CareFirst

Employee Benefits Enrollment Guide

Effective: January 1, 2020–December 31, 2020

OUR FOCUS IS You

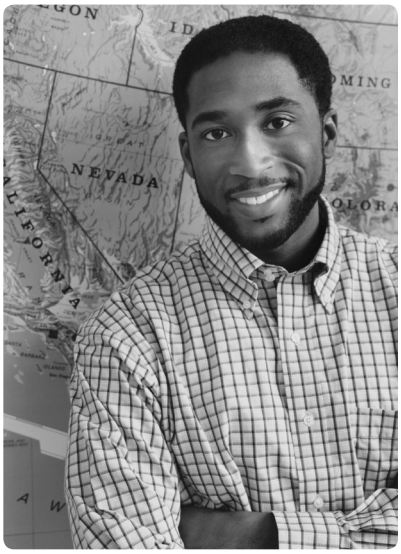
PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS

Contents

To All Benefit Eligible Employees

This enrollment guide contains information for the health insurance benefits which are available to you as an eligible employee of Prince George George's County Public Schools.

- Medical (Carefirst BlueChoice Triple Option Plan)
- Vision (Carefirst BlueVision Plus)



To enroll in benefits, access Oracle Employee Self Service. Use your PGCPS assigned username and password to log on to Oracle. As a new employee, you have 30 days to enroll in coverage(s).

Enrolling eligible dependents

If you are electing Employee+1 or Family coverage you must verify your eligible dependents. PGCPS has contracted Bolton's Dependent Verification Center to perform ongoing dependent eligibility verification services. Employees will receive correspondence directly from Bolton's Dependent Verification Center and are encouraged to respond to such correspondence as soon as possible. Dependents that are not verified in accordance with the terms included in the correspondence received from Bolton's Dependent Verification Center will not be eligible for coverage on PGCPS' group health plans.

For questions or concerns regarding enrollment

Please contact via:

Email: pgcps.benefits@pgcps.org

Phone: 301-952-6600

Or you may visit us at:
Benefits Services Office
14201 School Lane—Room 132
Upper Marlboro, MD 20772

Important Note: Once you have elected coverage, you may not make changes or cancel coverage until the next Open Enrollment unless you have a change in family status as defined by IRS regulations, and then only thirty-five (35) days of the qualifying event.

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BlueChoice Triple Option Open Access Health Plan

The benefits of three health care plans in one

The BlueChoice Triple Option Open Access Health Plan gives you three choices every time you need care. With BlueChoice Triple Option Open Access Health Plan, you have the flexibility to choose the providers you want to see when and where you want to see them.

Triple Option Plan advantages:

Option 1—BlueChoice HMO Open Access

- Choose from more than 37,000 BlueChoice providers, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- No PCP referral required to see a specialist.
- Receive coverage for preventive health care services at no cost.
- Avoid the unwelcome surprise of high medical costs with predictable copays and deductibles.
- Avoid balance billing when you receive care from a CareFirst BlueChoice provider.
- Enjoy your plan benefits when you're out of the area for more than 90 days with the Away From Home Care® program.

How the BlueChoice plan works

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

This plan has an Open Access feature, which means you have direct access to CareFirst BlueChoice specialists without needing to obtain a referral from your PCP. However, you may choose to call your PCP when you need care.

Your PCP can:

- Maintain your medical history.
- Work with you to determine when you should see a specialist.
- Assist you in the selection of a specialist.

Option 2—BluePreferred PPO

Provides greater flexibility of choice of providers locally and nationally

This option gives you the freedom to seek care from any provider you choose in the Blue Preferred PPO network. You will receive a high level of benefits when you see a provider who participates in the CareFirst Blue Preferred network. To locate preferred providers, visit **carefirst.com/pgcps**. Under Plan Type choose Blue Preferred.

When you are traveling your membership gives you a world of choices. More than 85% of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care here in the U.S. or abroad, you'll have access to health care in more than 190 countries.

If you travel outside the CareFirst service area of Maryland, Washington, D.C. and Northern Virginia, you have the freedom to select any provider who participates in the BlueCard PPO network. To locate participating doctors in the BlueCard PPO network, visit http://provider.bcbs.com.

Option 3—Indemnity provides the greatest flexibility

This option offers you the opportunity to receive care from any doctor or facility – even those who do not participate in a CareFirst provider network.

