative to a fixed bridge	80 %		50 %	
<b>Orthodontic Benefits</b> Dependent children to age 19	50 %		50 %	
<b>Orthodontic Maximums</b>	\$800 Lifetime		\$800 Lifetime	

\* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

\*\* Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055	<b>Customer Service</b> 800-932-0783	<b>Claims Address</b> P.O. Box 2105 Mechanicsburg, PA 17055-6999
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[deltadentalins.com](http://deltadentalins.com)

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT\_PPO\_2COL\_DDP (Rev. 4/17/2017)

**Plan Benefit Highlights for:** Harford County Public Schools  
**Group No:** 00528 - PPO Plus Premier - Standard

**DELTA DENTAL PPO<sup>SM</sup>**  
**BENEFIT HIGHLIGHTS**

<b>Eligibility</b>	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26		
<b>Deductibles</b>	\$25 per person / \$50 per family each plan year		
Deductibles waived for Diagnostic & Preventive (D & P)?	Yes		
<b>Maximums</b>	\$1,500 per person each plan year		
D & P counts toward maximum?	No		
<b>Waiting Period(s)</b>	Basic Benefits None	Major Benefits None	Prosthodontics None

<b>Benefits and Covered Services*</b>	<b>Delta Dental PPO dentists**</b>	<b>Non-Delta Dental PPO dentists**</b>
<b>Diagnostic &amp; Preventive Services</b> Exams, cleanings, x-rays and sealants	100 %	100 %
<b>Basic Services</b> Fillings, stainless steel crowns and posterior composite restorations	100 %	100 %
<b>Endodontics</b> (root canals)	100 %	100 %
<b>Oral Surgery</b>	100 %	100 %
<b>Periodontics</b> (gum treatment)	0 %	0 %
<b>Major Services</b> Crowns, inlays, onlays and cast restorations	0 %	0 %
<b>Prosthodontics</b> Bridges and dentures	0 %	0 %

\* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

\*\* Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055	<b>Customer Service</b> 800-932-0783	<b>Claims Address</b> P.O. Box 2105 Mechanicsburg, PA 17055-6999
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**deltadentalins.com**

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT\_PPO\_2COL\_DDP (Rev. 4/17/2017)

# Stay Connected



Want information about your dental plan? Take advantage of our web and mobile resources to:

- **check your eligibility**
- **look up coverage details**
- **check claims**
- **find a network dentist**
- **improve your oral wellness**
- **and more**

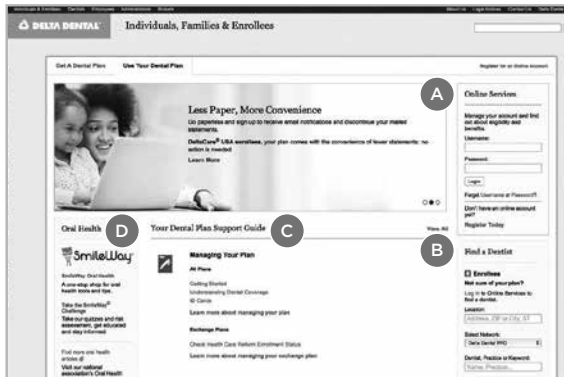
Whether you're on a computer, tablet or smartphone, you can access all the information you need at your fingertips.

1. Visit **deltadentalins.com**
2. Access the **mobile-optimized site**
3. Use the **free Delta Dental app**



We keep you smiling®  
[deltadentalins.com/enrollees](http://deltadentalins.com/enrollees)

## Check the site

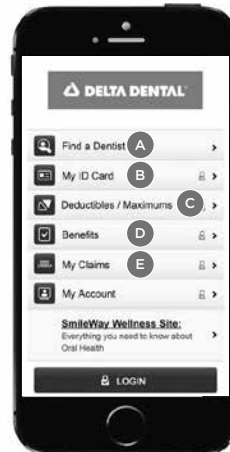


1. Enter **deltadentalins.com/enrollees** on your computer's browser.
2. Browse the features listed below. If you haven't already done so, register for Online Services. Already got an account? Log in!

