

HARFORD COUNTY
PUBLIC SCHOOLS

Benefits Enrollment & Reference Guide

EFFECTIVE JULY 1, 2026 - JUNE 30, 2027

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Important Resources	Member Services Telephone Number	Web or Claims Mailing Address	
CareFirst BlueCross BlueShield Medical Claims	866-263-9477	**carefirst.com**	Mailroom Administrator PO Box 14115 Lexington, KY 40512
Mental and Behavioral Health	800-245-7013	**carefirst.com/mentalhealth**	
CVS Caremark and Mail Order Pharmacy	800-241-3371	**carefirst.com/rx**	
CareFirst Dental and Vision	Vision: 800-783-5602 Dental: 866-891-2802	**carefirst.com**	Mailroom Administrator PO Box 14115 Lexington, KY 40512
Flexible Benefit Administrators, Inc. (FBA)	800-437-3539	**flex-admin.com** **https://fba.wealthcareportal.com**	
Acentra Health	866-795-5701	**EAPHelplink.com**; company code—HCPS	
State Retirement Agency	800-492-5909	**sra.maryland.gov**	
Lincoln Financial Tax Deferred Compensation Plan (457b) (403b)	800-234-3500 Press "Ø"	**hcps.org/departments/humanresources/benefits/retirement.aspx** **lincolnfinancial.com**	
Harford County Public Schools Benefits Office	410-588-5275	**www.hcps.org/departments/HumanResources** **benefits@hcps.org**	
Employee Incentives		**https://hcps365.sharepoint.com/sites/HumanResources/Staffing/RecruitmentandRetention/default.aspx**	

Welcome

As a Harford County Public Schools (HCPS) employee, you have access to a wide variety of benefits. HCPS benefit programs are designed to help keep you and your family healthy and financially secure with coverage options that feature choice, flexibility, and tax-savings opportunities.

Vision

We will **inspire** and **prepare** each student to achieve success in college and career.

Mission

Each student will attain academic and personal success in a safe and caring environment that honors the diversity of our students and staff.

Core values

- We empower each student to achieve academic excellence.
- We create reciprocal relationships with families and members of the community.
- We attract and retain highly-skilled personnel.
- We assure an efficient and effective organization.
- We provide a safe and secure environment.

It is up to you to make the most of these benefits. You have an opportunity during open enrollment to enroll in or change specific benefit plan selections. To help you choose wisely, HCPS provides this Enrollment and Reference Guide. Please take time to read this Enrollment Guide carefully and share it with other family members to help you make informed benefits decisions.

Every effort has been made to ensure that the information in this Guide is accurate; however, the provisions of the actual contracts for each plan will govern in the event of any discrepancy. Copies of the Employee Benefit Guides and plan contracts are available at our SharePoint (https://hcps365.sharepoint.com/sites/humanresources/benefits) or HCPS website, (https://hcps.org/departments/HumanResources/).

What's New for this Plan Year

Changes for 2026-2027

Open Enrollment is the time each year when you get to make your benefit choices for the following fiscal year. During this period, it's important that you set aside some time to learn all you can about your Harford County Public Schools benefit options and decide which ones make the most sense for you and your family.

All current 2025-26 medical, dental, vision and life benefits will automatically roll over for the 2026-2027 plan year. Flex Spending elections must be made each plan year.

Take this opportunity to:

- Review or change your medical, dental and vision insurance options
- Review and update eligible dependents as appropriate
- Review new 2026/2027 premium information
- Start or renew participation in Health and/or Dependent Care FSA(s)
- Enroll, increase or decrease life insurance Benefits (Statement of Health required for all enrollments)

Insurance premiums

Insurance premiums are detailed on pages 6–7 of this guide. The medical and dental premiums will increase beginning on July 1, 2026. Rates for vision and life insurance will not change.

Plan Updates

HCPS is committed to providing a comprehensive benefits package that supports the health and well-being of staff and their families. To ensure the long-term sustainability of our programs, please note the following updates to Board contributions and plan designs effective July 1, 2026.

Plan Design

1. Specialist Copay Increases: There will be a $5.00 increase for specialist visits across all three plan options. The new specialist visit copays can be found on page 20-21, and are outlined below:
   - BlueChoice HMO: The specialist copay increases from $20 to $25.
   - Core PPO: The specialist copay increases from $25 to $30.
   - Triple Option: The specialist copay increases from $20 (Tier 1) / $25 (Tier 2) to $25 (Tier 1) / $30 (Tier 2).
2. Triple Option Deductibles: The annual deductible in the Triple Option plan will adjust as follows:
   - Individual: Increases from $50 to $75 for Tiers 1 and 2.
   - Family: Increases from $100 to $150 for Tiers 1 and 2.

Changes to Board Contributions

The Board's contribution towards the medical premiums is being adjusted slightly across all three medical plans. This means employees/retirees will see a modest increase in their portion of the premium. The new contribution rates are as follows:

Plan Name	Current Board Rate	New Board Rate
BlueChoice HMO	95%	94%
Core PPO	90%	89%
Triple Option	85%	83%

Benefits and Eligibility

Basic benefits

With the exception of the defined benefit pension plans, the costs for the basic benefits for all regular part-time and full-time employees are paid in full by Harford County Public Schools. Basic benefits include:

- Sick Leave
- Family Bereavement Leave
- Personal Business
- Liability Insurance
- Tuition Reimbursement
- Employee Assistance Program
- Pension Plan

Membership in the Maryland State Teachers' and Employees' Pension System is mandatory and requires a 7% contribution based on your annual compensation.

Optional benefits

In general, full and part-time (.5) FTE status employees may choose to enroll in any combination of the following benefits. HCPS contributes a large portion toward the purchase of health and welfare benefits. This allows you the flexibility to choose the benefit plans that best meet your needs.

The Benefits Program for HCPS is a Section 125 Plan as defined by the Internal Revenue Code. Section 125 allows you to pay for certain employee benefits with pre-tax deductions from your paycheck. You pay for most benefits on a before-tax basis, which lowers the taxes taken out of each paycheck.

Your before-tax benefits include:

- Medical
- Dental
- Vision
- Group Life insurance
- Pet Insurnce
- Flexible Spending Accounts
- 403(b)/457(b) Plans

Your after-tax benefits include:

- U.S. Savings Bonds
- Dependent and spouse life Insurance
- Roth 403(b) Plans

Eligibility

Employees

You are eligible to participate in the HCPS Benefits Program if you are a:

- Regular full-time employee
- Part-time employee working .500 FTE

Dependents*

Eligible family members include your:

- Legal spouse
- Dependent children until the end of the month in which they reach age 26
- Unmarried dependent children over the age limit if:
  - They are dependent on you for primary financial support and maintenance due to a physical or mental disability,
  - They are incapable of self-support, and
  - The disability existed before reaching age 26 or while covered under the plan.

Eligible children include your:

- Natural children
- Stepchildren
- Legally adopted children
- Foster children
- A child for whom you have legal guardianship including grandchildren
- Child for whom the court has issued a QMSCO (Qualified Medical Child Support Order)

*** You must submit verification of eligibility for all dependents on your account within 30 days of enrollment.**

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, domestic partner, etc.)
- Dependents no longer covered by a court order
- Live-in partners
- Children of live-in partners
- Stepchildren following divorce from natural parent
- Parents of employees

Note: The Board will not provide two insurance programs, e.g., CareFirst PPO CORE and BlueChoice HMO program for any eligible employees or eligible members of their families. This applies to all employees and eligible members of their families whose spouses and/or children are also employees of the school system.

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	**Natural Child—Provide a copy of Social Security card and one of the following:** ▪ Copy of birth certificate showing employee's name or ▪ Hospital verification of birth (must include child's name, date of birth and parents' names) or ▪ Certificate of live birth **Step Child—Provide a copy of Social Security card and one of the above** showing employee's spouse name; and a copy of marriage certificate showing the employee and parent's name **Legal Guardian, Adoption, Grandchild(ren), or Foster Child(ren)—**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 **Child for whom the court has issued a QMSCO**—A copy of the Qualified Medical Child Support Order and a copy of Social Security card
Disabled Dependents	Unmarried dependent children over the age limit if: 1. They are dependent on you for primary financial support and maintenance due to a physical or mental disability, 2. They are incapable of self-support, and 3. The disability existed before reaching age 26 or while covered under the plan.	Copy of Social Security disability award (if a disability ruling by Social Security is pending, include a current copy of the application for disability) **and** Federal Tax Return for year just filed **and** copy of Social Security card **and** Completed Disability Form (Request from Benefits Office)

Medical, Dental and Vision Deductions—Active Employees

Plan	Total Annual Premium	Employee Monthly Premium at 100%	BOE % of Annual Cost	Employee % of Annual Cost	Biweekly Payroll Deduction 22 Pay Deductions for ALL Employees Your Bi-Weekly Deduction
Medical Insurance Rates					
CareFirst BlueChoice HMO			**94%**	**6%**	
Individual	$8,971.75	$747.65	$8,433.45	$538.31	$24.47
Parent & Child	$17,719.17	$1,476.60	$16,656.02	$1,063.15	$48.33
Employee & Spouse	$21,183.45	$1,765.29	$19,912.44	$1,271.01	$57.77
Family	$26,094.94	$2,174.58	$24,529.25	$1,565.70	$71.17
Carefirst Preferred Provider Core Plan			**89%**	**11%**	
Individual	$9,623.78	$801.98	$8,565.16	$1,058.62	$48.12
Parent & Child	$20,924.41	$1,743.70	$18,622.72	$2,301.68	$104.62
Employee & Spouse	$24,752.63	$2,062.72	$22,029.84	$2,722.79	$123.76
Family	$26,843.55	$2,236.96	$23,890.76	$2,952.79	$134.22
CareFirst Triple Option			**83%**	**17%**	
Individual	$11,869.08	$989.09	$9,851.34	$2,017.74	$91.72
Parent & Child	$25,806.23	$2,150.52	$21,419.17	$4,387.06	$199.41
Employee & Spouse	$30,527.99	$2,544.00	$25,338.23	$5,189.76	$235.90
Family	$33,104.17	$2,758.68	$27,476.46	$5,627.71	$255.80
Dental Insurance Rates					
CareFirst Standard			**90%**	**10%**	
Individual	$307.43	$25.62	$276.69	$30.74	$1.40
Parent & Child	$505.43	$42.12	$454.89	$50.54	$2.30
Employee & Spouse	$647.46	$53.96	$582.71	$64.75	$2.94
Family	$944.33	$78.69	$849.90	$94.43	$4.29
CareFirst Comprehensive			**90%**	**10%**	
Individual	$419.23	$34.94	$377.31	$41.92	$1.91
Parent & Child	$688.25	$57.35	$619.42	$68.82	$3.13
Employee & Spouse	$882.55	$73.55	$794.30	$88.26	$4.01
Family	$1,286.60	$107.22	$1,157.94	$128.66	$5.85
Vision Insurance Rates					
CareFirst BlueVision Plus			**0%**	**100%**	
Individual	$50.76	$4.23	$0.00	$50.76	$2.31
Parent & Child	$93.96	$7.83	$0.00	$93.96	$4.27
Employee & Spouse	$116.76	$9.73	$0.00	$116.76	$5.31
Family	$154.32	$12.86	$0.00	$154.32	$7.01

Premium deductions will begin the first pay for all staff of the 2026-2027 school year, and coverage will be effective July 1, 2026. New hire's coverage will start on the first day of the month following the hire date and enrollment in the plan. Deductions will begin with the first pay of the month following the date of hire and enrollment in the plan.

Medical, Dental and Vision Deductions—Active Part Time

Hired or transferred to a PT position of less than 25 hours per week on or after 7/1/2013

Plan	Total Annual Premium	Employee Monthly Premium at 100%	BOE % of Annual Cost	Employee % of Annual Cost	Biweekly Payroll Deduction 22 Pay Deductions for ALL Employees Your Bi-Weekly Deduction
Medical Insurance Rates					
CareFirst BlueChoice HMO			**47%**	**53%**	
Individual	$8,971.75	$747.65	$4,216.72	$4,755.03	$216.14
Parent & Child	$17,719.17	$1,476.60	$8,328.01	$9,391.16	$426.87
Employee & Spouse	$21,183.45	$1,765.29	$9,956.22	$11,227.23	$510.33
Family	$26,094.94	$2,174.58	$12,264.62	$13,830.32	$628.65
Carefirst Preferred Provider Core Plan			**44.5%**	**55.5%**	
Individual	$9,623.78	$801.98	$4,282.58	$5,341.20	$242.78
Parent & Child	$20,924.41	$1,743.70	$9,311.36	$11,613.05	$527.87
Employee & Spouse	$24,752.63	$2,062.72	$11,014.92	$13,737.71	$624.44
Family	$26,843.55	$2,236.96	$11,945.38	$14,898.17	$677.19
CareFirst Triple Option			**41.5%**	**58.5%**	
Individual	$11,869.08	$989.09	$4,925.67	$6,943.41	$315.61
Parent & Child	$25,806.23	$2,150.52	$10,709.59	$15,096.65	$686.21
Employee & Spouse	$30,527.99	$2,544.00	$12,669.12	$17,858.87	$811.77
Family	$33,104.17	$2,758.68	$13,738.23	$19,365.94	$880.27
Dental Insurance Rates					
CareFirst Standard			**45.0%**	**55.0%**	
Individual	$307.43	$25.62	$138.34	$169.09	$7.69
Parent & Child	$505.43	$42.12	$227.44	$277.99	$12.64
Employee & Spouse	$647.46	$53.96	$291.36	$356.10	$16.19
Family	$944.33	$78.69	$424.95	$519.38	$23.61
CareFirst Comprehensive			**45.0%**	**55.0%**	
Individual	$381.12	$31.76	$171.50	$209.62	$10.48
Parent & Child	$625.68	$52.14	$281.56	$344.12	$17.21
Employee & Spouse	$802.32	$66.86	$361.04	$441.28	$22.06
Family	$1,169.64	$97.47	$526.34	$643.30	$32.17
Vision Insurance Rates					
CareFirst BlueVision Plus			**0%**	**100%**	
Individual	$50.76	$4.23	$0.00	$50.76	$2.31
Parent & Child	$93.96	$7.83	$0.00	$93.96	$4.27
Employee & Spouse	$116.76	$9.73	$0.00	$116.76	$5.31
Family	$154.32	$12.86	$0.00	$154.32	$7.01

Premium deductions will begin the first pay for all staff of the 2026-2027 school year, and coverage will be effective July 1, 2026. New hire's coverage will start on the first day of the month following the hire date and enrollment in the plan. Deductions will begin with the first pay of the month following the date of hire and enrollment in the plan.

Be an Informed Health Care Consumer

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 **webmd.com**. Ask your physician which web-sites they believe are valuable. Be sure to let your physician know your findings.
- Visit **https://hcps365.sharepoint.com/sites/humanresources/benefits or carefirst.com** to link to our health care vendor 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 2025 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 and Explanation of Benefits (EOB)

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?

Enrollment Instructions

Enroll online with web enrollment

The Harford County Public Schools Benefits Open Enrollment will take place starting May 4 through May 21, 2026. Web enrollment offers you the convenience to enroll anytime, anywhere through the internet.

New hires must enroll in benefits within 30 days of hire or may be forced to wait for the next open enrollment period.

Before you enroll:

- Familiarize yourself with your options by reading your 2026 benefit guide. This guide is also available on the HCPS or SharePoint sites
- Have the following information about you and your dependents:
  - ☐ Social Security Number
  - ☐ Date of birth
  - ☐ Information on other medical coverage that you and your dependents have.

Starting July 1, 2026, to enroll in your benefits:

- Using a computer with internet, sign in to your account within Oracle.
- Click on the Home icon in the upper right-hand corner.
- Click on the Me heading.
- Click on the Benefits icon.
- Click on the Enroll Now button.
- Follow the step-by-step instructions on the screen to enroll in your FY2026 benefits.
- Review your elections to check for errors.
- Confirm that you have linked all dependents to your coverage, for which they will be enrolled.
- You MUST click on the Submit button to complete your elections and have them processed.
- Save and or print your enrollment summary for your records.
- If dependents have been added to your coverage, submit the dependent verification documentation via the Oracle pending actions item portal under the Benefits section.

You may make changes to your benefits on the enrollment website during open enrollment from May 4, 2026 until May 21, 2026. The last elections that you save will be your benefits beginning July 1, 2026.

The website may be unavailable periodically during your enrollment period for routine maintenance.

Remember your selections made during open enrollment will be effective July 1, 2026. Benefits for all new hires will be effective the first of the month following your date of hire.

Any employee needing assistance with enrollment should call the Benefits Office at 410-588-5275 Monday – Friday, 8 a.m. – 4 p.m. or email benefits@hcps.org.

Social security number required

Due to 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.

BlueChoice HMO Open Access

No referrals required

With BlueChoice HMO, your primary care provider (PCP) provides routine care and coordinates specialty care. This plan also allows you to visit specialists directly—no referrals needed. We also offer online tools and resources at **carefirst.com** that give you the freedom and flexibility to manage your health and wellness goals wherever you are.



Take advantage of your benefits

- A network of almost 47,000 CareFirst BlueChoice providers (PCPs, nurse practitioners, specialists, hospitals, pharmacies, urgent care centers, convenience care clinics and diagnostic centers) in Maryland, Washington, D.C. and Northern Virginia.
- After-hours care including a free 24-hour nurse advice line, virtual care options for physical and mental health and urgent care, convenience care clinics and in-person urgent care centers.
- $0 cost for comprehensive preventive healthcare visits.
- Predictable copays and deductibles (if applicable).
- The Away From Home Care® program allows you to take your plan benefits with you if you're out of the area for at least 90 days.
- Coverage for emergency or urgent care if you are outside CareFirst BlueCross BlueShield's service area (Maryland, Washington, D.C. and Northern Virginia).

Benefits at a glance

Preventive care and sick office visits

You are covered for all preventive care as well as sick office visits.