Keep in mind, when you visit non-participating providers you will likely have to:

- Pay the provider's charge in full
- File a claim (visit **carefirst.com/pgcps** and, under *For Members*, choose *Forms*)
- Satisfy a $200 deductible and a 30% coinsurance amount

Around the world

Like your passport, you should always carry your ID card when you travel or live outside the U.S. The BlueCard Worldwide program provides medical assistance services and access to doctors, hospital, and other health care professionals around the world.

Medical Assistance when outside the U.S.

Call 800-810-BLUE (2583) or toll-free at (include country code) 804-673-1177 24 hours a day, 7 days a week for information on doctors, hospitals, or other health care professionals to receive medical assistance.

Your benefits

Step 1: Meet your Option 2 & 3 deductible.

You have a deductible to meet under both options. You will be responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your full benefits will become available to you.

You will have a different deductible amount for Option 2 vs. Option 3. For example, when you see A PPO provider (option 2), your expenses will count toward your $100 deductible and the out of network (option 3) deductible is $200.

Members should refer to their Certificate or Evidence of Coverage for detailed deductible Information.

Step 2: Your plan will start to pay for services

After you satisfy your deductible, your plan will start to pay for covered services. The level of those benefits will depend on whether you see a PPO provider or indemnity.

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 an out-of-network provider, you will be balance billed based on the Providers charge. In addition, you may be required to pay the out of network total charge at time of service and may need to submit a claim to CareFirst for reimbursement. However, if you visit a participating provider, you are protected from balance billing.

Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Should you reach your out-of-pocket maximum; your plan will pay 100% of the allowed benefit for covered services for the remainder of the benefit period. The amounts you pay toward your copays and/or coinsurance will count toward your out-of-pocket maximum.

Important terms

Allowed benefit is the dollar amount CareFirst allows for the particular service in effect on the date that service is rendered.

Balance Billing is billing a member for the difference between the allowed charge and the actual charge.

Copay is a fixed dollar amount a member must pay for a covered service.

Coinsurance is a percentage of the provider's charge or allowed benefit a member must pay for a covered service.

Benefits At-a-Glance
BlueChoice Triple Option

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Plan Features	BlueChoice Triple Option Open Access—3 Health Care Plans in 1		
	Option 1 BlueChoice Open Access	Option 2 Preferred Provider Option PPO (BlueCard)	Option 3 Indemnity
ANNUAL DEDUCTIBLE			
Individual	None	$200 per calendar year	$500 per calendar year
Family (aggregate)	None	$600 per calendar year	$1,000 per calendar year
ANNUAL OUT-OF-POCKET MAXIMUM			
Individual	$1,000	$1,000	$2,000
Family (aggregate)	$2,000	$2,000	$4,000
LIFETIME MAXIMUM			
	Unlimited	Unlimited	Unlimited
COINSURANCE			
	$0	80% of Allowed Benefit	70% of Allowed Benefit
ADULT DEPENDENT (PARENT)			
	Not Eligible	Not Eligible	Not Eligible
ADULT DEPENDENT (CHILD)			
	Yes—Coverage ends at first month following 26th birthday		
	You Pay:	**You Pay:**	**You Pay:**
PREVENTIVE SERVICES			
Well-Child Care			
0–24 months	Covered in Full	Covered in Full	Covered in Full
2–18 years	Covered in Full	Covered in Full	Covered in Full
Routine GYN exam, routine Pap test	Covered in Full	Covered in Full	Covered in Full
Annual Physicals	Covered in Full	Covered in Full	Covered in Full
Routine Mammogram			
Billed by outpatient hospital	Covered in Full	Covered in Full	Covered in Full
Billed by independent network radiology facility	Covered in Full	Covered in Full	Covered in Full
DIAGNOSTIC AND TREATMENT SERVICES			
Office Visits	$10 primary care physician/$20 specialist copayment per visit	$20 PCP/$30 Specialist copayment	30% of Allowed Benefit after deductible
X-ray and Lab Tests	100% at network locations	20% of Allowed Benefit after deductible	30% of Allowed Benefit after deductible
Video Visit	$10 PCP/$20 Specialist copayment	Not applicable	Not applicable
Convenience Care (e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)	$10 copayment	Not applicable	Not applicable
Urgent Care	$15 per visit	$30 per visit	$30 per visit
MATERNITY SERVICES			
Inpatient obstetrical care	Covered in Full	20% of Allowed Benefit after deductible	30% of Allowed Benefit after deductible
Routine newborn care while mother is hospitalized for maternity care	Covered in Full	20% of Allowed Benefit after deductible	30% of Allowed Benefit after deductible
In vitro fertilization	50% of Allowed Benefit	50% of Allowed Benefit	50% of Allowed Benefit