### Features:

- A. **Online Services** (register or log in): See benefits and eligibility info; check claims; view or print an ID card
- B. **Find a dentist**
- C. **Dental Plan Support Guide**
- D. **SmileWay® Wellness site**

## Go mobile

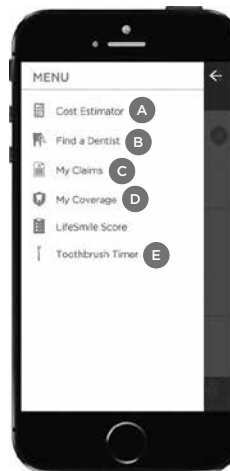


1. Enter **deltadentalins.com** on your smartphone's browser.
2. Click the **Visit Mobile Site** button.

### Features:

- A. **Find a dentist**
- B. **View your electronic ID card**
- C. **Check deductibles and maximums<sup>1</sup>**
- D. **Look up your benefits and eligibility**
- E. **Check claims<sup>1</sup>**

## Get the app



1. Open the **App Store** or **Google Play**.
2. Search for **"Delta Dental."**
3. Download the free app titled **Delta Dental** by Delta Dental Plans Association.

### Features:

- A. **Get a cost estimate<sup>1</sup>**
- B. **Find a dentist**
- C. **Check claims<sup>1</sup>**
- D. **Look up your benefits and eligibility<sup>1</sup>**
- E. **Use a musical timer to brush for 2 minutes**

<sup>1</sup> Applies to Delta Dental PPO<sup>SM</sup> and Delta Dental Premier<sup>®</sup> enrollees only.

Delta Dental Premier and Delta Dental PPO are underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV, TX and UT and by not-for-profit dental service companies in these states: CA - Delta Dental of California; PA, MD - Delta Dental of Pennsylvania; NY - Delta Dental of New York; DE - Delta Dental of Delaware; WV - Delta Dental of West Virginia. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

These enterprise companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to 75 million people in the U.S. The website [deltadentalins.com](http://deltadentalins.com) is the home of the Delta Dental companies listed above. For other Delta Dental companies, visit the Delta Dental Plans Association website at [deltadental.com](http://deltadental.com).

# Elevate Your Smile

8 ways to make the most of your dental plan



## 1 Save with PPO.

Visit a dentist in the PPO<sup>1</sup> network to maximize your savings.<sup>2</sup> These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.<sup>3</sup> Find a PPO dentist at [deltadentalins.com](http://deltadentalins.com).

If you can't find a PPO dentist, Delta Dental Premier<sup>®</sup> dentists offer the next best opportunity to save. Unlike non-Delta Dental dentists, they have agreed to set fees, and you won't get charged more than your expected share of the bill. What's more, they're part of the largest dentist network in the country.<sup>4</sup>

## 2 Seek preventive care.

Regular exams and cleanings are available at low or no cost. These services help catch problems before they require costly and extensive treatment.

## 3 Set up an online account.

Get information about your plan anytime, anywhere by signing up for an Online Services account. Available once your coverage kicks in, this free service lets you find a network dentist, view or print your ID card and more. The one-time registration process takes only a minute.

## 4 Go paperless.

Receive an email when a new dental benefits statement is available online. Save time, reduce clutter and preserve environmental resources! To enroll, log in to Online Services and update your settings.

Newly covered?  
Visit [deltadentalins.com/welcome](http://deltadentalins.com/welcome)

<sup>1</sup> In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

<sup>2</sup> You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. PPO dentists won't bill you for any amount over their PPO fees.

<sup>3</sup> You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

<sup>4</sup> NetMinder Dental Network Trend Report, September 2016. Delta Dental Premier is the largest dentist network nationwide, based on total unique dentists.