Large provider network

You can choose any doctor from our large network of providers. Our network also includes specialists, hospitals and pharmacies—giving you many options for your healthcare.

Specialist services

Your coverage includes services from specialists without a referral. Specialists are doctors who are highly trained to treat certain conditions, such as cardiologists or dermatologists.

Prescription drug coverage

Your plan covers prescription drugs.

Hospital services

You're covered for overnight hospital stays. You're also covered for outpatient services, those procedures you get in the hospital without spending the night. Your PCP or specialist must provide prior authorization for all hospital services.

Labs, X-rays or specialty imaging

Covered services include provider-ordered lab tests, X-rays and other specialty imaging tests (MRI, CT scan, PET scan, etc.).



Well-child visits

All well-child visits and immunizations are covered.



Maternity and pregnancy care

You are covered for doctor visits before and after your baby is born, including hospital stays. If needed, we also cover home visits after the baby's birth.



Mental health and substance use disorder

Your coverage includes behavioral health treatment, such as psychotherapy and counseling, mental and behavioral health inpatient services and substance use disorder treatment.

How your plan works

CareFirst BlueCross BlueShield has the region's largest network for doctors, pharmacies, hospitals and other healthcare providers that accept our health plans. Networks vary among CareFirst health plans. It is important that you familiarize with your specific plan's network.

In-network doctors and healthcare providers are those that are part of your plan's network (also known as participating providers). When you choose an in-network provider, you'll pay the lowest out-of-pocket care costs.

Out-of-network providers and doctors have not contracted with CareFirst. If you choose to receive care from an out-of-network provider, you can expect to pay more and, in some cases, may be responsible for the entire amount billed.

Your benefits

Step 1: Select a PCP

Establishing a relationship with one doctor is the best way to receive consistent, quality healthcare. When you enroll in a BlueChoice HMO Open Access plan, you select a PCP—either a physician or nurse practitioner—to manage your primary medical care. Make sure you select a PCP for yourself and each of your covered family members. Your PCP must participate in the CareFirst BlueChoice provider network and must specialize in family practice, general practice, pediatrics or internal medicine.

To ensure that you receive the highest level of benefits and pay the lowest out-of-pocket costs for all services, see your PCP for preventive and routine care.

Step 2: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the cost of your medical care up to the amount of your deductible. However, this deductible does not apply to all services.

Examples of in-network services not subject to deductible*:

- Adult preventive visits with PCP
- Well-child care and immunizations with PCP
- OB/GYN visits and pap tests
- Mammograms
- Prostate and colorectal screenings
- Routine prenatal maternity services

Step 3: Your plan will start to pay for services

Your full benefits will become available once your deductible (if applicable) is met as long as you visit participating CareFirst BlueChoice doctors and facilities. Depending on your particular plan, you may also have to pay a copay or coinsurance when you receive care.

Deductible requirements vary based on whether your coverage is an individual or family plan. If more than one person is covered under your plan, please refer to your Evidence of Coverage for detailed information on deductibles.

Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your 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.

Should you reach your out-of-pocket maximum, CareFirst will then pay 100 percent of the allowed benefit for all covered services for the remainder of the benefit period.

Please keep in mind that out-of-pocket requirements also differ if your coverage is an individual or family plan. Detailed information on out-of-pocket maximum amounts can be found in your Evidence of Coverage.

* This is not a complete list of all services. For a comprehensive explanation of your coverage, please check your Evidence of Coverage.

Labs, X-rays or specialty imaging

To get the most economical use out of your laboratory benefits, you must visit a LabCorp facility for any laboratory services. Services performed at a facility that isn't part of the LabCorp network will not be covered under your plan.

Also, any lab work performed in an out-patient hospital setting will require a prior authorization from your PCP.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. For locations near you, call 888-LAB-CORP (522-2677) or visit **labcorp.com**.

Diagnostic/imaging centers have equipment to produce various types of radiologic and electromagnetic images (such as X-rays, mammograms, CT and PET scans) and a professional staff to interpret the images. If you need X-rays or other specialty imaging services, you must visit a participating freestanding/non-hospital diagnostic center such as Advanced Radiology.

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 ID card.

Global coverage

If you travel outside of the United States for a period of less than six months, you have access to a worldwide network of traditional inpatient, outpatient and professional healthcare providers. With BlueCross BlueShield Global Core*, you receive:

- Access to a worldwide network of traditional inpatient, outpatient, and professional healthcare providers—more than 7,000 physicians and more than 2,000 hospitals.
- 24/7 care support via telephone.
- Seamless claims processing/reimbursement designed for occasional or short-term travel, Global Core connects members with their home plan benefits to provide basic medical coverage outside of the United States.

For more information on Global Core, please call 800-810-BLUE (2583).

Important terms

ALLOWED BENEFIT: The maximum amount CareFirst approves for a covered service, regardless of what the doctor actually charges. Providers who participate in the CareFirst BlueChoice network cannot charge our members more than the allowed amount for any covered service.

COINSURANCE: The percentage of the allowed benefit you pay after you meet your deductible.

COPAY: A fixed-dollar amount you pay when you visit a doctor or other provider.

DEDUCTIBLE: The amount of money you must pay each year before your plan begins to pay its portion for the cost of care.

IN-NETWORK: Doctors, hospitals, labs and other providers or facilities that are part of the CareFirst BlueChoice network.

OUT-OF-NETWORK: Doctors, hospitals, labs and other providers or facilities that do not participate in the CareFirst BlueChoice network. If you receive non-emergency or urgent services from an out-of-network provider or facility, you will be responsible for paying the entire amount billed.

*BlueCross BlueShield Global is a brand owned by BlueCross BlueShield Association.

Triple Option Open Access

No referrals required

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

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 Triple Option coverage will become available to you.

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** 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**.

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, 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 **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	$8,110	$50	$50 deductible
PPO/Level 2	$14,800	$9,180	$9,130	$50	$50 deductible
Participating*/Level 3	$14,800	$10,200	$7,910	$2,290	$250 deductible then 20% AB ($2,040)
Non-participating*/ Level 3	$14,800	$10,200	$7,910	$6,890	$250 deductible then 20% AB ($2,040 + 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	$49	$15	Office Visit copay
PPO/Level 2	$150	$72	$52	$20	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	Deductible was already met
PPO/Level 2	$5,864	$4,068	$4,068 (100% AB)	$0	Deductible was already met
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 $1,344

* 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

With Preferred Provider Organization (PPO), you have the freedom to visit any provider you choose.

Take advantage of your benefits

- $0 cost for comprehensive preventive healthcare visits.
- Choose any provider you want—no referrals required.
- PPO network of 95% of doctors, specialists and hospitals across the country.
- Freedom to visit providers outside of the PPO network and still be covered (but with higher out-of-pocket cost).



Benefits at a glance

Preventive care and sick office visits

You are covered for all preventive care as well as sick office visits.

Large provider network

You can choose any doctor from our large network of providers. Our network also includes specialists, hospitals and pharmacies—giving you many options for your healthcare.

Specialist services

Your coverage includes services from specialists without a referral. Specialists are doctors or nurses who are highly trained to treat certain conditions, such as cardiologists or dermatologists.

Prescription drug coverage

Your plan covers prescription drugs.

Hospital services

You're covered for overnight hospital stays. You're also covered for outpatient services, those procedures you get in the hospital without spending the night. Your primary care provider (PCP) or specialist must provide prior authorization for all inpatient hospital services and may need to provide prior authorization for some outpatient hospital services such as rehabilitative services, chemotherapy and infusion services.

Preferred Provider Organization

Labs, X-rays or specialty imaging
Covered services include provider-ordered lab tests, X-rays and other specialty imaging tests (MRI, CT scan, PET scan, etc.).

Well-child visits
All well-child visits and immunizations are covered.

Maternity and pregnancy care
You are covered for doctor visits before and after your baby is born, including hospital stays. If needed, we also cover home visits after the baby's birth.

Mental health and substance use disorder
Your coverage includes behavioral health treatment, such as psychotherapy and counseling, mental and behavioral health inpatient services and substance abuse disorder treatment.

How your plan works

In-network vs. out-of-network coverage

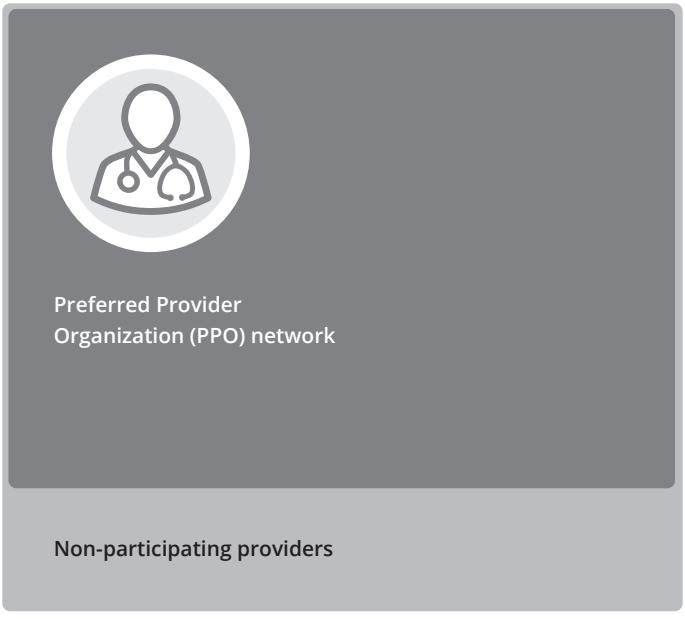
The amount of coverage your PPO plan offers depends on whether you see a provider in the PPO network (preferred provider). You will always receive a higher level of benefits when you visit a preferred provider. However, the choice is entirely yours. That's the advantage of a PPO plan.

In-network benefits provide a higher level of coverage. This means you have lower out-of-pocket costs when you choose a PPO network provider. 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.

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.

PPO gives you flexibility and choices when you need care.



In-network you pay: $
Visit a PPO provider.
No referrals necessary.

Out-of-network you pay: $$
Visit a non-participating provider
No referral required. Balance billing may apply.

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 at 866-PREAUTH (773-2884).

Getting started with your plan

No matter which health plan you have, one of the first things you should do is choose an in-network PCP. By visiting your PCP for routine visits as recommended, they will get to know you, your medical history and your habits. Having a PCP who is familiar with your health can make it easier and faster to get the care you need. In addition, when you choose a PCP, you are one step closer to earning a financial reward!

With access to the largest network across the country, with 96% of hospitals and 95% of physicians in-network. Visit our *Find a Provider* tool (**www.provider.bcbs.com**) and search by the PPO network.



Your benefits

Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the cost of your medical care up to the amount of your deductible. However, this deductible does not apply to all services.

Examples of in-network services not subject to deductible*:

- Adult preventive visits with PCP
- Well-child care and immunizations with PCP
- OB/GYN visits and pap tests
- Mammograms
- Prostate and colorectal screenings
- Routine prenatal maternity services

Step 2: Your plan will start to pay for services

Your full benefits will become available once your deductible (if applicable) is met. However, the level of those benefits will depend on whether you see in-network or out-of-network providers. Depending on your particular plan, you may also have to pay a copay or coinsurance when you receive care.

You will have a different deductible amount for in-network vs. out-of-network benefits and the in- and out-of-network medical deductibles contribute toward one another. For example, when you see in-network providers, your expenses will count towards both your in-network deductible and out-of-network deductible.

Deductible requirements vary based on your coverage level (e.g. individual, family) therefore if more than one person is covered under your plan, please refer to your Evidence of Coverage for detailed deductible information.

Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your 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.

Just like your deductible, the in- and out-of-network out-of-pocket maximum contributes toward one another.

* This is not a complete list of all services. For a comprehensive explanation of your coverage, please check your Evidence of Coverage.

Please keep in mind that out-of-pocket requirements also differ if your coverage is either an individual or family plan. Detailed information on out-of-pocket maximum amounts can be found in your Evidence of Coverage.

Out-of-area coverage

You have the freedom to take your healthcare 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 healthcare benefits when receiving care from a BlueCard preferred provider while living or traveling outside of your health plans service area. The BlueCard program includes the broadest coverage and largest number of participating providers, with more than 500,000 unique providers and 8,896 hospitals in the United States.

Global coverage

If you travel outside of the United States for a period of less than six months, you have access to a worldwide network of traditional inpatient, outpatient and professional healthcare providers. With BlueCross BlueShield Global Core*, you receive:

- Access to a worldwide network of traditional inpatient, outpatient, and professional healthcare providers—more than 7,000 physicians and more than 2,000 hospitals.
- 24/7 care support via telephone.
- Seamless claims processing/reimbursement designed for occasional or short-term travel, Global Core connects members with their home plan benefits to provide basic medical coverage outside of the United States.

For more information on Global Core, please call 800-810-BLUE (2583).

Important terms

ALLOWED BENEFIT: The maximum amount BlueCross BlueShield approves for a covered service, regardless of what the doctor actually charges. Providers who participate in the PPO network cannot charge our members more than the allowed amount for any covered service.

COINSURANCE: The percentage of the allowed benefit you pay after you meet your deductible.

COPAY: A fixed-dollar amount you pay when you visit a doctor or other provider.

DEDUCTIBLE: The amount of money you must pay each year before your plan begins to pay its portion for the cost of care.

IN-NETWORK: Doctors, hospitals, labs and other providers or facilities that are part of the national PPO network.

OUT-OF-NETWORK: Doctors, hospitals, labs and other providers or facilities that do not participate in the national PPO network.

*BlueCross BlueShield Global is a brand owned by BlueCross BlueShield Association

CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. which are both independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®´ Registered trademark of CareFirst of Maryland, Inc.

Medical Benefits Comparison Chart

The Benefits	BlueChoice HMO Open Access BlueChoice Providers	CareFirst BlueCross BlueShield Preferred Provider Organization	
		In-network BlueCross BlueShield PPO Providers	Out-of-network Participating and Non-participating Providers
DEDUCTIBLE—CONTRACT YEAR JULY 1–JUNE 30	$150 Individual / $300 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)	$150 Individual / $300 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)	$350 Individual / $700 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)
MEDICAL OUT-OF-POCKET MAXIMUM	$6,600 Individual/$13,200 Family (integrated with Rx out-of-pocket maximum)	$2,400 Individual / $4,800 Family (combined in- and out-of-network)	
LIFETIME MAXIMUM	Unlimited	Unlimited	
HOSPITAL			
Hospital Room/Semi-Private*	100% AB	90% AB	70% AB
Skilled Nursing Facility*	100% AB (limited to 60 days/ contract year)	90% AB	70% AB
Inpatient Rehabilitation*	100% AB (limited to 90 days/ contract year)	90% AB	70% AB
Outpatient Surgery	100% AB	90% AB	70% AB
Emergency Care**	Emergency Room—$75 copay (waived if admitted); Urgent Care Center—$35 copay	Emergency Room—$100 copay (no deductible—waived if admitted); Urgent Care Center—$25 copay (no deductible)	Emergency Room—$100 copay (no deductible—waived if admitted); Urgent Care Center—70% AB
PHYSICIAN SERVICES			
Surgeon	100% AB	90% AB	70% AB
Assistant Surgeon	100% AB	90% AB	Paid as in-network
Anesthesiologist	100% AB	90% AB	Paid as in-network
In-Hospital Medical	100% AB	90% AB	70% AB
MEDICAL SERVICES			
Office Visits	$15 PCP/$25 Specialist copay	$20 PCP / $30 Specialist copay (no deductible)	70% AB
Outpatient Facility	100% AB	100% AB	70% AB
Outpatient Physician	$15 PCP/$25 Specialist copay	$30 copay	70% AB
Diagnostic X-rays	100% AB	90% AB	90% AB inpatient / 70% AB office
Radiation Therapy	$25 Specialist copay	90% AB	70% AB
Chemotherapy	$25 Specialist copay	90% AB	70% AB
Laboratory Tests	100% AB (LabCorp only)	90% AB	90% AB inpatient / 70% AB office
Allergy Testing	$15 PCP/$25 Specialist copay	90% AB	70% AB
Allergy Treatment/Injections	$15 PCP/$25 Specialist copay	90% AB	70% AB

* Precertification required or penalties may apply.
** Overnight stays for observation are not considered an inpatient admission.
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 Comparison Chart

	Triple Option Open Access		
	Level 1 BlueChoice Providers	**Level 2 BlueCross BlueShield PPO Providers**	**Level 3 Participating and Non-participating Providers**
	$75 Individual / $150 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)	$75 Individual / $150 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)	$250 Individual / $500 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)
	$1,200 Individual /$2,400 Family (combined in- and out-of-network)	$1,200 Individual /$2,400 Family (combined in- and out-of-network)	
	Unlimited		
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB
	Emergency Room—$75 copay (waived if admitted); Urgent Care Center—$20 copay	Emergency Room—$75 copay (waived if admitted); Urgent Care Center—$25 copay	Emergency Room—$75 copay (waived if admitted); Urgent Care Center—80% AB
	100% AB	100% AB	80% AB
	100% AB	100% AB	Paid as Level 2
	100% AB	100% AB	Paid as Level 2
	100% AB	100% AB	80% AB
	$15 PCP/$25 Specialist copay	$20 PCP/$30 Specialist copay	80% AB
	100% AB	100% AB	80% AB
	$15 PCP/$25 Specialist copay	$30 copay	80% AB
	100% AB	100% AB	Inpatient—Paid as Level 2 Office & Outpatient—80% AB
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB
	100% AB (LabCorp only)	100% AB	Inpatient—Paid as Level 2 Office & Outpatient—80% AB
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB

Medical Benefits Comparison Chart

The Benefits	BlueChoice HMO Open Access BlueChoice Providers	CareFirst BlueCross BlueShield Preferred Provider Organization	
		In-network BlueCross BlueShield PPO Providers	Out-of-network Participating and Non-participating Providers
MEDICAL SERVICES (CONTINUED)			
Physical, Speech and Occupational Therapy (combined visits)	$25 Specialist copay; 60 visit maximum per condition per contract year combined with speech and occupational therapy	$30 Specialist office copay; $30 OP Facility, $30 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)
Chiropractic Care (Spinal Manipulation)	$25 Specialist copay; 60 visit maximum per condition per contract year	$30 Specialist copay	70% AB
Acupuncture	Not covered	$30 Specialist copay	70% AB
PREVENTIVE CARE			
Well Child Care/Immunization	100% AB (no deductible)	100% AB (no deductible)	70% AB
Routine Physical Exam	100% AB (no deductible)	100% AB (no deductible)	70% AB
Breast Cancer Screening/ Routine Mammography	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
Prostate Cancer Screening	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
Routine Gynecological Exam (one per contract year)	100% AB (no deductible)	100% AB (no deductible)	70% AB
Eye Exams	$10 copay per annual visit no-referral (Davis Vision provider) (no deductible)	No Benefit	No Benefit
Eye Glasses/Lenses/Contact Lenses	Discounts available; See pages 39-41	No Benefit	No Benefit
SPECIAL SERVICES			
Durable Medical Equipment	100% AB	90% AB	70% AB
Home Health Care Visits*	100% AB	90% AB	70% AB
Hospice*	100% AB	90% AB	70% AB
Maternity Care (Pre/Post/ Delivery)	100% AB	100% AB	70% AB
Nursery Care (Must be enrolled within 30 days)	100% AB	90% AB	70% AB
Infertility Services	Pre-approval required Artificial Insemination—50% AB of charges (limited to 6 attempts per live birth); In Vitro Fertilization—50% AB of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Artificial Insemination—90% AB, pre-approval required (limited to 6 attempts per live birth); 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 (limited to 6 attempts per live birth); 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)
Lapband Benefits	100% AB	90% AB	70% AB
Surgical Treatment for Morbid Obesity (Gastric Bypass & Gastric Sleeve) (prior authorization required)	100% AB at a BlueDistinction center	90% AB at a BlueDistinction center	70% AB at a BlueDistinction center

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 Comparison Chart

	Triple Option Open Access		
	Level 1 BlueChoice Providers	**Level 2 BlueCross BlueShield PPO Providers**	**Level 3 Participating and Non-participating Providers**
	$25 Specialist copay; 100 visit maximum per contract year combined with speech and occupational therapy	$30 Specialist office; $30 OP Facility; $30 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)
	$25 Specialist copay	$30 Specialist copay	80% AB
	$25 Specialist copay	$30 Specialist copay	80% AB
	100% AB (no deductible)	100% AB (no deductible)	80% AB
	100% AB (no deductible)	100% AB (no deductible)	80% AB
	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
	100% AB (no deductible)	100% AB (no deductible)	80% AB
	$10 copay per annual visit no-referral (Davis Vision provider) (no deductible)	$10 copay per annual visit no-referral (Davis Vision provider) (no deductible)	
	Discounts available; See pages 39-41	Discounts available; See pages 39-41	
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB
	Pre-approval required Artificial Insemination—100% AB of charges (limited to 6 attempts per live birth); In Vitro Fertilization—100% AB of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Artificial Insemination—100% AB, pre-approval required (limited to 6 attempts per live birth); 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 (limited to 6 attempts per live birth); 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)
	100% AB	100% AB	80% AB
	100% AB at a BlueDistinction center	100% AB at a BlueDistinction center	80% AB at a BlueDistinction center

* Precertification required or penalties may apply.
** Mandatory generic substitution—see the CareFirst Drug Program section.

Medical Benefits Comparison Chart

The Benefits	BlueChoice HMO Open Access BlueChoice Providers	CareFirst BlueCross BlueShield Preferred Provider Organization	
		In-network BlueCross BlueShield PPO Providers	Out-of-network Participating and Non-participating Providers
SPECIAL SERVICES (CONTINUED)			
Ambulance When Medically Necessary (surface, air, private, and public)	100% AB	90% AB	Paid as in-network
Hearing Exam	$25 copay	$30 copay	70% AB
Hearing Aids (one per hearing impaired ear every 36 months)	100% AB	90% AB (no deductible)	70% AB
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Inpatient Care*	100% AB	90% AB	70% AB
Outpatient Facility	100% AB	90% AB	70% AB
Office Visits	$15 copay	$20 copay (no deductible)	70% AB
PRESCRIPTION DRUGS USING FORMULARY 2			
Prescription Drug Out-of-Pocket Max.	$6,600 Individual / $13,200 Family (integrated with medical out-of-pocket maximum)	$4,200 Individual / $8,400 Family	
Retail Prescription Drug**	$10 copay—Generic drug (Tier 1); $20 copay—Preferred Brand (Tier 2); $40 copay—Non-preferred Brand (Tier 3); Maintenance drugs: 90 day supply, 2 times retail copay at CVS only: $20 copay—Generic drug (Tier 1); $40 copay—Preferred Brand (Tier 2) $80 copay—Non-preferred Brand (Tier 3)	$30 copay Preferred Brand (Tier 2) $45 copay Non-preferred Brand (Tier 3) Maintenance medication up to 90 day supply 1 times retail at CVS only: $15 copay—Generic drug (Tier 1) $30 copay—Preferred Brand (Tier 2) $45 copay—Non-preferred Brand (Tier 3)	
Mail Order Drug**	CVS Caremark Mail Order—2 times retail copay—up to 90 day supply $20 copay—Generic drug (Tier 1); $40 copay—Preferred Brand (Tier 2); $80 copay—Non-preferred Brand (Tier 3)	CVS Caremark Mail Order Prescription Program for maintenance medication 1 times copay—Up to 90 day supply $15 copay—Generic drug (Tier 1) $30 copay—Preferred Brand (Tier 2) $45 copay—Non-preferred Brand (Tier 3)	
Oral Contraceptives**	100% AB	100% AB	
Diabetic Supplies	100% AB	100% AB	
VISION			
Routine Exam(limited to 1 visit/benefit period)	$10 per visit at participating vision provider	n/a	
Eyeglasses and Contact Lenses	Discounts from participating vision centers	n/a	

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 Comparison Chart

	Triple Option Open Access		
	Level 1 BlueChoice Providers	**Level 2 BlueCross BlueShield PPO Providers**	**Level 3 Participating and Non-participating Providers**
	100% AB	100% AB	Paid as Level 2
	$20 copay	$25 copay	80% AB
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB
	100% AB	100% AB	80% AB
	$15 copay	$20 copay	80% AB
	$5,400 Individual / $10,800 Family		
	$15 copay Generic drug (Tier 1) $30 copay Preferred Brand (Tier 2) $45 copay Non-preferred Brand (Tier 3) Maintenance medication up to 90 day supply 1 times retail at CVS only: $15 copay—Generic drug (Tier 1) $30 copay—Preferred Brand (Tier 2) $45 copay—Non-preferred Brand (Tier 3)		
	CVS Caremark Mail Order Prescription Program for maintenance medication 1 times copay—Up to 90 day supply $15 copay—Generic drug (Tier 1) $30 copay—Preferred Brand (Tier 2) $45 copay—Non-preferred Brand (Tier 3)		
	100% AB		
	100% AB		
	$10 per visit at participating vision provider		
	Discounts from participating vision centers		

Away From Home Care®

Your HMO coverage goes with you

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

Coverage while you're away

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

Enrolling in Away From Home Care

To make sure you and your covered dependents have ongoing access to care:

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



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

- The Host HMO will send you a new, temporary ID card which will identify your PCP and information on how to access your benefits while using Away From Home Care.
- 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.

BRC6389-1P (8/17)

BlueCard & Blue Cross Blue Shield 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 (BCBS 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 **bcbs.com**, or call BlueCard Access at 800-810-BLUE (2583).
3. Call the Customer Service number on the back of your member ID card to verify benefits or find out if pre-certification or prior authorization is required.
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 Blue Cross Blue Shield Global® Core program (BCBS Global® Core) provides medical assistance services and access to doctors, hospitals and other health care professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- At hospitals in the BCBS Global Core Network, you shouldn't have to pay up front for inpatient care, in most cases. You're responsible for the usual out-of-pocket expenses. And, the hospital should submit your claim.
- At hospitals outside the BCBS Global Core Network, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the BCBS Global Core Service Center. The claim form is available online at **bcbsglobalcore.com**.
- To find a BlueCard provider outside of the U.S. visit **bcbs.com**, select *Find a Doctor or Hospital.*

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

Medical assistance when outside the U.S.

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



Visit **bcbs.com** to find providers within the U.S. and around the world.

CareFirst Prescription Drug Program

For BlueChoice HMO, Triple Option and PPO Plans

Your pharmacy benefit program is based on the CareFirst Formulary 2, 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 and PPO CORE Plan members and two 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 1 times the copayment ($15/30/45). For PPO CORE, you can order up to a 90-day supply of maintenance medication for 1 times the required copayment ($15/30/45). For HMO, you can order a 90-day supply of maintenance medication for 2 times the copayment ($20/40/80). The copayment cannot be reimbursed through your Medical Benefits Plan.



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** 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 by completing the CVS Brand Exemption Form available on Sharepoint, Benelogic and hcps.org.
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.

Rx Choice Pharmacy Network

With the Rx Choice network, you can purchase your prescription medications from any of 57,000 in-network pharmacies located around the corner and across the country.



The Rx Choice network contains 57,000 pharmacies nationwide.

Rx Choice gives you access to both independent and national pharmacies including:

- CVS (including inside Target)
- Kroger
- Rite Aid
- Safeway
- Target
- Walmart

Finding and using in-network pharmacies

1. If your pharmacy is already in the network, you don't have to do anything.
2. If your current pharmacy is not in the Rx Choice network and you want to transfer an existing prescription to a network pharmacy, simply take your current medication label to the new pharmacy and they will handle the rest.
3. To check if your pharmacy is in the network:
   - When your CareFirst benefits are effective, log in to My Account at **carefirst.com/myaccount**. Go to *Drug and Pharmacy Resources* and select *Find a Pharmacy*.
   - Or, call CareFirst Pharmacy Services at 800-241-3371.

Please note: your coverage only provides benefits for pharmacies within the network. If you choose to use an out-of-network pharmacy, your prescriptions will not be covered.

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Maintenance Choice® Program

Options and savings when filling your maintenance medications

Maintenance medications are used to treat chronic, long-term conditions, such as high blood pressure or diabetes, and are taken on a regular, recurring basis. With our Maintenance Choice program, you can fill your three-month supply of maintenance medications for only two copays.

There are two ways you can fill your three-month supply of maintenance medications:

With CVS Caremark Mail Service, you can:

- Enjoy convenient home delivery service
- Refill your prescriptions online, by phone, or email
- Check account balances and make payments through an automated phone system
- Receive email or text notifications of order status
- Access a pharmacist by phone 24 hours a day

At a retail location, you can:

- Enjoy same-day prescription availability
- Talk with a pharmacist face-to-face
- Pick up your medications at a time convenient to you

If you would like...	Then...
To register for CVS Mail Service	Choose the option that works best for you: ■ Online: Go to **carefirst.com/myaccount** to login or register for *My Account*. Under the Coverage tab, select *Drug and Pharmacy Resources* and select *Request a New Mail Order Prescription.* ■ By phone: Call CareFirst Pharmacy Services at 800-241-3371 and our Customer Care representatives can walk you through the process.
To find a CVS Pharmacy retail location	Go to **carefirst.com/myaccount** to login or register for *My Account.* Click *Drug and Pharmacy Resources* and select *Find a Pharmacy* to find a location convenient for you.

A one-month supply of maintenance medications will only be covered up to two times at any network retail pharmacy. Afterwards, a three-month supply of maintenance medications will only be covered through CVS Caremark Mail Service or at a CVS Pharmacy retail location. For both options you will only pay the equivalent of two copays for a three-month supply of maintenance medications.

For more information, call CareFirst Pharmacy Services at 800-241-3371.

CareFirst Drug Program Summary of Benefits

Formulary 2

Plan Feature	BlueChoice HMO Open Access	Triple Option Open Access	Preferred Provider Organization	Description
Deductible	None	None	None	Your benefit does not have a deductible.
Prescription Drug Out-of-Pocket Maximum	$6,600 Individual/ $13,200 Family	$5,400 Individual/ $10,800 Family	$4,200 Individual/ $8,400 Family	Your benefit does not have a family deductible maximum.
Preventive Drugs (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.*
Oral Chemotherapy & Diabetic Supplies (up to a 34-day supply)	$0	$0	$0	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	$10	$15	$15	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	$20	$30	$30	All preferred brand drugs are covered at this copay level.
Non-Preferred Brand Drugs (Tier 3) (up to a 34-day supply)	$40	$45	$45	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Maintenance Copays (up to a 90-day supply)				Maintenance medication must be purchased at a CVS pharmacy or through Mail Service for a 90-day supply.
Retail (CVS only):				
Generic	$20	$15	$15	
Preferred	$40	$30	$30	
Non-preferred	$80	$45	$45	
Mail Order:				
Generic	$20	$15	$15	
Preferred	$40	$30	$30	
Non-preferred	$80	$45	$45	
Prior Authorization	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 **carefirst.com/rxgroup**.			
Mandatory Generic Substitution	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 66,000 participating pharmacies[1]
- Access to thousands of covered prescription 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 prescription drug benefit program, 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/rxgroup** 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 **(carefirst.com/myaccount)** by selecting *Drug and Pharmacy Resources* under *Coverage.*

[1] If your employer has selected the RxChoice network, you will have access to 57,000 retail pharmacies.

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
Tier 0: $0 Drugs	■ 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. ■ Oral chemotherapy drugs and diabetic supplies (e.g. insulin syringes, pen needles, lancets, test strips, and alcohol swabs) are also available at a zero dollar cost share.
Tier 1: Generic Drugs $	■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. ■ Generic drugs generally cost less than brand-name drugs.
Tier 2: Preferred Brand Drugs $$	■ Preferred brand drugs are brand-name drugs that may not be available in generic form, but are chosen for their cost effectiveness compared to alternatives. Your cost-share will be more than generics but less than non-preferred brand drugs. If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand category.
Tier 3: Non-Preferred Brand Drugs $$$	■ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost share will be lower.

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[2] national Pharmacy and Therapeutics (P&T) committee. By using the 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 formulary and Preferred Drug List, go to **carefirst.com/rxgroup**.

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

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/rxgroup**.

- **Quantity limits** are placed on selected drugs for safety, quality or utilization reasons. Limits may be placed on the amount of the drug covered per prescription or for a defined period of time. If your doctor decides that a different quantity of medication is right for you, your doctor can request prior authorization for coverage.
- **Prior authorization** is required before you fill prescriptions for certain drugs. Your doctor must obtain prior authorization before they can be filled. Without prior authorization approval, your drugs may not be covered.
- **Step therapy** ensures you receive a lower-cost drug option as the first step in treating certain health conditions. When similar drugs are available, step therapy guides your doctor to prescribe the lower-cost option first. You may then move up the cost levels until you find the drug that works best for you. Higher step drugs may require prior authorization by your doctor before they can be covered.

Two ways to fill

Retail pharmacies

With access to 66,000 pharmacies[1] across the country, you can visit **carefirst.com/rxgroup** 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 order 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, 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% 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 the Drug Pricing Tool**—this tool allows you to compare the cost of a drug purchased at a pharmacy versus purchasing the same drug through mail order, as well as view generic drugs available at a lower cost.
- **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.

[1] If your employer has selected the RxChoice network, you will have access to 57,000 retail pharmacies.

Care management programs

We offer care management programs and tools designed to improve your health while lowering your overall health care costs.

Specialty Pharmacy Coordination Program

This program addresses the unique clinical needs of members taking high-cost specialty drugs for certain complex health conditions like multiple sclerosis, rheumatoid arthritis and hemophilia. Members 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
- A one-month supply of your specialty drugs mailed to your home or office, or available for pick up at any CVS retail pharmacy

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.

SUM5041-1P (7/23)

BlueDental Plus–PPO Comprehensive Summary of Benefits

Includes access to a national provider network

	In-Network You Pay	Out-of-Network You Pay
DEDUCTIBLE APPLIES TO ALL BASIC AND MAJOR SERVICES*	$25 Individual/ $50 Family	$50 Individual/ $150 Family
ANNUAL MAXIMUM APPLIES TO ALL BASIC AND MAJOR SERVICES*	Plan pays $1,500 maximum	
PREVENTIVE & DIAGNOSTIC SERVICES		
▪ Oral Exams ▪ Prophylaxis ▪ X-rays ▪ Sealants	No charge[1]	35% of Allowed Benefit; Deductible does not apply; Non-participating providers may bill for the difference between the allowed benefit and the provider's charges.[1]
BASIC SERVICES		
▪ Fillings—includes posterior composite restorations ▪ Periodontics (gum treatment) ▪ Endodontics (root canals) ▪ Denture repair/relining ▪ Stainless steel crowns ▪ Bridges, bridge recementation/repair ▪ Implants—covered only as an alternative to a fixed bridge ▪ Oral surgery	20% of Allowed Benefit after deductible[1]	50% of Allowed Benefit after deductible; Non-participating providers may bill for the difference between the allowed benefit and the provider's charges[1]
▪ Surgical removal of impacted teeth	No charge after deductible[1]	35% of Allowed Benefit after deductible; Non-participating providers may bill for the difference between the allowed benefit and the provider's charges.[1]
MAJOR SERVICES		
▪ Dentures ▪ Crowns, inlays, onlays and cast restorations	50% of Allowed Benefit after deductible[1]	70% of Allowed Benefit after deductible; Non-participating providers may bill for the difference between the allowed benefit and the provider's charges.[1]
ORTHODONTIC SERVICES		
▪ Benefits for orthodontic services are available for dependent children up to age 19	50% of Allowed Benefit[1]	50% of Allowed Benefit; Deductible does not apply; Non-participating providers may bill for the difference between the allowed benefit and the provider's charges.[1]
ORTHODONTIC LIFETIME MAXIMUM	Plan pays $800 combined maximum	

[1] CareFirst payments are based on the CareFirst Allowed Benefit. Participating and Preferred Dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.