BlueChoice Triple Option Open Access Health Plan

Plan Features	BlueChoice Triple Option Open Access—3 Health Care Plans in 1		
	Option 1 BlueChoice Open Access	Option 2 Preferred Provider Option PPO (BlueCard)	Option 3 Indemnity
	You Pay:	You Pay:	You Pay:
HOSPITAL SERVICES (OUTPATIENT)			
Operating/recovery room	Covered in Full	20% of Allowed Benefit after deductible	30% of Allowed Benefit after deductible
Diagnostic procedures, laboratory tests, X-rays	Covered in Full	20% of Allowed Benefit after deductible	30% of Allowed Benefit after deductible
HOSPITAL SERVICES (INPATIENT)			
Semiprivate room and board, anesthesia, surgical expenses, lab tests and X-rays	Covered in full if authorized by CareFirst BlueChoice and provided by an approved Option 1 provider	20% of Allowed Benefit after deductible	30% of Allowed Benefit after deductible
Emergency room care	$150 for a bona fide medical emergency (waived if admitted)	All emergency care claims will be considered for benefits under Option 1 first. If benefits are not available under Option 1, benefits may be payable under the appropriate option, see above.	
HOME HEALTH CARE			
	Benefits limited to services meeting specific guidelines and receiving prior approval	20% of Allowed Benefit after deductible. Benefits provided up to 40 days per calendar year (combined with Option 3)	30% of Allowed Benefit after deductible. Benefits provided up to 40 days per calendar year (combined with Option 2)
SKILLED NURSING FACILITY			
	Covered in full if admission began within seven days following discharge from an authorized Option 1 admission	20% of Allowed Benefit after deductible, limited to 30 days per calendar year (combined with Option 3)	30% of Allowed Benefit after deductible, limited to 30 days per calendar year (combined with Option 2)
HOSPICE CARE			
Inpatient facility of home hospice care	Covered in Full	20% of Allowed Benefit after deductible. (Benefit maximums are combined with Option 3)	30% of Allowed Benefit after deductible. (Benefit maximums are combined with Option 2)
MENTAL HEALTH AND SUBSTANCE USE DISORDER			
Inpatient Hospital-billed services	Covered in Full	Covered in Full	30% of Allowed Benefit after deductible
Inpatient Physician—billed services	Covered in Full	Covered in Full	30% of Allowed Benefit after deductible
Outpatient Facility and Physician-billed services	Covered in Full	Covered in Full	30% of Allowed Benefit after deductible
Office visits for Mental Health & Substance Abuse	$10 copayment	$20 copayment	30% of Allowed Benefit after deductible

Member Services: 800-628-8549 ■ carefirst.com/pgcps

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

CST3749-1P (10/19) ■ Prince George's County Public Schools

Know Before You Go

Your money, your health, your decision

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

Primary care provider (PCP)

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

24-Hour Nurse Advice Line

Call 800-535-9700 anytime to speak with a registered nurse. Nurses can discuss your symptoms with you and recommend the most appropriate care.

CareFirst Video Visit

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

Convenience care centers (retail health clinics)

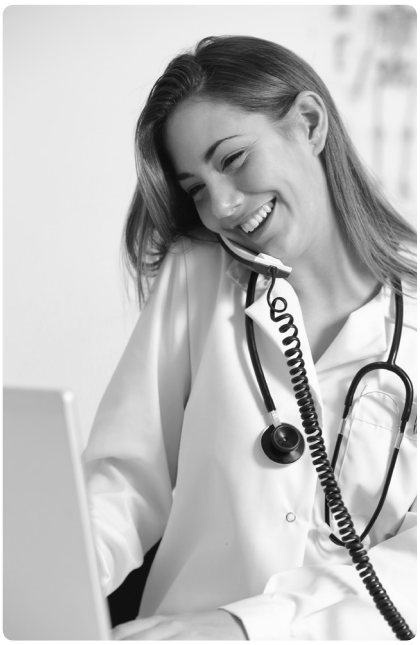
These are typically located inside a pharmacy or retail store (like CVS MinuteClinic or Walgreens Healthcare Clinic) and offer accessible care with extended hours. Visit a convenience care center for help with minor concerns like cold symptoms and ear infections.