We keep you smiling<sup>®</sup>  
[deltadentalins.com/enrollees](http://deltadentalins.com/enrollees)

**5 Try mobile.**  
Visit [deltadentalins.com](http://deltadentalins.com) on your smartphone to access mobile-optimized Online Services on the go — including a helpful dentist locator tool. Or, download the Delta Dental app, available through the App Store or Google Play, to access your plan information and try out the handy toothbrush timer.

**6 Coordinate benefits.**  
Are you covered under a second dental plan? Ask your dentist to include information about both plans with your claim, and we'll handle the rest.<sup>5</sup>

**7 Talk to your dentist.**  
From pregnancy to diabetes, overall health can affect your dental health. Start each visit with a quick chat about any issues.

**8 Stay informed.**  
Get oral health tools and tips at our SmileWay® Wellness site ([mysmileway.com](http://mysmileway.com)). Don't forget to subscribe to *Grin!*, our free dental wellness e-magazine.

<sup>5</sup> Group- and state-specific exceptions may apply. Please review your plan booklet for details about coordination of benefits, including rules for determining primary and secondary coverage.

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## Contact us

### Online assistance:

For quick and easy online assistance, go to [deltadentalins.com](http://deltadentalins.com) > **Contact Us**, select the Delta Dental company and choose the applicable customer service form.

### Telephone assistance:

Delta Dental of California: **800-765-6003**

California School District Employees: **866-499-3001**

Delta Dental of Delaware; Delta Dental of the District of Columbia; Delta Dental of New York; Delta Dental of Pennsylvania (and Maryland); Delta Dental of West Virginia: **800-932-0783**

Delta Dental Insurance Company (Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas, Utah): **800-521-2651**

**Got a simple question?** Use our automated phone system, available 24/7. You can check your coverage levels, remaining maximum and more. Just call one of the customer service numbers listed above and follow the prompts.

Delta Dental Premier® and Delta Dental PPO<sup>SM</sup> are underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV, TX and UT and by not-for-profit dental service companies in these states: CA - Delta Dental of California; PA, MD - Delta Dental of Pennsylvania; NY - Delta Dental of New York, Inc.; DE - Delta Dental of Delaware, Inc.; WV - Delta Dental of West Virginia, Inc.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

**LEGAL NOTICES:** Access federal and state legal notices related to your plan: [deltadentalins.com/about/legal/index-enrollee.html](http://deltadentalins.com/about/legal/index-enrollee.html).



# Life Insurance

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For those retirees participating, this policy is written through the MetLife Insurance Company. The policy provides an initial death benefit of \$20,000. The death benefit will be reduced annually by \$2,000 on July 1 until the amount of \$10,000 has been reached. Thereafter, the coverage will remain at \$10,000 for as long as the policy is in force.

Currently, the Board of Education pays 90% and the retiree will pay 10% of the premium for this coverage. The monthly cost to the retiree for \$20,000 is currently \$.33 cents. This premium will be deducted from your monthly State Retirement System check.



# Frequently Asked Questions

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## **When should I apply for Medicare?**

You're eligible when you turn 65. Contact Social Security 3 months prior to your 65th birthday.

## **How can I sign up for Part A & B of Medicare?**

- Apply online at [www.socialsecurity.gov](http://www.socialsecurity.gov).
- Visit your local Social Security office.
- Call Social Security at 1-800-772-1213

## **What happens once a covered member becomes eligible for Medicare?**

Once you or your dependent becomes eligible for Medicare, enrollment in Medicare Part A & B is required to maintain coverage with HCPS. All retirees are required to provide the HCPS Benefits office with a copy of their Medicare card.

If you are participating in a CareFirst Preferred Provider (PPO) health program, the medicare eligible member will automatically be transferred to the CareFirst Medicare Supplemental plan once eligible for Medicare. The Medicare eligible member will have the supplemental plan and the remaining member(s) will stay in the PPO Plan with Individual, Parent/Child, Husband/Wife or Family coverage.