* Deductible and Annual Maximum Combined In-network/Out-of-network.

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

CareFirst of Maryland, Inc.: CFMI/BLUEDENTAL EOC (1/15); CFMI/BLUEDENTAL DOCS (R.7/21); CFMI/BLUEDENTAL SOB (R.7/21); CFMI/51+/GC (R. 1/13); CFMI/ELIG/D-V (7/09) and any amendments.

BlueDental Plus–PPO Comprehensive Summary of Benefits

Our plusses

- Most plans cover 100% of preventive and diagnostic services
- No claim forms or paperwork to fill out when a member sees a participating dentist
- We coordinate benefits for members with dental coverage from another carrier
- National network of participating dentists and specialists across the United States.

Our plans

With BlueDental Plus, you'll save the most money by seeing a participating provider.

What's a participating provider?
It's a dentist or specialist who is in our network and accepts our reduced negotiated fees as payment in full. This means no balance for you to pay, keeping your out-of-pocket costs low.

- **Option 1**—By choosing a dentist in the Preferred Provider Network, you pay the lowest out-of-pocket costs. These dentists accept CareFirst's allowed benefit as payment in full. You're only responsible for deductibles and coinsurance. And for your convenience, your provider is reimbursed directly.
- **Option 2**—By choosing a dentist who participates with CareFirst, but not through the Preferred Provider Network, you'll pay slightly higher out-of-pocket costs. Similar to Option 1, there is no balance to pay. You're still responsible for deductibles and coinsurance, and have the convenience of your provider being reimbursed directly.

Can I see a non-participating provider?
Of course. But your out-of- pocket expenses will be highest with providers outside our network. You may have to pay the difference between the dentist's fee and what your plan allows for those services.

Where can I find a dentist?
Visit **carefirst.com/doctor** and select *BlueDental* to view in-network providers.

When do I get my ID card?
Member ID cards are mailed to your home after enrollment. You can also access your ID card—along with other claims and benefit information—at My Account or on the CareFirst mobile app. Visit **carefirst.com/myaccount** to register.

Who can I call with questions about my dental plan?
Call Dental Customer Service toll free at 866-891-2802 between 8 a.m. and 6 p.m. ET, Monday–Friday.

Common dental insurance terms

Deductible: The amount you are responsible for before CareFirst pays for dental services.

Family deductible: A deductible that is satisfied by the combined expenses of all covered family members. For example, a plan with a $25 deductible may be limited to a maximum of three deductibles ($75 per family) regardless of the number of family members.

Coinsurance: Your share of the dentist's fee after CareFirst has paid its share.

Annual maximum: The yearly reimbursement level for an individual/family set by your CareFirst dental plan.

BlueDental Plus–PPO Standard Summary of Benefits

Includes access to a national provider network

	In-Network You Pay	Out-of-Network You Pay
DEDUCTIBLE APPLIES TO ALL BASIC AND MAJOR SERVICES*	$25 Individual/ $50 Family	$25 Individual/ $50 Family
ANNUAL MAXIMUM APPLIES TO ALL BASIC AND MAJOR SERVICES*	Plan pays $1,500 maximum	
PREVENTIVE & DIAGNOSTIC SERVICES (Deductible and Annual Maximum do not apply)		
▪ Oral Exams ▪ Cleanings ▪ X-rays ▪ Sealants	No charge[1]	Deductible does not apply; Non-participating providers may bill for the difference between the allowed benefit and the provider's charges.[1]
BASIC SERVICES		
▪ Fillings (includes posterior composite restorations) ▪ Endodontics (root canals) ▪ Oral surgery ▪ Stainless steel crowns	No charge after deductible[1]	Deductible applies; Non-participating providers may bill for the difference between the allowed benefit and the provider's charges.[1]
MAJOR SERVICES (NOT COVERED UNDER PLAN)		
▪ Periodontics ▪ Crowns ▪ Inlays ▪ Onlays ▪ Cast restorations ▪ Bridges ▪ Dentures	Not covered	Not covered

[1] CareFirst payments are based on the CareFirst Allowed Benefit. Participating and Preferred Dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.

* Deductible and Annual Maximum Combined In-network/Out-of-network.

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

CareFirst of Maryland, Inc.: CFMI/BLUEDENTAL EOC (1/15); CFMI/BLUEDENTAL DOCS (R.7/21); CFMI/BLUEDENTAL SOB (R.7/21); CFMI/51+/GC (R. 1/13); CFMI/ELIG/D-V (7/09) and any amendments.

BlueDental Plus–PPO Standard Summary of Benefits

Our plusses

- Most plans cover 100% of preventive and diagnostic services
- No claim forms or paperwork to fill out when a member sees a participating dentist
- We coordinate benefits for members with dental coverage from another carrier
- National network of participating dentists and specialists across the United States.

Our plans

With BlueDental Plus, you'll save the most money by seeing a participating provider.

What's a participating provider?
It's a dentist or specialist who is in our network and accepts our reduced negotiated fees as payment in full. This means no balance for you to pay, keeping your out-of-pocket costs low.

- **Option 1**—By choosing a dentist in the Preferred Provider Network, you pay the lowest out-of-pocket costs. These dentists accept CareFirst's allowed benefit as payment in full. You're only responsible for deductibles and coinsurance. And for your convenience, your provider is reimbursed directly.
- **Option 2**—By choosing a dentist who participates with CareFirst, but not through the Preferred Provider Network, you'll pay slightly higher out-of-pocket costs. Similar to Option 1, there is no balance to pay. You're still responsible for deductibles and coinsurance, and have the convenience of your provider being reimbursed directly.

Can I see a non-participating provider?
Of course. But your out-of- pocket expenses will be highest with providers outside our network. You may have to pay the difference between the dentist's fee and what your plan allows for those services.

Where can I find a dentist?
Visit **carefirst.com/doctor** and select *BlueDental* to view in-network providers.

When do I get my ID card?
Member ID cards are mailed to your home after enrollment. You can also access your ID card—along with other claims and benefit information—at My Account or on the CareFirst mobile app. Visit **carefirst.com/myaccount** to register.

Who can I call with questions about my dental plan?
Call Dental Customer Service toll free at 866-891-2802 between 8 a.m. and 6 p.m. ET, Monday–Friday.

Common dental insurance terms

Deductible: The amount you are responsible for before CareFirst pays for dental services.

Family deductible: A deductible that is satisfied by the combined expenses of all covered family members. For example, a plan with a $25 deductible may be limited to a maximum of three deductibles ($75 per family) regardless of the number of family members.

Coinsurance: Your share of the dentist's fee after CareFirst has paid its share.

Annual maximum: The yearly reimbursement level for an individual/family set by your CareFirst dental plan.

Core BlueVision Summary of Benefits

(Included with BlueChoice and Triple Option only)

12-month benefit period

In-Network	You Pay
EYE EXAMINATIONS[1]	
Routine Eye Examination with dilation (per benefit period)	$10
FRAMES[1,2]	
Priced up to $70 retail	$40
Priced above $70 retail	$40, plus 90% of the amount over $70
SPECTACLE LENSES[2]	
Single Vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
LENS OPTIONS[2,3] (add to spectacle lens prices above)	
Standard Progressive Lenses	$75
Premium Progressive Lenses (Varilux®, etc.)	$125
Polarized Lenses	$75
High Index Lenses	$55
Glass Lenses	$18
Polycarbonate Lenses	$30

In-Network	You Pay
LENS OPTIONS[1,2] (add to spectacle lens prices above)	
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
CONTACT LENSES[1]	
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
LASER VISION CORRECTION[1]	
Up to 25% off allowed amount or 5% off any advertised special[3]	

[1] At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.

[2] CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.

[3] Special lens designs, materials, powers and frames may require additional cost.

[4] Some providers have flat fees that are equivalent to these discounts.

Exclusions

The following services are excluded from coverage:

1. Diagnostic services, except as listed in What's Covered under the Evidence of Coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
3. Prescription drugs obtained and self-administered by the mem
4. 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.
5. Services or supplies not specifically approved by the Vision Care Designee where required in What's Covered under the Evidence of Coverage.
6. Orthoptics, vision training and low vision aids.
7. Glasses, sunglasses or contact lenses.
8. Vision Care services for cosmetic use.
9. 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)

BlueVision—a plan for healthy eyes, healthy lives

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

How the plan works?

How do I find a provider

To find a provider, go to **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[1].

Mail order replacement contact lenses

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



Need more information?
Visit **carefirst.com** or call 800-783-5602.

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

BlueVision Plus Summary of Benefits

12-month benefit period

Benefit	In-Network You Pay	Out-of-Network You Pay
EYE EXAMINATIONS (once per 12-month benefit period)		
Routine Eye Examination with dilation	No copay	Plan pays $40, you pay balance
FRAMES (once per 12-month benefit period)		
Davis Vision Frame Collection[1]	No copay for over 200 frames	Not applicable
Non-Collection Frame	Plan pays up to $200, you pay balance minus 20% discount[3,4]	Plan pays $70, you pay balance
SPECTACLE LENSES (once per 12-month benefit period)		
Basic Single Vision	$10 copay	Plan pays $40, you pay balance
Basic Bifocal	$10 copay	Plan pays $60, you pay balance
Basic Trifocal	$10 copay	Plan pays $80, you pay balance
Progressive Lenses (stand/prem/ultra/ultimate)	$0/$0/$140/$175	Up to $60 (in lieu of bifocal reimbursement)
CONTACT LENSES (initial supply; once per 12-month benefit period, in lieu of eyeglasses)		
Medically Necessary Contacts	No copay with prior approval	Plan pays $250, you pay balance
Davis Vision Contact Lens Collection[1]	No copay	Not applicable
Other (Non-Collection) Contact Lenses	Plan pays up to $200, you pay balance minus 15% discount[3,4]	Plan pays $100, you pay balance
CONTACT LENS EVALUATION, FITTING AND FOLLOW-UP CARE (once per 12-month benefit period)		
Davis Vision Collection[1], Standard Contact Lenses & Medically Necessary Contact Lenses	Covered	Not applicable
Specialty Contact Lenses that are non-collection, including, but not limited to, toric, multi- focal and gas permeable lenses	$40 Copay[3,4,]	Not applicable

Value Add and Discounts[3,4] (fixed fee)			
LENS OPTIONS[3,4] (add to spectacle prices above)			
Tinting of Plastic Lenses (Solid/Gradient)	$0	Anti-Reflective (AR) Coating (Standard/Premium/Ultra/Ultimate)	$35/$48/$60/$85
Scratch-Resistant Coating	$0	High-Index Lenses (1.67/1.74)	$55/$120
Polycarbonate Lenses (Children/Adults)[2]	$0	Polarized Lenses	$75
Ultraviolet Coating	$12	Plastic Photochromic Lenses	$65
Blue Light Coating	$15	Scratch Protection Plan: Single Vision/ Multifocal Lenses	$20/$40
ADDITIONAL DISCOUNTED SERVICES[3,4]			
Retinal Imaging—Member Charge	$39		
Laser Vision Correction[3]	Up to 25% off allowed amount or 5% off any advertised special[3]		

[1] Collection is available at most participating independent provider offices. Collection is subject to change.
[2] Polycarbonate lenses are covered for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.
[3] These discounts are not considered covered benefits under the Plan. This portion of the Plan is not an insurance product. Additional plan discounts may not be available at all provider locations in all states. Please confirm that discounts are accepted when making your appointment. Discounts are not insurance and subject to change without notice.
[4] Available additional discounts not applicable at Glasses.com, 1-800 Contacts, Walmart locations, Sam's Club locations, or Costco locations or where limited by law or manufacturer restrictions.
[5] Reena Mukamal, "20 Surprising Health Problems an Eye Exam Can Catch," American Academy of Ophthalmology, aao.org.

BlueVision Plus Summary of Benefits

Did you know that eye exams allow eye care professionals to take a non-invasive look inside the body? An eye care professional can detect up to 20 chronic medical conditions during an eye exam, from diabetes and heart disease to hypertension and cognitive dysfunction, even before symptoms occur[5].

How the plan works

Our Plusses

Davis Vision® administers BlueVision Plus. Our vision plans provide an affordable way for members to receive their annual eye exams. And if you need corrective lenses, we have you covered there too.

National Network

More than 121,000 access points across the U.S. accept BlueVision Plus. This includes private practices, retailers, and online retailers such as Visionworks, Walmart, Costco and Glasses.com.

How do I find a provider?

To find a provider, go to **carefirst.com** and use the Find a Provider feature or call Davis Vision for a list of network providers closest to you at 800-783-5602, available seven days a week. Service is available 8 a.m.–11 p.m., Monday through Friday; 9 a.m.–4 p.m., Saturday; and noon–4 p.m. on Sunday.

Be sure to ask your provider if they participate with the Davis Vision network before receiving care.

How do I receive care from a network provider?

Call your provider and schedule an appointment. Identify yourself as a CareFirst BlueVision Plus member and provide the doctor with your identification number, as well as your date of birth. Then go to your appointment and receive care. There are no claim forms to file.

What if I go out-of-network?

Staying in-network gives you the best benefit, but BlueVision Plus does offer some out-of-network coverage. However, you will be responsible for all payments upfront and need to file a claim with Davis Vision for reimbursement. You must also pay any balances over the allowed benefit to the non-participating provider. Find the claim form at **carefirst.com:** locate *For Members*, then click on *Forms, Vision, Davis Vision.*

Can I get contacts and eyeglasses in the same benefit period?

No. BlueVision Plus covers one pair of eyeglasses OR a supply of contact lenses per benefit period.

When do I get my ID card?

Member ID cards are mailed to your home after enrollment. You can also access your member ID card—along with other claims and benefit information—at My Account or on the CareFirst mobile app. Visit **carefirst.com/myaccount** to register.

BlueVision Core vs BlueVision Plus

Some CareFirst members have an embedded vision product called BlueVision Core (exam only with discounts) plan AND a BlueVision Plus plan. To ensure you are receiving your BlueVision Plus benefits look for the **VU indicator on your member ID card**.



Other benefits

- **Access to in-network online retail partners:** Glasses.com, Warby Parker and Befitting
- **Hearing aid discounts** through YourHearing Network
- **Free LASIK consultation**
  - **Under $1,000/eye for conventional LASIK** (usually $1,677/eye)
  - **40-50% off** the national average price
  - **1,000 locations nationwide**

Mental Health Support

Well-being for mind and body

Living your best life means taking care of your body *and* your mind. Emotional well-being is important at every stage in life, from adolescence through adulthood.

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

CareFirst BlueCross BlueShield (CareFirst) is here to help. Members have access to specialized services and programs for depression, anxiety, substance use disorders, and more. Our support team is made up of specially trained service representatives, registered nurses, licensed clinicians and care managers ready to:

- Help you find the right mental health provider(s) and schedule appointments
- Connect you with a care coordinator who will work with your doctor to create a tailored action plan
- Find support groups and resources to help you stay on track



To find help, call us at 800-245-7013.

988 SUICIDE & CRISIS LIFELINE

Manage Your Healthcare with My Account

As a CareFirst BlueCross BlueShield (CareFirst) member, your personalized benefit information is available 24/7. Register for My Account for secure online access to your coverage details, ID card and more. Plus, you'll also be able to quickly locate in-network providers and facilities nationwide.

Scan the QR code or visit carefirst.com/myaccount to register.

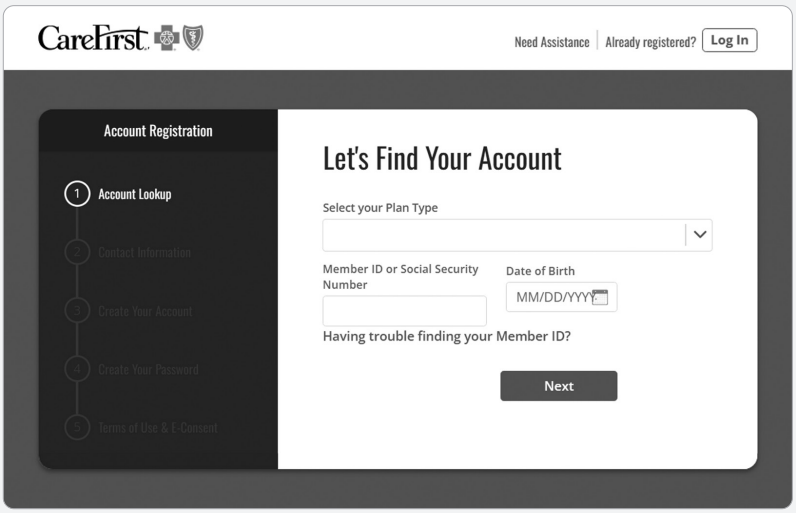
Get started

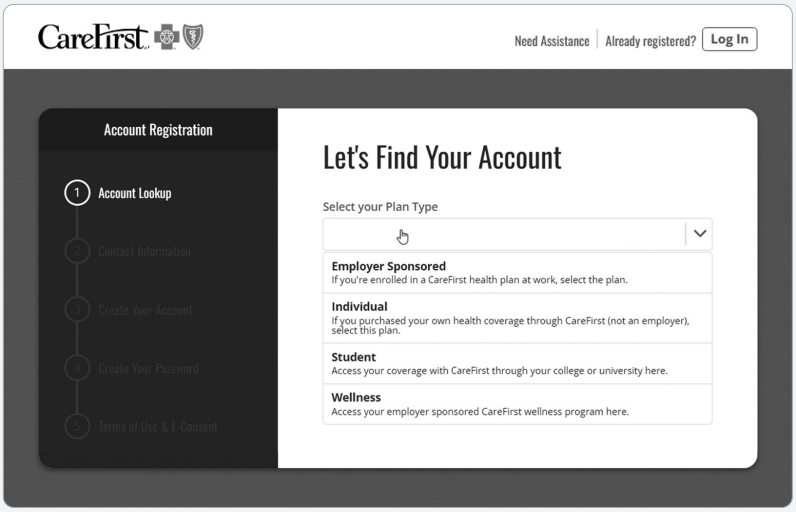
Members 12 years of age and older may register for My Account. Have your member ID or, the last four digits of your social security number. Signing up is easy and only takes a few minutes.