Urgent care centers

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

Emergency room (ER)

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



For more information, visit **carefirst.com/pgcps.**

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

When you need care

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

	Member cost in-network	Sample symptoms	Available 24/7	Prescriptions?
Video Visit	$10 PCP/$20 Specialist	▪ Cough, cold and flu ▪ Pink eye ▪ Anxiety ▪ Food allergies ▪ Breastfeeding issues	✔	✔
Convenience Care (e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)	$10	▪ Cough, cold and flu ▪ Pink eye ▪ Ear pain	✘	✔
Urgent Care (e.g., Patient First or ExpressCare)	$15	▪ Sprains ▪ Cut requiring stitches ▪ Minor burns	✘	✔
Emergency Room	$150	▪ Chest pain ▪ Difficulty breathing ▪ Abdominal pain	✔	✔

To determine your specific benefits and associated costs:

- Log in to *My Account* at **carefirst.com/pgcps**
- 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/pgcps**.

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.

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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.

SUM3119-1P (9/19)_C

CareFirst Video Visit

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

Get treatment for common health issues 24/7

Use Video Visit when you're facing uncomplicated, non-emergency issues such as allergies, a sinus infection, a cold or the flu and more. Video Visit doctors will provide you a consultation, diagnosis and even prescriptions (when available and appropriate). They are all U.S. board-certified, licensed and credentialed medical professionals.

Schedule visits for additional services

- **Therapy/psychiatry**—Talk with a therapist or psychologist for help managing mental health issues including anxiety, depression and grief.
- **Diet/nutrition**—Connect with a registered dietitian to get support with dietary and nutrition needs, from weight loss to food allergies and more.
- **Breastfeeding support**—Speak with a lactation consultant who can advise you on breastfeeding topics like latching issues, milk supply and others.

The cost for Video Visit varies based on your benefits, but your specific cost information will be shown to you before your visit begins. Take advantage of this great benefit and register today!

Register today so you'll be ready when you need care! Visit **carefirstvideovisit.com or d**ownload the CareFirst Video Visit app from your favorite app store.

* 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.

In the case of a life-threatening emergency, you should always call 911 or your local emergency services. CareFirst Video Visit does not replace these services.

SUM3420-1P (5/19)

BlueVision

A plan for healthy eyes, healthy lives

BlueVision is included as a complement to the medical plan

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

How the plan works

How do I find a provider?

To find a provider, go to **carefirst.com** 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 BlueCross BlueShield or 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.

What if I go out-of-network?

BlueVision offers an allowance for a routine eye exam, eyeglasses, and contact lenses at a non-Davis Vision provider. You will be responsible for paying the entire amount of the service fees up-front. Out-of-network benefits are limited to an allowed benefit. After the services, you can submit your claim to Davis Vision for reimbursement. You can find the claim form by going to **carefirst.com**, locate *For Members*, then click on *Forms, Vision, Davis Vision*.

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/pgcps** or call 800-783-5602.

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

BRC6421-1P (9/17)_C ■ 12 month/$10 copay ■ BlueVision ■ Option 2

BlueVision is included as a complement to the medical plan

Summary of Benefits

(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	
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
Ultra Progressive Lenses (digital)	$140
Polarized Lenses	$75
High Index Lenses	$55
Glass Lenses	$18
Polycarbonate Lenses	$30
Blended invisible bifocals	$20
Intermediate Vision Lenses	$30
Photochromic Lenses	$35
Scratch-Resistant Coating	$20
Standard Anti-Reflective (AR) Coating	$45
Ultraviolet (UV) Coating	$15
Solid Tint	$10
Gradient Tint	$12
Plastic Photosensitive Lenses	$65
CONTACT LENSES[1,2]	
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[3]	
Up to 25% off allowed amount or 5% off any advertised special[4]	

Out-of-Network	You Pay
Routine Eye Examination with dilation (per benefit period)	Plan pays $33, you pay balance
Frames[2]	Plan pays $15, you pay balance
Single Lenses[2]	Plan pays $20, you pay balance
Bifocal Lenses[2]	Plan pays $35, you pay balance
Trifocal Lenses[2]	Plan pays $45, you pay balance
Medically Necessary Contacts[2]	Plan pays $80, you pay balance
Routine Contact Lenses[2]	Plan pays $10, you pay balance
Bifocal Contact Lenses[2]	90% of retail price

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

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

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

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

Exclusions
The following services are excluded from coverage:

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

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/BCOO/VISION (R. 1/06) • DC/BCOO/VISION (R. 1/06) • VA/BCOO/VISION (R. 1/06).