Medicare will be your primary insurance and your HCPS plan will be secondary.

## **Will my pharmacy benefit change once I go on Medicare?**

Yes. Your Mail Order will be \$20 for a 90 day supply of a maintenance medication. At retail you will be responsible for 20% of the cost.



### **What about Medicare Part D?**

Currently, all retirees of HCPS should waive Medicare Part D. Any retiree who chooses to enroll in a Medicare D plan will lose prescription benefits with their HCPS plan. Harford County receives a Medicare subsidy for retirees who are not enrolled in Part D. Currently, this money is designated to other post employment benefits OPEB.

### **Who is an eligible dependent?**

- Your legal spouse
- Your dependent children up to age 26.
- Your unmarried children of any age who are physically/mentally incapable of self-support and cannot earn their own living (onset of disability must be prior to age 26 or while covered under the plan).

### **When can I add a spouse, child or newborn to my insurance coverage?**

Contact the Benefits Office to obtain an Enrollment/Change Application to add your new child or spouse. You have 30 days from date of birth/adoption or marriage to add him/her to your health/dental plans. Coverage will take effect retroactively to the date of birth/date of adoption or marriage. Failure to add within the 30 days will result in your dependent losing the opportunity to enroll in our benefits. You will need to provide proper documentation (birth certificate, marriage certificate, adoption paperwork).

### **When does coverage end for my dependents should I die?**

End of the month in which the death occurred. Your surviving spouse/dependent will have the option of continuing coverage on Harford County Public Schools plan throughout their lifetime but is responsible for paying 100% of the premium.

### **What should I do when my dependent loses eligibility for coverage?**

You are responsible for notifying the Benefits Office as soon as you know that your dependent will no longer meet the eligibility requirements for coverage. You should notify the Benefits Office in advance so the dependent can be removed from coverage at the appropriate time. There are no refunds of premiums paid during any period of ineligibility.

When coverage ends for a dependent, he or she may choose to continue coverage under COBRA for a maximum of 36 months, providing the Benefits Office is notified within 60 days of the loss of eligibility.

Should any of your dependents become ineligible for coverage due to any of the following reasons: over the age limit, divorce, military or death, their coverage ceases the end of the month in which the event occurred. It is your responsibility to notify the Benefits Office.

NOTE: Coverage continues for a child until the end of the month in which the child turns 26. For example, a child whose 26th birthday is May 12 can be covered through May 31st.

### **What if I move?**

Should your address change, you will need to notify the State Retirement Agency in writing at 120 E. Baltimore Street, Baltimore MD 21202 and the HCPS Benefits Office of your new address and telephone number.

### **Moving out-of-state?**

Members enrolled in the HMO should contact the Benefits Office for guidance.

# Health Insurance Portability Accountability Act (HIPAA)

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The Health Insurance Portability and Accountability Act (HIPAA) places limitations on a group health plan's ability to impose pre-existing condition exclusions, provides special enrollment rights for certain individuals, and prohibits discrimination in group health plans based on health status.

We are electronically transmitting data to the vendors for eligibility purposes. The vendors and HCPS are in compliance with the HIPAA requirements. No personally identifiable information may be released to a third party.

## Special enrollment rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

\* If you, your spouse or eligible dependent child loses coverage under Medicaid or a State Children's Health Insurance Program (S-CHIP) or becomes eligible for state-provided premium assistance, the affected individual(s) has 60 days from the date of the event to elect coverage in the HCPS Healthcare plans. Contact HR/Benefits Office for more information.

For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

# Important Notice from Harford County Public Schools About Your Prescription Drug Coverage and Medicare

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Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Harford County Public Schools and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Harford County Public Schools has determined that the prescription drug coverage offered by our CareFirst BlueCross Medicare Supplemental Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

## When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

## What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current Harford County Public Schools coverage will be affected. For those individuals who elect Part D coverage, prescription coverage under Harford County Public Schools medical plan will end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your Harford County Public Schools prescription drug coverage, be aware that you and your dependents will not be able to get this coverage back.