Complete a few more steps and you're ready to access your personalized member portal.

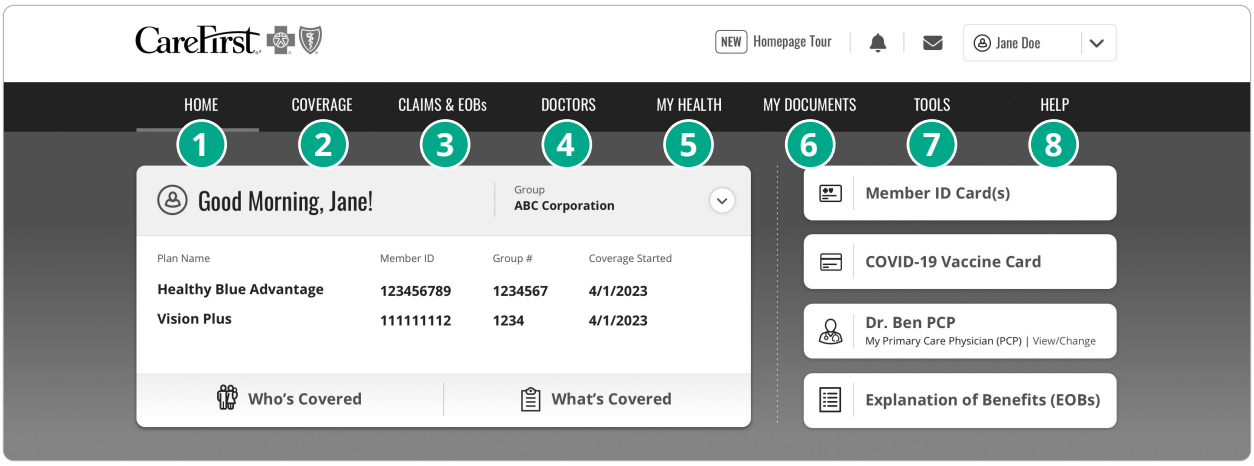
Already registered?

Explore the features My Account offers on the next page.





Manage Your Healthcare with My Account



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)[1]
- Order and refill prescriptions
- View prescription drug claims

3 Claims & EOBs

- 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[1]
- Track your Blue Rewards progress[1]

6 My Documents

- Look up plan forms and documents[2]
- Download *Vitality*, your annual member resource guide

7 Tools

- Access the Treatment Cost Estimator to calculate costs for services and procedures[3]
- Use the Drug Pricing Tool to determine prescription costs

8 Help

- Find answers to many frequently asked questions
- Send a secure message
- Locate important phone numbers

[1] Only if offered by your plan.

[2] Only available when using a computer.

[3] The doctors accessed via this website are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

SUM4146-1E (7/24)

Take the Call

As part of your medical benefits, you may receive a call from us (or a letter or postcard in the mail) telling you more about our personal, one-on-one health support programs that can help with whatever you're facing. These programs are confidential, and there's no obligation to participate.

Confidential, one-on-one support

Below are a few examples of when we might contact you about our personal health programs.

	Program name	Overview	Why it's important	Communication
	**Health & Wellness**	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 ***coach***
	**Care Management**	Support for a variety of acute and chronic medical conditions and healthcare concerns and/or supporting transition from hospital to home	Connecting you with a nurse who works closely with your primary care provider (PCP) or specialist to help you understand your doctor's recommendations, medications and treatment plans. The nurse may provide interventions and resources to help you independently manage your healthcare or transition safely from the hospital to home.	Introduction by PCP or a phone call from a ***registered nurse care manager***
	**Pharmacy Advisor**	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 ***CVS Caremark pharmacy specialist***
	Comprehensive Medication Review	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 ***CVS Caremark pharmacist***
	Specialty Pharmacy Coordination	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 ***CVS Caremark specialty nurse***
	**Behavioral Health and Substance Use Disorder**	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 ***CareFirst behavioral health care coordinator***

CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst members. CVS Caremark does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the pharmacy benefit management services it provides.



You don't need to wait for us to contact you. If you would like to learn more about our one-on-one coaching and support programs, visit **carefirst.com/takethecall**.

Know Before You Go

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

Primary care provider (PCP)

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

CloseKnit Virtual Care

Our virtual-first practice, CloseKnit, offers 24/7/365 virtual primary care, behavioral health, and urgent care services.

Primary care patients have access to a dedicated Care Team equipped to treat most medical concerns virtually, through CloseKnit's convenient mobile app. The team can direct to in-person or specialty care when needed and can help patients manage medications, chronic conditions, navigate billing and more.

Urgent care services, for conditions such as cold or flu, and behavioral health visits, are available to patients regardless of whether they've selected CloseKnit as their primary care provider.

24-Hour Nurse Advice Line

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

Convenience care centers (retail health clinics)

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

Urgent care centers

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

Emergency room (ER)

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

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.

* The medical providers mentioned in this document are independent providers making their own medical determinations and are not employed by CareFirst BlueCross BlueShield. 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	Needs or Symptoms	24/7	Rx
24-Hour Nurse Advice Line		If you are unsure about your symptoms or where to go for care, call 800-535-9700, anytime day or night to speak to a registered nurse.		
CloseKnit Virtual Care *(24/7/365 virtual-first care for members)*		■ Cough, cold and flu ■ Urgent care needs ■ Illness while traveling ■ Therapy	✔	✔
Convenience Care *(e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)*		■ Cough, cold and flu ■ Pink eye ■ Ear pain	✘	✔
Urgent Care *(Non-life threatening illness or injury requiring immediate care, e.g., Patient First or ExpressCare)*		■ Sprains ■ Cut requiring stitches ■ Minor burns	✘	✔
Emergency Room *(Life-threatening illness or injury)*		■ Chest pain ■ Difficulty breathing ■ Abdominal pain	✔	✔

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

To determine your specific benefits and associated costs:

- Log in to My Account at **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.

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.

SUM3424-1P (7/24)

Selecting a Primary Care Provider (PCP)

A PCP is a health care practitioner who specializes in your overall health as well as the coordination of your specialty care. Everyone can benefit from having a PCP but only certain CareFirst plans require you to formally select a PCP in the system. For you to select a practitioner as your PCP, they must display the blue PCP oval **PCP** next to their name.

Before you start

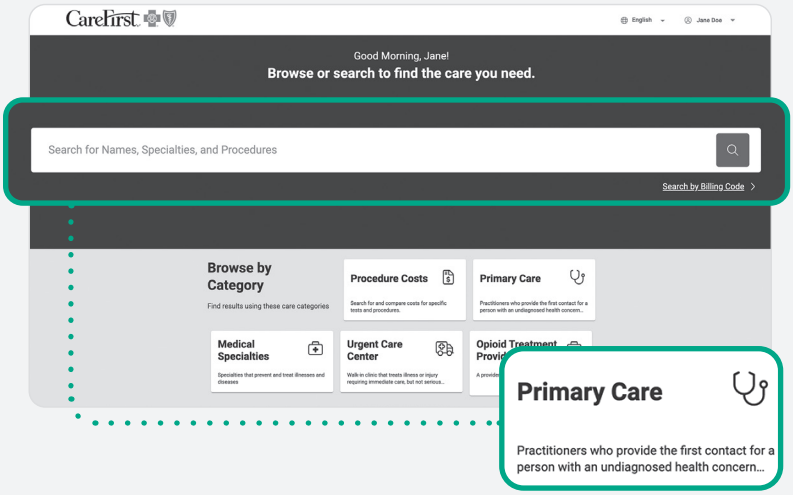
First, you'll need to log in to your My Account page. To do this, visit **member.carefirst.com** and enter your username and password. Then follow these steps.

1. Click on *Doctors* in the main navigation bar.
2. Select *Find a Doctor* from the drop-down menu.
3. On the following page, click *Proceed*.

Step 1: Start your PCP search

To start searching for a PCP, select the *Primary Care* tile.

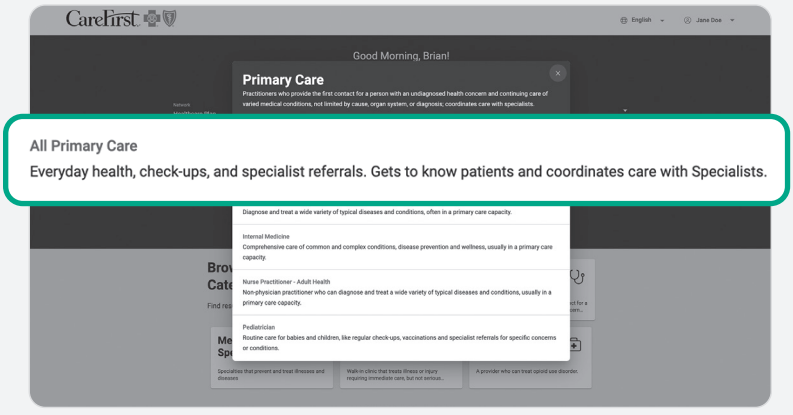
If you already have the name of a primary care provider and would like to see if they're in our network, you can enter their name in the search bar.



Step 2: Focus your search

It's best to begin a new search by selecting *All Primary Care*.

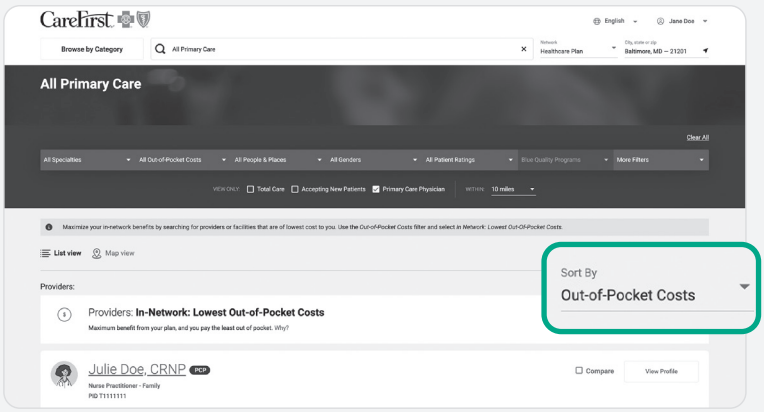
If you know you need a specific type of PCP, you can choose it from the list.



Step 3: Review your results

A list of providers will be displayed. In-network doctors will appear at the top of the list, with those closest to your zip code shown first.

You can change how the results are sorted by clicking on the *Sort By* menu. You can also change the area you're searching by clicking *City, State or Zip.*

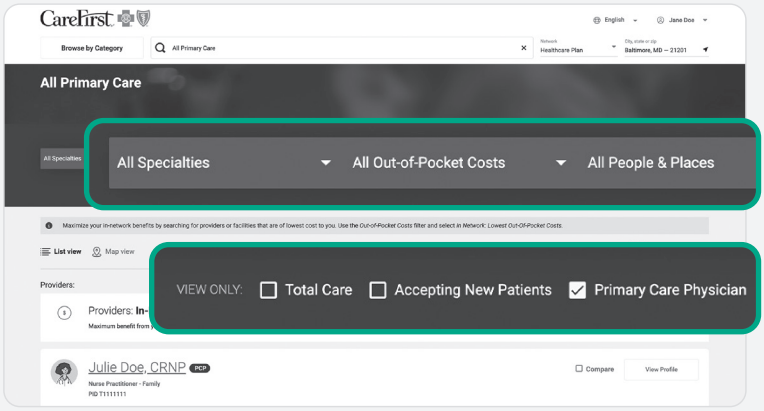


Step 4: Refine your results

You can refine your search results in two places:

- Filter bar
- View Only bar

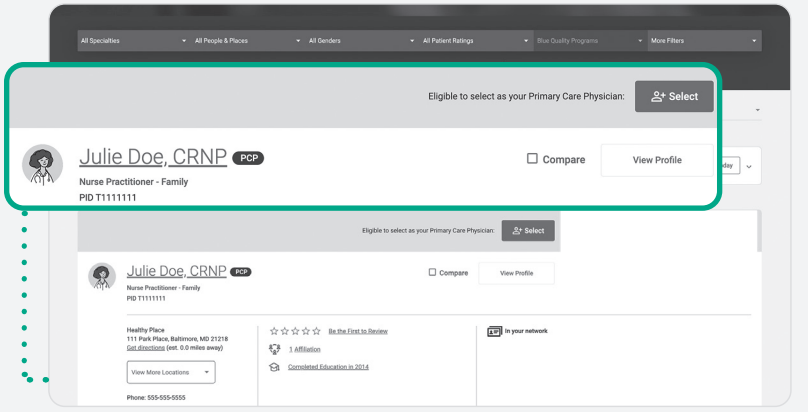
When you make a selection from either of the two bars, the Find a Doctor tool will automatically refresh your search results.



Step 5: Make your selection

Once you've found a PCP that fits your needs, click the blue *Select* button above their profile. This will return you to your My Account page. Just follow the prompts to confirm your selection.

Remember: The blue PCP oval indicates that a provider meets the requirements to serve as your primary care provider. You cannot select a provider that doesn't display this oval.



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

SUM7102-1N (6/24)

CareFirst WellBeing

Putting the power of health in your hands

Welcome to CareFirst WellBeing℠—your personalized digital connection to your healthiest life. Catering to your unique health and wellness goals, CareFirst WellBeing offers motivating digital resources accessible anytime, plus specialized programs for extra support.

Ready to take charge of your health?

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

Exclusive features

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

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



Download the mobile app to access well-being tools and resources whenever and wherever you want.

Specialized programs

The following programs can help you focus on specific wellness goals.

Health coaching

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

Weight management program

We offer two weight management programs in our WellBeing collection. If eligible, you can choose either psychology-based program to help you achieve and sustain a healthier weight, as well as reduce your risk for type 2 diabetes.

Tobacco cessation program

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

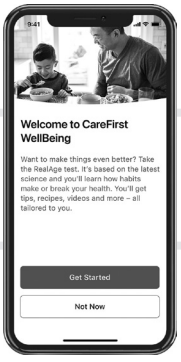
Financial well-being program

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

Additional offerings

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

To explore or register for the program, visit **carefirst.com/wellbeing** or download the CareFirst WellBeing app.



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

SUM6174-1P (9/23)

Flexible Spending Account (FSA) Highlights

What is a Flexible Spending Account?

A Flexible Spending Account (FSA) permits you to pay for certain health care and/or dependent care expenses with pre-tax dollars. Because you will not pay any federal, state or social security taxes on income placed into the plan, you can potentially save $30-$40 for every $100 you elect to defer.

Who is eligible?

All active benefit eligible employees working for Harford County Public Schools are eligible to participate in the Flexible Spending Accounts.

Two types of FSAs available to you

Health care spending account

You may set aside up to $3,400 annually in a Health Care Spending Account to pay for qualified medical, prescription drug copayments, certain over-the-counter (OTC) supplies, dental and vision care expenses. The health care expenses may be for you, your spouse, or your dependents (as long as you claim them as dependents on your tax return or through the tax year in which they turn 26.)

Dependent care spending account

The Dependent Care Account helps you pay the cost of day care for your dependents so you and your spouse can work. Eligible dependents for this account must be claimed as dependents on your federal tax return and either be:

- Under age 13, or
- Mentally or physically unable to care for him/herself regardless of age (this may be a spouse or older relative).

If you are single or are married and filing a joint tax return, you may contribute up to $7,500 each contract year. If you are married and filing a separate tax return, you may contribute up to $3,750 per year.

How FSAs work

- During open enrollment (or when you first become eligible) you decide how much you want to contribute from your pay to a FSA. You can establish a FSA for your health care expenses and/or for your dependent care expenses. Note that health care FSAs and dependent care FSAs are two separate accounts, and not interchangeable.
- When you enroll, you authorize your employer to deduct a certain portion of your earnings each pay period, before taxes. Your contributions are set aside in your FSA throughout the year via payroll deduction.
- When you have an eligible expense, you can use your FBA Benefits Card or pay the cost up front and be reimbursed from your account. Remember, you do not pay taxes on the money reimbursed to you from your Flexible Spending Account.
- You can contribute up to $7,500 a year to the dependent care FSA (or $3,750 a year if you are married but file a separate tax return from your spouse). You can contribute up to $3,400 a year to the health care FSA.
- If you have money left in your account at the end of the plan year, it cannot be returned to you nor carried over to the next plan year. For strategies on using your account balance, see Planning Your Election.

How flexible spending accounts will save you money

When you elect to participate in a FSA, you will have a specific amount of dollars deducted from your gross earnings (before tax) each pay period. By contributing pre-tax dollars, you will lower your taxable income and increase your spendable income! In fact, by participating you are actually using dollars you would have paid in taxes to help pay for your medical and/or dependent care costs. Below are some examples of how much YOU can save on your everyday expenses.

Sample health care expenses	Your cost without a FSA	Your cost with a FSA	Your estimated out-of-pocket savings*
PPO Doctor Copay	$20.00	$14.00	$6.00
HMO Doctor Copay	$15.00	$10.50	$4.50
PPO Generic Retail Rx Copay	$15.00	$10.50	$4.50
HMO Non-preferred Brand Rx Copay	$30.00	$21.00	$9.00
Over-the-Counter Pain Reliever	$10.00	$7.00	$3.00
Monthly Diabetic Supplies	$100.00	$70.00	$30.00
Monthly Orthodontic Payment	$125.00	$87.50	$37.50
Eyeglasses	$300.00	$210.00	$90.00
Laser Eye Surgery	$2,500.00	$1,750.00	$750.00
Sample dependent care expenses			
Daycare for child under age 13	$5,000.00	$3,500.00	$1,500.00
Before/After School Care	$4,000.00	$2,800.00	$1,200.00
Summer Camp	$2,400.00	$1,680.00	$720.00
Disabled/Elder Adult Daycare	$5,000.00	$3,500.00	$1,500.00

*Assuming 15% Federal Tax Bracket

Important Flexible Spending Accounts information

IRS regulations impose a "use it or lose it" rule that requires you to forfeit any money not used by the end of the Plan Year. HCPS can neither refund money to you nor carry it forward from one Plan Year to the next.