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

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Patient-Centered Medical Home

Supporting the relationship between you and your doctor

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

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

Extra care for certain health conditions

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

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

A PCP is important to your health

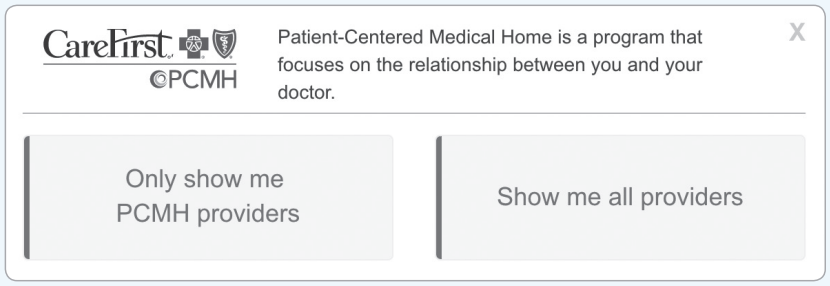
By visiting your PCP for routine visits, you build a relationship, and your PCP will get to know you and your medical history.

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

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

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

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



[1] All references to CareFirst refer to CareFirst BlueCross BlueShield and CareFirst, BlueChoice, Inc., collectively.

CST1310-1P (9/17)

Find Providers and Estimate Treatment Costs

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

Find providers

carefirst.com/pgcps

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

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

Review providers

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

Make low-cost, high-quality decisions

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

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

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

Want to view personalized information about doctors in your plan's network? Be sure to log in to *My Account* from your computer, tablet or smartphone.

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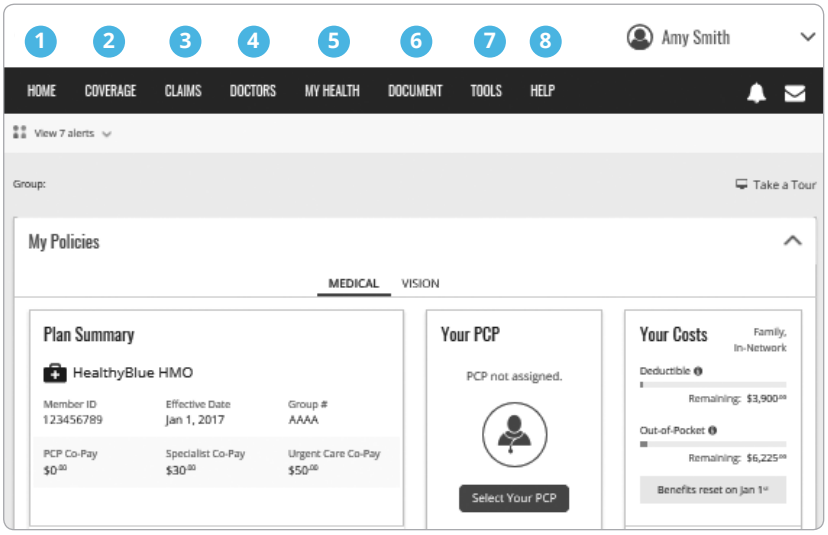
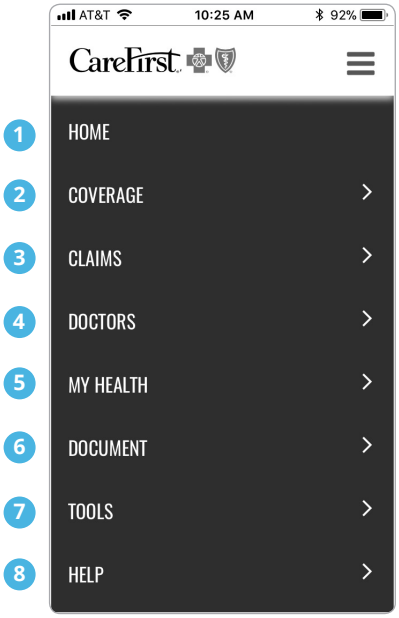
My Account

Online access to your health care information

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



As viewed on a computer.