## When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Harford County Public Schools and don't join a Medicare drug plan within

## Important Notice from HCPS About Your Prescription Drug Coverage and Medicare

63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

### For more information about this notice or your current prescription drug coverage

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Harford County Public Schools changes. You also may request a copy of this notice at any time.

### For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Name of Entity/Sender:  
Harford County Public Schools

Contact—Position/Office:  
Audrey Simpson, Coordinator of Benefits

# Privacy Notice

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Your privacy is a high priority for Harford County Public Schools and it will be treated with the highest degree of confidentiality.

Harford County Public Schools (the Board) is required under the Medical Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) to provide all of its employees and retirees participating in its self-funded health care plans with this PRIVACY NOTICE, which concerns personal, protected health information you have provided to the Board as a condition of your employment.

In providing health insurance benefits to you, the Board collects the following types of personal information: (1) information you provide to us on an application or enrollment form in order to obtain insurance including your name, address, telephone number, date of birth, and Social Security number; (2) premium payments the Board pays on your behalf; (3) the fact that you are currently or have been one of our employees; (4) information you have given to us from any of your physicians or other health care providers; (5) information related to your health care status including diagnosis and claims payment information and (6) other information about you that is necessary for us to have in order to provide you with health insurance.

We may disclose this information to our third party vendors (the Vendors) without prior authorization, as permitted by law. We do not disclose any personal information about either our current employees or former employees to anyone, except as permitted by law. We may, from time to time, disclose personal information about you without prior authorization, as permitted by law, to the Vendors to perform services or functions on our behalf. If we make such a disclosure, we will do so only if we have a contract in place that prohibits the Vendors from disclosing or using the information for any purpose other than the purpose of the disclosure, except as permitted by law. We restrict

access to your personal information to those employees of the Board who need to know that information in order to provide services to you.

We maintain physical, electronic and procedural safeguards that comply with HIPAA regulations to guard your personal information. Employees, who have access to your personal information, are required to abide by the following standards: (1) to safeguard and secure confidential personal information as required by law; (2) to limit the collection and use of any participants information to the minimum necessary and (3) to permit only trained, authorized employees to have access to your personal information. Employees who violate the policy will be subject to our established disciplinary policy. In addition, the Board will: (1) provide all of our participants, at least annually, with any updates to this policy; (2) provide information about you to the Vendors only in accordance with the law; (3) require the Vendors to enter into a contract that prohibits disclosure or the use of your personal information other than to carry out the purpose of the disclosure, except as permitted by law; (4) not share your personal information for purposes other than allowed by law; (5) allow participants the opportunity to correct personal information that they believe is not accurate.



# Definitions

These definitions have been developed to help you become familiar with some of the terms in this manual.

## Allowed Benefit

The criteria CareFirst BlueCross BlueShield uses to determine payments to your physician. It is based upon the Resource Based Relative Value Unit System. This system takes 3 factors into consideration; work value (amount of skill/time/effort required for service), practice expense (cost of overhead expenses), and the liability/malpractice expense for covered services.

## Card (Identification/Membership)

Identification or membership card for medical/pharmacy coverage. The card identifies the employee, types of elected coverage, type of membership and the effective date of coverage.

## Coinsurance

A cost-sharing requirement under your CareFirst BlueCross BlueShield policy which requires you to assume a percentage of the costs of covered services.

## Copay

Cost sharing in which you pay a flat amount per service. Unlike coinsurance the amount does not vary as a percentage of the cost of the service.

## Deductible

Amount of expense you must incur before CareFirst BlueCross BlueShield or Delta Dental will assume any liability for all or part of the remaining cost of covered services.

## Eligibility

State of fulfilling requirements for coverage.

## In-network Provider

A preferred provider within a Preferred Provider Organization.

## Medical Emergency

The sudden and unexpected onset of a serious illness or condition which requires necessary, immediate medical care.