You must re-enroll in FSAs each Plan Year, even if you keep the amount of your contributions the same.

You may participate in one or both of the Flexible Spending Accounts, but the Health Care and Dependent Care spending accounts are separate. Money cannot be transferred from one account to the other.

You may choose either the pre-tax advantage of the dependent care spending account, or claim a tax credit on your federal income return, but you may not do both. Consult your tax advisor to determine whether the FSA or the tax credit gives you the greater tax advantage.

New hires (or enrollments due to a qualified life event) joining the plan after the beginning of the Plan Year should determine how many payroll deductions for benefits remain before deciding upon the amount to set aside in FSAs. Payroll deductions are taken from 22 consecutive pays from September 1—June 30.

Planning your election

Here are just a few strategies you can use to be sure that you are making every penny count in your FSA!

Plan ahead when enrolling

Base your contribution on your anticipated expenses for the plan year which are not covered by other insurance or benefit plans.

Look back to last year

One way to estimate those expenses is to look back at the health care and dependent care expense you paid out of your own pocket during the past year. This can be the starting point for your annual contribution, adjusted of course for any past or future extraordinary expenses.

Look outside your health plan

Many health care plans offer some, but not full, coverage for certain expenses such as laser eye surgery, orthodontia, over-the-counter (OTC) medicines*, etc.

Evaluate your home pharmacy

Start by throwing away all expired over-the-counter (OTC) medications. Then, the next time your visit your health care provider, ask for a prescription for the OTC medications you use on a regular basis. These may include allergy medications, antacids, cold medications, pain relievers. Bandaids, ace bandages, contact lens solutions, and other OTC items (non-medication) can be reimbursed without a prescription.

Be conservative

Any unused funds cannot carry forward to the next plan year and are forfeited.

Enrolling in the plan

Make your election during open enrollment (or when you first become eligible).

- Determine your election amount(s) by using the FSA Worksheet.
- Elect up to the plan maximums.
- Remember you do not have to participate in the health plan to be eligible for the FSA.
- Annual election(s) will be deducted equally pre-tax over the course of your plan year.

FSA debit card

Participating in a FSA with FBA Benefits Card has many advantages! Look at what the card can do for you.

- Eliminates the need of filling out claims forms and waiting for a reimbursement check.
- Most transactions will not require supporting documentation.
- FBA Benefits will notify you by email when substantiation is required and will also provide you with a monthly statement of unsubstantiated claims.
- If you choose not to use the card or if your provider does not accept MasterCard®, you can pay out-of-pocket and submit for reimbursement.

Look how the advantages really add up. It's time for YOU to begin saving money and simplifying your expenses.

FSA grace period

You have an extended 2 1⁄2 months time frame (until 9/15/2026) to incur expenses and have them applied towards your 7/1/2025–6/30/2026 account. Expenses incurred during the Grace Period (July 1 through September 15) and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. It is important to keep the extension in mind when you determine your new FSA contributions. This added feature will help to virtually eliminate the "use it or lose it" clause associated with Flexible Spending Accounts.

Amounts remaining in your account at the end of the Plan Year that are not applied to pay expenses submitted on or before the October 28th deadline will be forfeited. Claim forms are available at **flex-admin.com**.

The FBA Benefits Card

The FBA Benefits Card offers the convenience of paying for your eligible expenses directly at the

Flexible Spending Account (FSA) Highlights

Type of FSA	Maximum Annual Contribution	Examples of Eligible Expenses*	
Health Care	$3,400 (NOTE: Deduction amounts must be in whole dollar increments)	▪ orthodontia** ▪ copayments ▪ deductibles ▪ acupuncture ▪ chiropractic care ▪ hearing aids and batteries	▪ eyeglasses ▪ smoking cessation expenses ▪ LASIK eye surgery ▪ Prescription drug copayments ▪ certain OTC supplies
Dependent Care	$7,500 (NOTE: Deduction amounts must be in whole dollar increments)	▪ licensed day care facility, child or adult ▪ pre-school or nursery school (not kindergarten) ▪ before and after-school programs	▪ care in someone else's home ▪ housekeeper who performs dependent care duties ▪ day care provided by a non-dependent relative over the age of 19

* The Internal Revenue Service (IRS) determines which expenses are eligible and which are ineligible. For a detailed list of examples, please refer to hfsbenefits.com.

** For orthodontia reimbursement, send a copy of your orthodontia agreement (orthodontic contract) along with your completed claim form when treatment begins. The orthodontic agreement must state:

1. The beginning date of service
2. The approximate length of service
3. Total cost of service
4. Record fee
5. Initial fee (down payment)
6. Subsequent monthly fees
7. Total insurance coverage (if applicable)

** The fee for orthodontic records is eligible for reimbursement on the date the x-rays, photos, and casts are taken. Proper documentation is a statement of services rendered from orthodontist. The initial fee (down payment) is eligible for reimbursement on the date of the first treatment. Again proper documentation is a statement of services rendered from orthodontist.

Subsequent monthly fees are eligible for reimbursement as monthly orthodontic adjustments occur. Proper documentation is a statement of services rendered, a receipt from orthodontist showing date of payment ("orthodontic" clearly noted on receipt), or a copy of payment stub from orthodontic payment booklet. Special payment schedules, which do not coincide with dates of service (such as full payment at banding) will be paid in equal installments over the period of service. Orthodontics is an ongoing treatment and the IRS prohibits pre-payment of these services.

point of sale. It works like any other credit card. Since the card lets you pay for eligible health care expenses directly from your health care FSA, it means no more paying cash for services up front. It also eliminates the waiting period for reimbursement checks and the hassle of filling out claims forms. The FBA Benefits Card can be used at authorized health care providers where MasterCard® is accepted. If you plan to use your FBA Benefits Card to pay for daycare expenses, please check with your daycare provider to see if they are equipped to accept MasterCard®.

Since the FSA plan is a pre-tax benefit, the Internal Revenue Service (IRS) requires that all purchases be substantiated. Therefore, you may be required to submit copies of your receipts to the plan administrator to comply with the guidelines provided by the IRS.

For the health care FSA, the limit on your card is your annual elected contribution amount. For the dependent care FSA, the limit on your card is your YTD payroll deduction less your YTD reimbursed. If a service provider does not accept the card, you can always submit a claim for reimbursement. FBA Benefits will either mail a reimbursement check to your home address or issue a direct deposit into the bank account that you have provided. More information about the FBA Benefits Card is available at **flex-admin.com**.

Required record keeping

Save all your receipts in a convenient location since all purchases made with your FBA Benefits Card must be verified. The plan administrator is required to substantiate all transactions that do not match an exact copayment associated with your employer's health plan. This system will also be helpful when preparing your taxes!

Flexible Spending Account (FSA) Highlights

Your FSA administrator

Please contact Flexible Benefit Administrators, Inc. with any questions regarding your FSA plan. The flex division is available Monday-Friday 8:30 a.m. – 5 p.m. ET.

Flexible Benefit Administrators, Inc.
509 Viking Drive, Suite F
Virginia Beach, VA 23450

Phone: 800-437-3539
Website Address: **flex-admin.com**

All forms are available on HCPS SharePoint at: **HumanResources/benefits** or the FBA website.

Online account access

You also have 24/7 access to your account balance and claim information. If you are a first-time user, you will need to go to the New User link to set up your account. You must have an email address on your account to proceed with the online account creation. Please follow the steps below for account creation:

- Go to **https://fba.wealthcareportal.com**
- Click on *Register*.
- Employee ID is your SSN (without dashes)
- Enter your **Email**.
- Employer ID is FBAHCPS or benefits card number
- Click on *Submit*.

If you need assistance in setting up your account, please contact FBA Benefits and a representative will assist you.



FSA frequently asked questions

Q. When is the plan year for FSA?.

A. The plan FSA is July 1 to June 30.

Q. Can I participate in the FSA Plans if I am not enrolled in my employer's health plan.

A. Yes. As long as you meet the benefit eligibility requirements you can participate in either FSA.

Q. Can I use the Medical Care FSA to pay for my spouse's deductibles or copayments if they aren't covered by my group medical plan?

A. Yes. However, health care premiums deducted from your spouse's paycheck and premiums for individual health policies are not eligible.

Q. Do I ever pay taxes on the money I put into either account?

A. No. With the exception of New Jersey and Pennsylvania (Dependent Care FSA) state tax, you do not pay tax on money taken out of these accounts.

Q. Can I change the amount of money I set aside in my account(s) during the plan year?

A. As a general rule, no. The IRS, however, does allow you to make changes when a qualifying event occurs, such as marriage, divorce, or gaining or losing a spouse or dependent.

Q. What happens if I terminate employment during the plan year?

A. You will have a period after your termination date (check your SPD) to submit expenses incurred while you were an active employee. Also, you may have the option to continue contributing to your Health Care FSA using after-tax dollars through COBRA.

Q. To what age may I use the Dependent Care FSA for expenses incurred for my child?

A. You may submit expenses incurred for your dependent child on or before his/her 13th birthday.

Q. Are expenses for before/after school programs considered eligible expenses?

A. Yes, but you must separate the cost of such care from the cost of the school.

Q. When I complete my personal tax return, do I have to report anything regarding my FSA?

A. Yes. When you participate in a Dependent Care FSA, you will need to complete and file IRS Form 2441. Instead of completing Part I and Part II, you should complete Part I and III of the form 2441. No action is required for the Medical Care FSA.

Q. What happens if my expenses are lower than I anticipated?

A. The IRS stipulates that you must forfeit any funds remaining in your account at the end of the plan year. However, you are given a grace period of an additional 120 days to submit receipts for services incurred during the plan year or grace period. Please review section titled "Planning Your Election".

Q. How can I obtain my account balance information?

A. You can contact our FBA Benefits Customer Care during normal business hours or you can view your account information online 24 hours a day, 7 days a week at **https://fba.wealthcareportal.com**. You may view detailed information such as your account balance, claim status and check information. You can also access this information via the free FBA Benefits mobile app or elect to receive this information via text notifications.

Q. How do I receive a reimbursement for my claims?

A. All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week. Please allow 2-3 business days for processing of your submitted claims once they have been received. Reimbursement checks will be sent directly to your home address. Reimbursements made through Direct Deposit are available in your bank account within 1-2 business days after processing. Always verify with your bank that funds are available before making withdrawals.

Q. How do I submit a claim?

A. In order to file a claim for an expense that you did not purchase using your FBA Benefits Card or to respond to a documentation request for a card purchase, you will need to complete and sigri a coordinating form. Please visit our website **flex-admin.com** to access the form(s) you nee. Each form contains instruction on how to submit your claim for reimbursement.

Basic Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance

A group life and accidental death and dismemberment insurance program is available to all benefit eligible employees of Harford County Public Schools through MetLife Insurance Company as a financial resource to protect their families.



Basic Life and AD&D insurance allows an employee to purchase a benefit equal to one times their annual earnings (rounded up to the nearest $1,000), minimum of $8,000 up to a maximum of $300,000. AD&D provides financial protection for you and your family against expenses associated with accidental death or injury. A reduced benefit is payable should you become dismembered as a result of an accident.

Supplemental Life Insurance

Supplemental Life Insurance allows you to purchase an additional amount of life insurance on yourself equal to 1x–6x your salary minimum $16,000 up to a maximum of $900,000 combined with Basic Life.

Dependent Life Insurance*

Dependent Life Insurance allows you to purchase coverage for your spouse or child(ren). You may purchase a flat coverage amount for your spouse of $25,000. You may purchase a flat coverage amount for your child or children up to age 26** of $10,000—no health questions are required. You must be enrolled in Supplemental Life to enroll your dependents. Spouses who did not elect to enroll when first eligible may need to complete a Evidence of Insurability form

Dependent	Bi-weekly Rate
Spouse	$4.36
Child(ren)	$.55

*Your spouse and eligible child(ren) must not be confined to a hospital on the enrollment date, or at home for any medical reason or be receiving or entitled to receive disability income for any medical reason on the date coverage is scheduled to become effective.

**Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by law. Proof of such handicap must be sent to MetLife within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

The completed SOH form must be returned to MetLife no later than June 15, 2026.

Eligibility

You will be eligible for coverage on the first day of the month following your date of hire.

If you do not enroll within 31 days after becoming eligible and are enrolling in more than 3x your salary or $300,000 of coverage the following limitations will apply to a later enrollment:

1. You and your spouse must submit Statement of Health (SOH); and
2. You may not enroll until an Annual Open Enrollment Period.

If you apply for coverage during an Annual Open Enrollment Period the coverage will start the later of the date MetLife approves your Statement of Health or July 1st following the Annual Enrollment Period.

Cost of coverage

The Board pays 90 percent of the cost of Basic Life and AD&D insurance. The employee is responsible for 100% of the cost of Supplemental and Dependent coverage. The current monthly cost of Basic Life & AD&D is $.236 cents per thousand dollars of coverage. Supplemental rates are per thousand dollars of coverage based on your age, see chart below for exact rate. Dependent rates are a flat monthly rate.

Age	Rate
<25	$0.030
25-29	$0.030
30-34	$0.040
35-39	$0.050
40-44	$0.060
45-49	$0.080
50-54	$0.130
55-59	$0.240
60-64	$0.370
65-69	$0.700
70-74	$1.140
75+	$1.140

Grief counseling

Grief counseling services are offered with your basic life insurance coverage. Whether it's help coping with a loss or a major life change, the professional counselors and services we offer through LifeWorks US Inc. are ready to support you and your family to move forward[1]—at no extra cost.

1. **Confidential support 24/7**—Making sure you receive professional and confidential support during life's difficult times is our priority.
2. **Easy-to-access resources**—Sometimes you just need a little guidance. LifeWorks offers self-help resources online to help you through the grieving process, giving the level of support you need at your own pace.
3. **Funeral assistance services**—Through private sessions, counselors can help you, your loved ones and your beneficiaries with customizing funeral arrangements.

WillsCenter.com*

Having a will is one of the most important things you can do for your family. Making sure your will is up-to-date can help ensure that your assets are distributed the way you want.

As an added benefit with your MetLife Basic Life plan, you have access to MetLife's online will preparation services to create a will, living will, or assign a power of attorney in a secure web environment. This service is provided by an outside vendor, SmartLegalForms, Inc., and was created exclusively for MetLife to be an easy–to-use website, available to you 24 hours a day, 7 days a week. Visit **WillsCenter.com** to get started.

Funeral Planning is a complementary program that can help ease the challenges and stress that policyholders and their families often face at this difficult time.

[1] Grief Counseling and Funeral Assistance services are provided through an agreement with LifeWorks. US Inc. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife. LifeWorks has a nationwide network of over 30,000 counselors. Counselors have masters or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms.

* WillsCenter.com is a document service provided by SmartLegalForms, Inc., an affiliate of Epoq Group, Ltd. SmartLegalForms, Inc. and is not affiliated with MetLife. The WillsCenter.com service is separate and apart from any insurance or service provided by MetLife. The WillsCenter.com service does not provide access to an attorney, does not provide legal advice, and may not be suitable for your specific needs. Please consult with your financial, legal, and tax advisors for advice with respect to such matters. WillsCenter.com is available to anyone regardless of affiliation with MetLife.

Discounts on funeral services through the largest network of funeral homes and cemetery providers with compassionate experts that guide you through the pre-planning process.

In-person will preparation services with a professional attorney

As an added benefit when you enroll in MetLife's Supplemental Term Life plan, you have access to personal Will Preparation services offered by Hyatt Legal Plans—at no additional cost to you! You and your spouse can access professional attorneys to help you prepare or update a will, living will or assign a power of attorney. Choose to meet in-person or by phone with a participating attorney. Fees are fully covered and there are no claim forms to file!

Without a will, your final wishes may not be acknowledged and assets may be distributed according to state law. With Will Preparation services, you have access to professional resources to help ensure your final wishes are clear.

These services, offered through Hyatt Legal Plans, fully covers attorney fees by a participating plan attorney to settle an estate. You are eligible for this service if you are enrolled in MetLife's Supplemental Term Life. Some covered services are:

- Unlimited in-person or telephone consultations with an attorney to discuss matters or general questions relating to probating an estate.
- Preparation of estate documents and professional court representation at court proceedings available to help properly distribute probated assets from the estate.
- Preparation of correspondence needed to transfer non-probate assets, as well as any associated tax filings.

Get started today

1. Contact MetLife Legal Plans at 1-800-821-6400 and a Client Service Representative will:
   - ☐ Ask for your Company name, Group Number, and the last 4 digits of your Social Security or Employee ID number
   - ☐ Locate a participating plan attorney in your area
   - ☐ Provide you with a case number to give to the attorney of your choice
   - ☐ Answer any questions you have
2. Then call the office of your chosen attorney to make an appointment at a time that works best for you.

Included with Supplemental Life Insurance. Will Preparation Services are offered by Hyatt Legal Plans, Inc., a MetLife company, Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. Tax Planning and preparation of Living Trusts are not covered by the Will Preparation Service.

Included with Supplemental Life Insurance. MetLife Estate Resolution Services are offered by Hyatt Legal Plans, Inc., a MetLife company, Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. Certain services are not covered by Estate Resolution Services, including matters in which there is a conflict of interest between the executor and any beneficiary or heir and the estate; any disputes with the group policyholder, MetLife and/or any of its affiliates; any disputes involving statutory benefits; will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.

Employee Assistance Program

Harford County Public Schools is pleased to offer an Employee Assistance Program (EAP) for all employees, and their family members or significant others that reside in their immediate household. Acentra Health will provide these confidential services.

EAP

Sometimes personal and family problems can have a direct impact on personal well being and work performance. Getting timely, professional help can result in a healthier, more productive individual. We recognize the value in assisting employees and their dependents to find the best possible help in a timely manner.

HCPS provides an EAP which is administered by Acentra Health. We encourage employees, their covered eligible family members, or other members of their immediate household, to take advantage of this important benefit when needed.

What is an EAP?

An EAP provides the opportunity to talk confidentially with a mental health professional about a wide range of personal matters, such as:

- Family or relationship problems
- Parenting difficulties
- Work-related problems
- Financial issues
- Child and eldercare issues
- Substance abuse and alcohol misuse
- Grief and loss
- Emotional and physical abuse
- Anxiety and stress
- Emotional / mental health concerns
- Convenience Services
- Legal Services*

* Currently this benefit is not available to HCEA or HCEA-ESP eligible members.



What does an EAP offer?

The EAP may provide up to eight (8) visits per issue per year with a local licensed mental health counselor at no cost to you. These sessions are to assist you with problem identification, short-term counseling, or refer you for assistance based on their assessment of your specific situation and treatment needs. Up to eight visits are available to you for each type of situation for which you may want to seek assistance. If additional services outside the EAP are recommended, the EAP professionals provide and help facilitate the referral to the appropriate health care provider or community resource. Keep in mind that the financial responsibility for additional services outside the EAP is yours; however, your medical insurance may cover part of these costs. To determine coverage for behavioral health services and covered providers, please check with your health care plan.

Employee Assistance Program

HCPS employees and their family members also have access to thousands of lawyers, certified public accountants, certified financial planners, and insurance specialists. An EAP counselor will assess your needs and arrange a no-cost 30 minute consultation for you with an attorney or financial consultant. If a member elects to retain the attorney, they will receive a 25% reduction of the professional's customary fee.

A full range of work/life support resources are available to HCPS employees and their family members. Child and Elder Care services include child and elder care referrals, which are researched to your preferences and provider/site availability. Employees and members of their family have consultation, educational materials, and referrals available to address issues involving a dependent or elder care. Dependent care specialists provide case management, educational material, consultations, and referrals on many child/adult/elder care issues. Referrals include, but are not limited to, prenatal care, adoption, summer camps, back-up care, long-term care options, support services, meals, transportation, respite care, day care, and recreational activities.

Convenience services allow you to productively focus your time and attention by letting the EAP research information for you. Convenience services include consultation and referrals for household shopping such as home repairs, pet sitters, cleaning services and other day to day needs. In addition, referrals can be made for dining, entertainment, and travel requests. Please note that the EAP will locate the resources; however the employee or family member is responsible for the cost of the goods/services.

Who may use the EAP?

All employees and their dependents or significant others in their immediate household.

What about confidentiality?

The decision to take advantage of this service is yours. All conversations remain confidential. Except as required by law, Acentra Health will not disclose to anyone that you have inquired about benefits, are considering treatment, or are receiving treatment. If you are referred to the EAP due to attendance or disciplinary issues, the referral will be known to HCPS with your permission, but the details of your visits will remain confidential between you and your counselor.

What does the EAP cost?

There is no cost to employees and eligible members of their household to access and use the EAP. The initial assessment and short-term counseling are free. For many people, the one to eight visits (per issue per year) may be sufficient. For others, additional services and treatment may be needed. Your EAP counselor will work with you to determine if further treatment is necessary. Additional treatment is subject to the provisions of the health care plan in which you are enrolled. It is the participant's responsibility to verify coverage whenever a referral for treatment is recommended.

How do I make an appointment?

For more information about the EAP, or to arrange an appointment, please call: **1-866-795-5701**.

Information and assistance is also available via the internet, at **EAPHelpLink.com**, just enter HCPS as your Company Code.

EAP counselors are available 24 hours, 7 days a week.

The EAP is an important resource to help you better manage your personal, work, and family situations. It's easy to use, does not cost you anything, and it can make a difference.

MetLife | Pet Insurance

HARFORD COUNTY PUBLIC SCHOOLS
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If you're thinking about taking advantage of discounted rates[1] on MetLife Pet Insurance, you won't want to miss our complimentary webinar. It's a great way to find out how pet insurance helps protect your pet's health and your wallet from the rising cost of vet care.

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- How to customize your policy to suit your needs
- What an accident and illness policy covers
- What optional preventive care covers
- How the claims process works
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- **7/16/2026**
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Pet Insurance coverage issued by Metropolitan General Insurance Company, a Rhode Island insurance company headquartered at 700 Quaker Lane, Warwick, RI 02886. Coverage subject to restrictions, exclusions and limitations and application is subject to underwriting. See policy or contact MetLife Pet Insurance Solutions LLC ("MetLife Pet") for details. MetLife Pet is the policy administrator. It may operate under an alternate or fictitious name in certain jurisdictions, including MetLife Pet Insurance Services LLC (New York and Minnesota) and MetLife Pet Insurance Solutions Agency LLC (Illinois).

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1. A multi-policy discount is not available with Family Plans.
2. Family plan policies are limited to dogs age 12 and under and cats age 14 and under. Multi-policy discount is not available with Family Plans.
3. When using multiple discounts, discounts cannot exceed 30%. Each discount may not be available in all states. Please contact MetLife Pet for further details.
4. Reimbursement options include: 50%, 70%, 80% and 90%. Pet age restrictions may apply.
5. Virtual veterinary services are available through the MetLife Pet app and are provided entirely by AskVet, a third-party partner; MetLife is not responsible for any pet guidance or advice provided or taken. Veterinarians providing virtual veterinary services cannot prescribe medication or answer questions about the pet policy.
6. Your pet's deductible automatically decreases by $50 each policy year, so you don't receive a claim reimbursement.
7. If a policy's annual limit is at least $5,000 and the policyholder has at least $1,000 of unused benefits remaining at the end of the policy year, then upon renewal, MetLife will automatically increase the annual limit by $500 for the renewal policy at no additional cost. The automatic annual limit increase will not apply if changes are made to the renewed policy. May not be available in all states.

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Savings & Retirement Benefits

Harford County Public Schools offers you several ways to begin saving money through payroll deductions. We offer our employees both U.S. Savings Bonds and Tax Sheltered Annuities (403(b) and 457 (b) Plans.)

U.S. Savings Bonds

Savings Bonds are available to all employees through a payroll distribution to the U.S. Department of the Treasury. The TreasuryDirect program is a convenient and secure web-based system which allows you to purchase, manage, and redeem electronic (paperless) savings bonds at work or from home. TreasuryDirect is not limited to just U.S. Savings Bonds. Employees may purchase the following Treasury marketable securities: bills, notes, bonds and TIPS. For more information go to **treasurydirect.gov**. Additionally, for step by step instructions on how to open an account with the U.S. Department of the Treasury, go to the HCPS SharePoint HR Benefits web site (hcpsshare) and click on *"Treasury Direct Directions"*.

Defined Benefit Pension Plan

Did you know that the average person needs to replace 60% to 80% of his final income in order to afford retirement? Did you know that regardless of your years of service the Defined Benefit Pension Plan will not provide 60%–80% of your final income? Therefore, it is important to participate in the 403(b) and 457(b) Tax-Deferred Annuity Plans, described below. When it comes to retirement planning, it's never too soon to start. Your retirement income will come from more than one source. However, the principal sources of income when you retire are personal savings, Social Security, and your pension from one of the systems in which Harford County Public Schools participates. It is important to understand which retirement plan you are eligible for, how to enroll, and the benefits your plan will provide at retirement.

Which retirement plan am I eligible for?

Depending on your job classification and the date you were employed, you may be eligible for one of two retirement programs listed below:

Maryland State Teachers'/Employees Retirement System	
Eligibility provision	Must have enrolled prior to 1980 as a public school educator, administrator, or clerical employee.
Vesting Provision	Automatic membership after 1980 for eligible employees as defined by Maryland COMAR regulations (State Personnel and Pensions Article).
Maryland State Teacher's/Employees Pension System	
Eligibility provision	Vested allowance is payable at age 60 after accruing 5 years of creditable service.
Vesting Provision	A vested allowance is payable at age 65 for members of the Reformed Contributory Pension Benefit after accruing 10 yrs. of eligible service and at age 62 for all other members after accruing 5 years of eligible service.

Lincoln Financial 403(b) and 457(b) Retirement Plans

You may save for retirement and reduce your current taxes by participating in 403(b) and 457(b) retirement plans. Sections 403(b) and 457(b) of the Internal Revenue Code authorize a tax-deferred retirement savings program for employees of public schools. The account shelters your money from taxes in two ways:

- Pre-tax investing—Investments are made through the convenience of automatic payroll deductions before federal and state taxes are calculated on your income. FICA tax is also withheld and this lowers your current taxable income.

- Tax-deferred compounding—Your contributions and investment earnings accumulate tax-free while in your 403(b) account. You pay taxes only when you withdraw the money.

Your savings in these accounts are generally not available until age 59 1⁄2 unless you have a financial hardship, as defined by the IRS. If you meet the hardship requirements, you may be able to borrow or withdraw money from your account before 59 1⁄2.

Note: An "early withdrawal" penalty from the 403(b) plan will apply to employees separating from service before age 55. Distributions from a 457(b) plan are not subject to the 10% "early withdrawal" penalty.

Roth 403(b) contributions — What are they?

As a part of the 403(b) plan, you can make after-tax Roth 403(b) contributions. A Roth 403(b) contribution allows you to make after-tax contributions on a regular basis. When Roth 403(b) contributions are withdrawn, investment earnings may be tax-free, and your contributions are always tax free, which may result in reduced income taxes during retirement.

If you would like more information, call Lincoln Financial at 800-234-3500, Press "Ø" to speak to a representative or the Finance Office at (410) 588-5200.

Retiree insurance benefits

Your retiree insurance benefits are provided by Harford County Public Schools regardless of the retirement plan from which you are receiving your pension. Please note that the insurance benefits and the Board's contribution percentages as shown on the following page are subject to change in the future depending upon the Board and its funding authorities.

While you may be vested in your pension plan, your ability to participate in the retirement insurance plans of HCPS may be limited. In order to be eligible to participate in retiree benefits now or in the future, you must be enrolled for the benefit prior to your retirement date, retire in good standing and begin to receive a monthly pension directly following at least 10 years of continuous service to HCPS immediately preceding retirement. An employee who does not qualify to receive a pension or who elects to defer pension benefits or has not completed the last 10 years of continuous service with HCPS is ineligible for future participation in the Board's benefit plans.

Key Points: 403(b) and 457(b) Retirement Plans

- All Employees are eligible to participate in the 403(b) and 457(b) plans.
- There is no waiting period to begin saving in a plan. You may enroll or disenroll at anytime.
- Participation is 100% voluntary. Harford County Public Schools does not match your contributions.
- Deductions are taken from 26 paychecks per contract year for 11- and 12-month employees and from 22 paychecks per contract year for 10-month employees. You decide how to invest your contributions and how much of your salary to invest.
- An additional contribution can be made if you are age 50 or older by the end of the contract year. Contact your approved vendor to assist you in determining your personal annual maximum.
- After you have obtained the age of 50 or older, the IRS permits you to contribute an additional $8,000 per year.
- Harford County Public Schools offers one company, Lincoln Financial, to provide you the 403(b) and 457(b) Plans.

Enrolling in your retiree insurance

Prior to retirement, you must submit a letter of retirement to the Superintendent with a copy to your supervisor. Human Resources/Benefits will be notified of your retirement from the Superintendent and will send you a letter and the appropriate retirement forms with instructions to contact a retirement coordinator to schedule your retirement conference.

You must be enrolled in benefits at the time of your retirement to elect retiree benefits. Employees who retire any date other than July 1 of each year will have a one-time opportunity to change their health insurance benefit plan after retirement. In order to take advantage of this one-time opportunity the employee must indicate their desire to participate in the next open enrollment following their retirement date when meeting with the Harford County Public Schools (HCPS) retirement coordinator before they retire. If the employee does not select this option they will not be able to change plans during the next scheduled open enrollment. Harford County Public Schools' retirees may not enroll in a health, dental, vision or life insurance plan following their retirement date. Employees who elect to discontinue coverage at or after retirement may not elect coverage at a later date.

Health insurance

The cost of your health insurance is paid by you and Harford County Public Schools. For employees hired prior to July 1, 2006, the Board contributes 83-94 percent of the total cost of your health, dental or life insurance. Employees hired or rehired after July 1, 2006 receive benefits based on a tiered structure based on consecutive years of service. Service of thirty consecutive years or more receive the full Board contribution, retirees with 20–29 years of consecutive service receive two-thirds of Board contribution and 10–19 years of consecutive service receive one-third of Board contribution. (Only continuous service time with the Harford County Public Schools applies.)

Health insurance premiums are deducted from a retiree's monthly pension check. Normally, retirements occur at the end of a school year and employees have already paid premiums for coverage through August 31. Therefore, if an employee retires on July 1, the first health insurance premium deduction will be taken from the September retirement check. Special handling is required for retiring individuals and/or their spouses who are Medicare eligible.

The same plans available to active employees are available to retiree's who are ineligible for Medicare. Upon reaching eligibility for Medicare (usually at age 65 or earlier if eligible due to disability) retiree's and/or their spouses **must enroll in Medicare Parts A & B** in order to continue participation in the Board's health insurance plans, and will be enrolled in a Medicare Supplemental health plan which coordinates with Medicare. Please note that each of the medical plans offered by Harford County Public Schools includes coverage for prescription drugs. If you elect a Medicare D plan, you will lose your prescription coverage with Harford County Public Schools and cannot re-elect coverage at a later date.

Dental coverage

Dental coverage may be continued into retirement. The cost of the plan, if elected, will be deducted from your pension check.

Vision coverage

Vision coverage may also be continued into retirement. The cost of the plan, if elected, will be deducted from your pension check.

Life insurance

Life Insurance may be continued into retirement. Premiums are deducted from your pension check. Upon retirement, a retiree's life insurance coverage starts at $20,000. The amount of insurance reduces by $2,000 July 1 each year until it is at $10,000, which is where it remains.

What is Creditable Coverage?

Medicare beneficiaries have the opportunity to receive subsidized prescription drug coverage through the Medicare Part D program. Beneficiaries who choose not to sign up at the first opportunity may have to pay more if they wait to enter the program later after the open enrollment period.

Beneficiaries who have other sources of drug coverage—through a current or former employer or union, for example—may stay in that plan and

choose not to enroll in the Medicare drug plan. If their other coverage is at least as good as the new Medicare drug benefit and therefore considered "creditable coverage", then the beneficiary can continue to get the high quality care they have now as well as avoid higher payments if they sign up for the Medicare drug benefit.

Under Section 423.56(a) of the final regulation, coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines.

In general, the actuarial equivalence test measures whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Part D benefit.

Required disclosures to Medicare beneficiaries

Harford County Public Schools must provide a notice of creditable prescription drug coverage to Medicare beneficiaries who are covered by, or who apply for, prescription drug coverage under any of the Harford County Public Schools plans.

<table>
<tr><th>Plans</th><th>Retiree Benefits</th><th>Additional Details</th></tr>
<tr><td>Non-Medicare (‹65)
■ CareFirst BlueCross BlueShield PPO CORE
■ BlueChoice HMO
■ Triple Option

Medicare Eligible
■ UnitedHealthcare Medicare Advantage Plus Part D</td><td>HCPS contributes toward health care premiums for employees with 10 or more consecutive years of service who are approved for retirement from the Maryland State Retirement and Pension Systems. Board contributions are:
<table><tr><th>Years of Consecutive Service to HCPS</th><th>Hired Prior to 7/1/06</th><th>Hired After 7/1/06</th></tr><tr><td>10-19 yrs.</td><td>Full Board contribution*</td><td>⅓ Board contribution*</td></tr><tr><td>20-29 yrs.</td><td>Full Board contribution*</td><td>⅔ Board contribution*</td></tr><tr><td>30 yrs. & up</td><td>Full Board contribution*</td><td>Full Board contribution*</td></tr></table>Upon eligibility for Medicare (usually at age 65 or if eligible due to disability), retiree's and/or their Medicare-eligible dependents are required to convert to coverage which supplements Medicare.</td><td>Continuation of Insurance After Retirement — Deducted monthly from pension in combination with dental, vision and life.</td></tr>
<tr><td>CareFirst Dental Insurance</td><td>Retirees may elect to continue to participate in the dental plans offered to active employees. *For contribution, see chart in medical row above.</td><td>Deducted monthly from pension in combination with health insurance.</td></tr>
<tr><td>Vision Insurance</td><td>Retirees may elect to participate in vision plans offered to active employees. *For contribution, see chart in medical row above.</td><td>Deducted monthly from person in combination with health insurance.</td></tr>
<tr><td>Life Insurance</td><td>The $20,000 basic term life insurance will continue with a reduction of $2,000 each July 1 until the coverage is at $10,000. *For contribution, see chart in medical row above.</td><td>Deducted monthly from pension in combination with health insurance.</td></tr>
<tr><td>Surviving Spouse's Benefit</td><td>Upon retiree's death, if the spouse has been covered under a HCPS health care or dental plan, he or she will have the option to continue coverage. If elected coverage will continue without any Board contribution. *For contribution, see chart in medical row above.</td><td>Billed monthly by HCPS or deducted from monthly pension benefit check if applicable.</td></tr>
</table>

* 94% for BlueChoice HMO, 89% for PPO Core, and 83% for Triple Option plan members. Part-time HCEA and HCEA-ESP members receive 50% of board contribution.

Frequently Asked Questions

What are my 2026-27 Open Enrollment options?

- Enroll in a medical, dental, vision and/or flexible spending plan
- Change from one medical and/or dental plan to another
- Add or delete a dependent
- Cancel enrollment of your life, medical, and/or dental and/or vision insurance plan.
- Apply for or increase life insurance (Basic—1x salary; Supplemental—1x–6x salary). You must complete an Evidence of Insurability for Underwriting and be approved by the Life Insurance Company before coverage can become effective.
- Apply for Dependent Life (must be enrolled in Supplemental to apply)

When can I enroll online?