## Non-Participating Provider

A physician or other provider who has not signed an agreement with the CareFirst BlueCross BlueShield plan to accept the Allowed Benefit as payment in full.

## Out-of-network Provider

A provider that is not part of the PPO network

## Out-of-pocket

The deductible copayment plus any coinsurance amount that the subscriber pays; once this has been met the policy will normally pay at 100% of the Allowed Benefit for most covered services.

## Participating Provider

Individual physicians, hospitals and professional health care providers who have a contract with CareFirst BlueCross BlueShield and/or CareFirst BlueChoice, Inc. to provide services to its members at a discounted rate and to be paid directly for covered services.

## Medical and Dental Plan Year

The Plan Year is twelve months July 1–June 30.

## FSA Plan Year

FSA Plan Year is twelve months July 1–June 30.

## Professional Component

That portion of a charge for x-ray or laboratory services performed in a hospital which is allocated to a physician as his professional fee.

## Provider

An individual or institution that provides medical care.

# Fully-Insured vs. Self-Insured

## *What is the difference?*

Employers that offer health insurance benefits finance those benefits in one of two ways: They purchase health insurance from an insurance company (fully-insured plans), or they provide health benefits directly to employees (self-insured plans). Typically, these plans differ by who assumes the insurance risk, plan characteristics, and employer size.

### **If an employer-sponsored plan is fully-insured:**

The insurance company is ultimately responsible for the health care costs and the employer pays premiums. In a fully-insured plan, the employer pays a per-employee premium to someone else (an insurance company) to take on the risk that they will pay out more in benefits than they collect from you in premiums. The insurer collects the premiums and pays the health care claims based on your policy benefits. The covered persons are responsible to pay any deductible amounts or copayments required for covered services under the policy.

### **If an employer-sponsored plan is self-insured:**

The employer assume the financial risk and acts as its own insurer and is ultimately responsible for the health care costs, and pays for all of those costs plus administration fees. Self-insured plans often contract with an insurance company or other third party to administer the plan, but the employer bears the risk associated with offering health benefits.

### **Harford County Public Schools (HCPS) self-insures all medical and dental plans offered**

This means we assume the risk for every dollar of health care expense our employees and their families incur. We use the dollars collected through your payroll contributions and HCPS's contributions to pay employees' claims and the administration costs of the plans. In addition we also share in costs with employees at the point of care, through the plan's benefit features (e.g., coinsurance and copayments). Our third party administrators are CareFirst and Delta Dental.

Self-insuring our medical and dental plans benefits HCPS and our employees in many ways:

### ■ **Our benefit dollars go toward benefits.**

Built into the cost of any insurance policy is the insurer's profit. When we self-insure, we eliminate the middleman—the insurer—and its built-in profit. Though third-party insurers administer our plans, they do so on a fee-for-service basis; they take no financial risk for paying our claims. And since HCPS is not making a profit by providing health insurance coverage to you, every dollar of your and HCPS's contributions are used to pay claims and the administrative expenses for our plans.

### ■ **We have more flexibility.** When we self-insure our plans, HCPS, and not an insurance company, decides how our plans work. This provides us with more flexibility in designing our plans (e.g., deciding on copayment and coinsurance levels) to fit the needs of our employees. The insurance carrier is responsible for negotiating rates with in-network providers and the processing of claims.

### ■ **We have more control.** Self-insured plans are subject to federal regulations, while fully-insured plans are regulated by the state in which the plan operates. This exempts HCPS from providing for state-mandated benefits in our plans (which can be costly) and from paying state-mandated taxes on health care premiums (an additional expense for the plans).

Even though HCPS plans are self-funded, HCPS does not assume 100% of the risk for catastrophic claims. Rather, we purchase what is known as Stop-Loss insurance to protect against large individual claims as well as total claims which exceed the expected level for our group of covered persons.

The total cost of a self-funded plan is the fixed costs plus the claims expense less any stop-loss reimbursements.

# Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. 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](mailto: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>.

REV. (12/17)

## Foreign Language Assistance

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

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

*Èdè Yorùbá (Yoruba) Ìtẹ̀lẹ̀kọ: Àkíyèsí yìí ní iwífún nípa isẹ̀ adójú tòfò rẹ̀. Ó le ní àwọn déèti pátó o sì le ní láti gbé igbésẹ̀ ní àwọn ojú gbèdèké kan. O ni ètò láti gba iwífún yí àti iránlówó ní èdè rẹ̀ lófèfè. Àwọn omo-egbé gbòdò pe nòmbà fòdùn tò wà lẹ̀yìn kààdi idánimò wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ijiròrò títi a ó fí sọ fún ọ̀ láti tẹ̀ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ̀ a ó sì sọ ọ̀ pọ̀ mọ̀ ògbufọ̀ kan.*

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

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

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

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



## Notice of Nondiscrimination and Availability of Language Assistance Services

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

**Bàsɔ̀-wùdù (Bassa)** Tò Dùù Cáo! Bǎ nǎ ke bá nyɔ bɛ́ ké m̄ gbo kpá bó nì fùà-fúá-tiín nyɛɛ jè dyí. Bǎ nǎ ke bédé wé jéé bɛ́ bɛ́ m̄ ké dɛ wa m̄ m̄ ké nyuɛɛ nyu hwɛ́ bɛ́ wé bɛ́a ké zi. ɔ̀ m̄ nì kpé bɛ́ m̄ ké bǎ nǎ ke kè gbo-kpá-kpá m̄ m̄ɛɛ dyé dɛ́ nì bídí-wùdù mú bɛ́ m̄ ké se wídí dò péé. Kpooò nyɔ bɛ́ m̄ dǎ fúùn-nòbà nǎ dɛ́ waà I.D. káàò dɛ́in nyɛ. Nyɔ̀ tòò séin m̄ dǎ nòbà nǎ ke: 855-258-6518, ké m̄ m̄ fò tee bɛ́ wa kée m̄ gbo cɛ́ bɛ́ m̄ ké nòbà m̄à 0 kɛɛ dyi pàdàin hwɛ́. ɔ̀ jǔ ké nyɔ̀ dò dyi m̄ gǔ̀ jǔin, po wuɔ̀ m̄ m̄ pɔɛ dyiɛ, ké nyɔ̀ dò mu bó nìin bɛ́ ɔ̀ ké nì wuɔ̀ò mú zà.

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

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

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

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

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

*Igbo (Igbo)* Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. Ọ nwere ike inwe ụbọchị ndị dị mkpa, ị nwere ike ime ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike inweta ozi na enyemaka a n'asụsụ gi na akwughị ụgwọ ọ bụla. Ndi otu kwesiri ikpo akara ekwentị di n'azu nke kaadi njirimara ha. Ndi ozọ niile nwere ike ikpo 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ipi 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị choro, a ga-ejikọ gi na onye okowa okwu.

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

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

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

*Diné Bizaad (Navajo)* Ge': Díí bee íł hane'ígíí bii' dahólq bee éédahózin béeso ách'ááh naanil ník'ist'i'ígíí bá. Bii' dahólq doo iyisíi yoolkáálgíí dóo t'áadoo le'é ádadoolyíílgíí da yókeedgo t'áa doo bee e'e'aahí ájiil'ííh. Bee ná ahót'i' díí bee íł hane' dóo níká'ádoowł t'áa nínizaad bee t'áa jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nit'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóo náánáta' éi kóji' dahódoonih 855-258-6518 dóo yii diiłts'ííł yatí'ígíí t'áa níléjji áádóo éi bikéé'dóo naasbaas bił adidiilchił. Áká'ánidaalwó'ígíí neidiitáágo, saad bee yáníłt'i'ígíí yii diikił dóo ata' halne'é lá níká'ádoowł.





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