Beginning May 4. The site will be open from May 4 through May 21.

Do I have to go online to enroll for benefits?

YES. If you do not currently participate and wish to elect benefits for the 2026-27 plan year you must go online to enroll.

Will I get a new FBA Benefits Card?

If you have previously been issued a debit card within the last three years, you will not be issued a new card. New participants and those with an expired card will receive a new debit card. Debit cards are for three years. Cards will be mailed to your home address.

If I was enrolled in the Flexible Spending Account (FSA) this year will I need to enroll for the next plan year online?

YES. You must enroll for FSA each plan year. Your benefit election **will not** carry over into the next plan year.

If you are currently participating in a Flexible Spending Account your benefits will end on June 30, 2026. To participate in FSA for the 2026–27 plan year **you must** go online during open enrollment to enroll. **If you do nothing, you will not be able to contribute to the Flexible Spending Accounts for 2026–27.**

If I want to change or enroll in Life insurance, do I have to enroll online?

If you are currently enrolled in Basic + Supplemental and wish to enroll in Basic only, you must waive the Supplemental coverage. If you are currently enrolled in Basic Life 1x and want to add the Supplemental Life or if you have no coverage and wish to apply for life insurance, complete the online Statement of Health Application through the MetLife enrollment portal, at the time you are completeing your enrollment through the HCPS enrollment website. Please ensure to come back to the HCPS enrollment website to finalize and submit your open enrollment/new hire elections.

I realized that I made a mistake when I enrolled. Can I correct my error?

Yes. You may log back on at any time during the Open Enrollment period (through May 21) and make your changes.

I was interrupted and when I came back to continue enrolling the system timed out and/or I had to stop part way through the session. What should I do?

You will have to log on again. The system will remember what you saved, so you do not have to re-enter the information.

Will I be able to log back on and check my elections after Open Enrollment?

Yes. Using the same password you created, you may log back on at any time and review your elections or plan information. However, you will not be able to make changes after May 21.

Frequently Asked Questions

Who is an eligible dependent?

Refer to the Benefits and Eligibility section of this booklet on pages 4–5.

NOTE: If you and your spouse are both employees of HCPS you can each enroll as an individual or one of you can elect Employee/Spouse or Family coverage. If you elect coverage separately, you cannot cover each other as dependents and your eligible dependent children may only be covered by one of you.

Can I change my elections during the year?

IRS regulations require you to keep your elections through June 30 unless you have a Qualified Life Event. Changes must be requested within 30 days of the Qualified Life Event.

What is a Qualified Life Event?

- Birth or adoption of a child
- Death
- Marriage or divorce
- Termination of employment or commencement of employment
- Covered dependent ceasing to be an eligible dependent
- Spouse's loss of benefits
- Court ordered custody

To be considered a qualified life event, the event must result in the employee or dependent gaining or losing eligibility for benefits. Only the coverage category can be changed (not the plan choice).

When can I add a spouse, child or newborn to my insurance coverage? (This is usually not an open enrollment event)

You have 30 days from date of birth/adoption or marriage to add the dependent to your health/dental plans. Coverage will take effect retroactively to the date of birth/date of adoption or marriage. If you miss this 30-day period, the next opportunity to add the child or spouse would be during the open enrollment period held annually. You will need to provide a dependent verification form and documentation (birth certificate, marriage certificate, adoption paperwork).

If I am enrolled in a Medical or Dental plan and my doctor leaves the network, can I change my election?

No. This is not considered a qualified life change.

When do dependents lose eligibility for coverage?

Refer to the Benefits and Eligibility section of this booklet. You must notify 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 bi-weekly deductions deducted during the period of ineligibility. Remember, when coverage ends for a dependent, he or she may choose to continue coverage under COBRA for a maximum of 36 months, as long as you have notified the Benefits Office of your request to continue coverage within 60 days of the loss of eligibility.

If I enroll for benefits online, when does my coverage start?

Benefits will become effective July 1, 2026 for anyone who elects coverage during our open enrollment period. For all new hires, the benefits are effective the first of the month following your date of hire. ID cards will be mailed to your home address.

When does my coverage end if I resign?

If your employment ends following the close of the school year, your benefits terminate as of August 31. If your employment ends during the school year, benefits terminate on the last day of the month in which you are on active pay status.

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 through COBRA but is responsible for paying 102% of the premium for up to 36 months.

COBRA

Continuation Coverage Rights Under COBRA

Once you become covered under a group health plan (the Plan) you have COBRA rights. This summary contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The cost is the monthly premium equivalent to the full cost of coverage plus an administrative charge of 2%.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
  - The parent-employee dies;
  - The parent-employee's hours of employment are reduced;
  - The parent-employee's employment ends for any reason other than his or her gross misconduct;
  - The parents become divorced; or
  - The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Benefits Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or the death of the employee, the Benefits Office will be notified of the qualifying event.

How is COBRA coverage provided?

Once the Benefits Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Benefits Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide written notice to: The Benefits Office, 102 South Hickory Ave., Bel Air, MD 21014.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Benefits Office. For COBRA rates, please visit the benefits website.

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the Benefits Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Benefits Office.

Harford County Public Schools Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communications
- Ask the Plan to limit the information the Plan shares
- Get a list of those with whom the Plan has shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

The Plan's Uses and Disclosures

The Plan may use and share your information to:

- Help manage the health care treatment you receive
- Help administer and review the operation of the Plan
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Privacy Contact for questions about the Plan's Health Information Privacy Practices:

Harford County Public Schools
c/o Health Plan Privacy Official
102 S Hickory Ave, Bel Air, MD 21014
410-558-5275

Introduction

The health plans sponsored by Harford County Public Schools (referred to in this Notice as the "Health Plans" or just the Plan) may use or disclose health information about participants and their covered dependents as required for purposes of administering the Health Plans. Some of these functions are handled directly by Harford County Public Schools, while other functions are performed by other service providers under contract with the Health Plans or by insurance carriers.

This Notice applies to each Health Plan sponsored by Harford County Public Schools, including but not limited to plans that provide medical, vision, prescription drug, dental, long-term care, health reimbursement arrangement, and health care flexible spending account benefits.

The Plan is required by law to maintain the privacy of certain health information about you and to provide you with this Notice of the Plan's legal duties and privacy practices with respect to that protected health information. This Notice also provides details on certain rights you may have under federal law regarding medical information about you maintained by the Plan.

The Plan is required by law to abide by the terms of this Notice while it is in effect. This Notice is effective beginning February 16, 2026, and will remain in effect until it is revised.

If the Plan's health information privacy practices, policies, and/or procedures are changed so that any part of this Notice is no longer accurate, the Plan will revise this Privacy Notice. A copy of any revised Privacy Notice will be available upon request to the Privacy Contact Person indicated later in this Notice. Also, if required under applicable law, the Plan will automatically provide a copy of any revised notice to employees who participate in the Plan. The Plan reserves the right to apply any changes in its health information policies and/or procedures retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies/procedures were revised.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- The Plan will provide a copy or a summary of your health and claims records, usually within 30 days of your request. The Plan may charge a reasonable, cost-based fee.

Ask the Plan to correct health and claims records

- You can ask the Plan to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask the Plan to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- The Plan will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask the Plan to limit what it uses or shares

- You can ask the Plan not to use or share certain health information for treatment, payment, or the Plan's operations.
- The Plan is not required to agree to your request and may say "no" if it would negatively affect the administration of the Plan.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times the Plan has shared your health information for 6 years prior to the date you ask, who received it, and why.
- The Plan will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked the Plan to make). The Plan will provide one accounting per year at no charge, but will charge a reasonable, cost-based fee if you request another within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- The Plan will make sure the person has this authority and can act for you before taking any action.

File a complaint if you feel your rights are violated

- You can complain if you feel the Plan has violated your rights by contacting the Plan using the Privacy Contact information on page 1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- Harford County Public Schools will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell the Plan your choices about what it may share. If you have a clear preference for how the Plan shares your information in the situations described below, please let us know. Tell us what you want us to do, and we will follow your instructions.

You have both the right and the choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

  If you are not able to tell the Plan your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety, as permitted by law.

In these cases, the Plan will never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

The Plan's Uses and Disclosures

How does the Plan typically use or share your health information?

The Plan typically uses or shares your health information in the following ways, including treatment, payment, and health care operations, except where 42 CFR Part 2 ("Part 2") imposes stricter rules regarding substance use disorder (SUD) information. See the discussion of the special rules that apply to certain SUD records below, as we will not disclose your SUD information subject to Part 2 without your written consent, except as expressly permitted by Part 2.

Pay for your health services

The Plan can use and disclose your health information to pay for your health services.

Example: The Plan processes your health care claims to coordinate payment to providers or to reimburse you for eligible expenses you have paid.

Health care operations

- The Plan may use or disclose PHI for purposes that are related to the operation of the Plan, including utilization review programs, quality assurance reviews, insurance or reinsurance contract renewals, and other functions that are appropriate for purposes of administering the Plan.
- The Plan is not allowed to use genetic information to decide whether to offer you coverage or the price of that coverage.

  Example: The Plan may use health information about you to offer wellness program services for you

Help manage the health care treatment you receive

The Plan may use and share your health information with the professionals treating you.

Example: A doctor sends the Plan information about your diagnosis and treatment plan so we can arrange additional services.

Administer your plan

The Plan may disclose your health information to the plan sponsor for plan administration.

Example: A business associate of the Plan may provide certain statistics to the Plan sponsor to explain the Plan's costs.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many legal conditions, including those described in the discussion of the special rules that apply to certain SUD records below, before we can share your information for these purposes.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

The Plan can share health information about you for certain situations, such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

The Plan can use or share your information for health research.

Comply with the law

The Plan will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- The Plan can share health information about you with organ procurement organizations.
- The Plan can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

The Plan can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

The Plan can share health information about you in response to a court or administrative order, or in response to a subpoena.

The Plan's Responsibilities

- The Plan is required by law to maintain the privacy and security of your protected health information in the manner required by applicable law, including the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and information subject to more stringent protections under other applicable law, such as Part 2 relating to SUD diagnosis, treatment, or referral.
- The Plan will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The Plan must follow the duties and privacy practices described in this notice (as may be amended from time to time) and give you a copy of it.
- The Plan will not use or share your information other than as described here unless you authorize the Plan, in writing, to use or share your information for another purpose. If you tell us we can use your information for another purpose, you may change your mind at any time. Let the Plan know in writing if you change your mind.
- Please note that protected health information shared with entities not bound by HIPAA (e.g., law enforcement, etc.) may be re-disclosed and lose federal protection. That is, if the Plan shares your health information (as permitted by HIPAA) with a recipient that is not subject to HIPAA, your health information may be re-disclosed by that recipient and may no longer be protected by federal privacy laws.

  Example: If you authorize the disclosure of your health information to a third party in connection with a legal action, that information may not be protected under HIPAA once shared with the third party.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Special Protections for Substance Use Disorder (SUD) Information Under 42 CFR Part 2 ("Part 2")

The Plan may receive SUD treatment information from providers or programs covered by 42 CFR Part 2 (42 USC 290dd-2) (a "Part 2 Program"), other HIPAA-covered entities (that are not Part 2 Programs), or the business associates of HIPAA-covered entities. Part 2 provides stricter confidentiality protections than HIPAA. For example, we may only receive SUD treatment information that is subject to Part 2 if you consent to the disclosure or as otherwise permitted by law.

When we lawfully receive such information, we will only use and disclose it (or testimony relaying the content of such records) as follows:

- •You provide the Plan with your written consent for the use or disclosure.
- A court order entered after notice and an opportunity to be heard, and that meets the requirements of Part 2, authorizes the disclosure.
- The disclosure is permitted without your consent by Part 2 regulations (such as in the case of medical emergencies, to public health authorities in certain cases where the records have been de-identified, or for scientific research, audit, or evaluation in certain cases, etc.).
- The Plan received SUD information about you from a Part 2 Program, other HIPAA covered entity, or HIPAA business associate through your consent to uses and disclosures of your SUD records for purposes of treatment, payment or health care operations, and the Plan uses or further discloses your SUD records for any of the purposes permitted by HIPAA as described elsewhere in this Notice. Note that in this circumstance, the consent through which the Plan received your SUD records was limited to treatment, payment, and health care operations, but Part 2 rules permit the Plan to more broadly redisclose those records for any purpose permitted by HIPAA.

In no event, however, will the Plan use or disclose your SUD records subject to Part 2 (or testimony that describes the information contained in such records), in any civil, criminal, administrative, or legislative proceedings against you, unless (a) you provide written consent or (b) unless we are required to do so pursuant to a court order after you (or the holder of the record) are provided notice of the court order and the opportunity to be heard in the manner required by applicable law. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Information disclosed pursuant to Part 2 or HIPAA may be subject to redisclosure and may no longer be protected by federal law.

Family and Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) was passed by Congress to protect eligible employees who cannot attend work for reasons related to birth, adoption, and/or serious health conditions involving the employee or the need to care for a spouse, child or parent with a serious health condition.

Eligibility for FMLA leave is also based upon length of time employed and number of hours worked within the 12 month period immediately before date leave is to begin. An eligible employee can take up to 12 work weeks in a 12 month period.

Eligibility will be determined by the Benefits Office upon notification and/or submission of required documents. School system employees who are in need of FMLA leave for one of the reasons noted above must complete an FMLA electronic leave request and provide medical certification or other documentation based upon the reason for the leave request. The request should be submitted 30 days in advance for any foreseeable need for leave.

In accordance with the law, FMLA may be granted for the following reasons:

- The birth of a child and in order to care for that child.
- The placement of a child with an employee for adoption or foster care.
- The care of a spouse, parent, or child with a serious health condition as defined by the FMLA regulations.
- The serious health condition of the employee.

Military Family Leave

The FMLA also provides certain military family leave entitlement. You may take FMLA leave for specified reasons related to certain military deployment. Additionally, you may take up to 26 weeks of FMLA leave in a single 12 month period to care for a covered service member with a serious injury or illness.

- Military Caregivers Leave
- Qualifying Exigency Leave

The electronic leave request and required documents can be found on SharePoint*. For additional information, contact the Benefits Office at (410) 588-5275.

Harford County Public Schools will maintain group health insurance coverage on the same terms and conditions as if the employee continued to work. Further information concerning benefits and FMLA leave can be obtained by calling the Benefits Office or visiting the HCPS SharePoint website at: ***https://hcps365.sharepoint.com/sites/humanresources/benefits**

From a non-HCPS computer, the electronic leave request form can be accessed via **my.hcps.org**. Log in with your HCPS username and password, select *HCPS FMLA* web link and continue through the process of submitting your request.

Privacy Notice

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.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Harford County Public Schools		4. Employer Identification Number (EIN) 526000955
5. Employer address 102 South Hickory Avenue		6. Employer phone number 410-838-7300
7. City Bel Air	8. State MD	9. ZIP code 21014
10. Who can we contact about employee health coverage at this job? Benefits Office		
11. Phone number (if different from above) 410-588-5275	12. Email address Benefits@hcps.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ⊡ Some employees. Eligible employees are:

    Regular Full-time employees
    Part-time employees working .500 FTE or 18 hours per week or more
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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 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 is CareFirst.

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

(UPDATED 4/15/2025)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 14858 Lexington, KY 40512
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

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

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

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

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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 identification card. All others may call 1-855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

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

انتبه (Arabic): يحتوي هذا الإشعار على معلومات حول تغطيتك التأمينية. قد يحتوي على تواريخ رئيسية وقد تحتاج إلى اتخاذ إجراء بحلول مواعيد نهائية معينة. لديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. يجب على الأعضاء الاتصال برقم الهاتف الموجود على ظهر بطاقة هوية العضوية الخاصة بهم. يمكن للآخرين الاتصال بالرقم 855-258-5618 والانتظار طوال الحوار حتى يُطلب منهم الضغط على الرقم 0. عندما يجيبك أحد الوكلاء، حدد اللغة التي تحتاجها وسيتم توصيلك بمترجم فوري.

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

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

توجه (Farsi): این اطلاعیه حاوی اطلاعاتی درباره پوشش بیمه‌ای شما است. ممکن است شامل تاریخ‌های مهم باشد و لازم باشد تا مهلت‌های مشخصی اقدام کنید. شما حق دارید این اطلاعات و کمک را به زبان خود و به‌صورت رایگان دریافت کنید. اعضا باید با شماره تلفن درج‌شده در پشت کارت شناسایی عضویت خود تماس بگیرند. سایر افراد می‌توانند با شماره *855-258-6518* تماس بگیرند و منتظر بمانند تا دستور داده شود که عدد 0 را فشار دهند. هنگامی که یک نماینده پاسخ داد، زبان مورد نیاز خود را اعلام کنید تا به یک مترجم متصل شوید.

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

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

Notice of Nondiscrimination and Availability of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

توجہ (Urdu): اس نوٹس میں آپ کی انشورنس کوریج کے بارے میں معلومات شامل ہیں۔ اس میں کلیدی تاریخیں شامل ہو سکتی ہیں اور آپ کو کچھ آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑ سکتی ہے۔ آپ کو یہ معلومات اور مدد اپنی زبان میں، بغیر کسی قیمت کے حاصل کرنے کا حق ہے۔ ممبران کو اپنے رکنیتی کارڈ کی پشت پر دئے گئے فون نمبر پر کال کرنی چاہیے۔ باقی تمام لوگ *855-258-6518* پر کال کر سکتے ہیں اور 0 دبانے کا اشارہ ملنے تک ڈائیلاگ پر انتظار کرنا چاہئیے۔ جب کوئی ایجنٹ جواب دیتا ہے تو اپنی مطلوبہ زبان بتائیں اور آپ کا رابطہ ایک مترجم سے کر دیا جائے گا۔

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

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