As viewed on a smartphone.

My Account at a glance

1 Home

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

2 Coverage

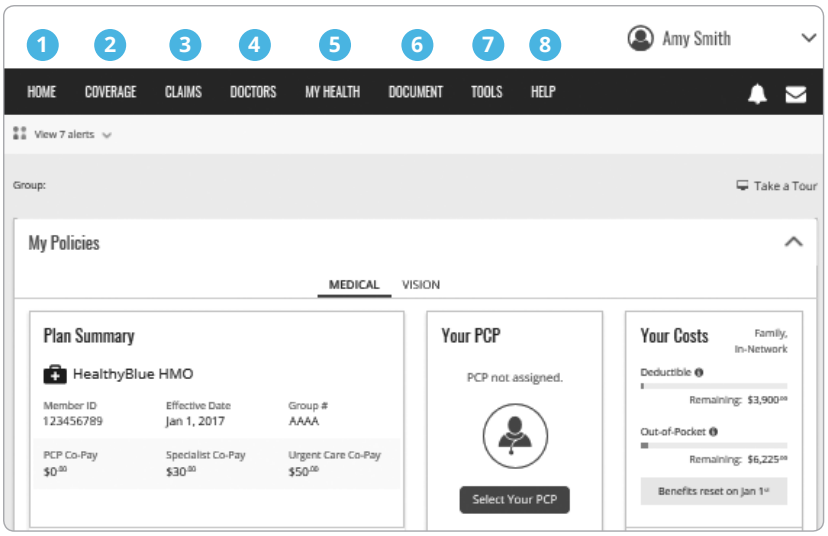
- Access your plan information—plus, see who is covered
- Update your other health insurance information, if applicable
- View, order or print member ID cards

Signing up is easy

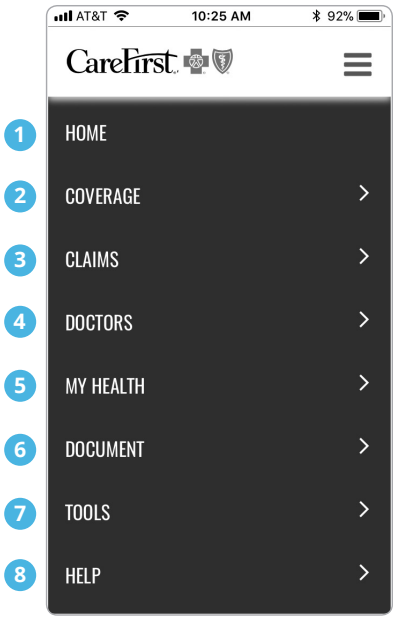
Information included on your member ID card will be needed to set up your account.

- Visit **carefirst.com/pgcps**
- Select *Register Now*
- Create your username and password

My Account



As viewed on a computer.



As viewed on a smartphone.

3 Claims

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

4 Doctors

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

5 My Health

- Access health and wellness discounts through Blue365

6 Documents

- Look up plan forms and documentation[1]
- Download *Vitality*, your annual member resource guide

7 Tools

- Access the Treatment Cost Estimator to calculate costs for services and procedures[2]

8 Help

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

[1] Only available when using a computer.

[2] 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.

BRC6499-1P (2/18)_C

Health & Wellness

Putting the power of health in your hands

Improving your health just got easier! CareFirst BlueCross BlueShield (CareFirst) has partnered with Sharecare, Inc.* to bring you a new, highly personalized wellness program. Catering to your unique health and wellness goals, our program offers motivating digital resources—accessible anytime—to help you live a healthier life.

Ready to take charge of your health?

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

Exclusive features

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

- **A personalized health newsfeed:** Receive insights, content and services.
- **Trackers:** Connect your wearable devices to monitor daily habits like sleep, steps, nutrition and more.
- **Challenges:** Having trouble staying motivated? Join a challenge to make achieving your health goals more entertaining.
- **A health profile:** Access your important health data like biometric information, vaccine history, lab results and medications all in one place.

Download the mobile app to access wellness tools and resources whenever and wherever you want.

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

Specialized programs

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

Health coaching

You may receive a call or email inviting you to participate in 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 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

If you are age 18 or older, have a body mass index (BMI) of 30 or greater and are looking to lose weight, our weight management program offers a personalized solution for long-term weight loss.

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 wealth of tools make quitting easier than you might think.

Financial well-being program

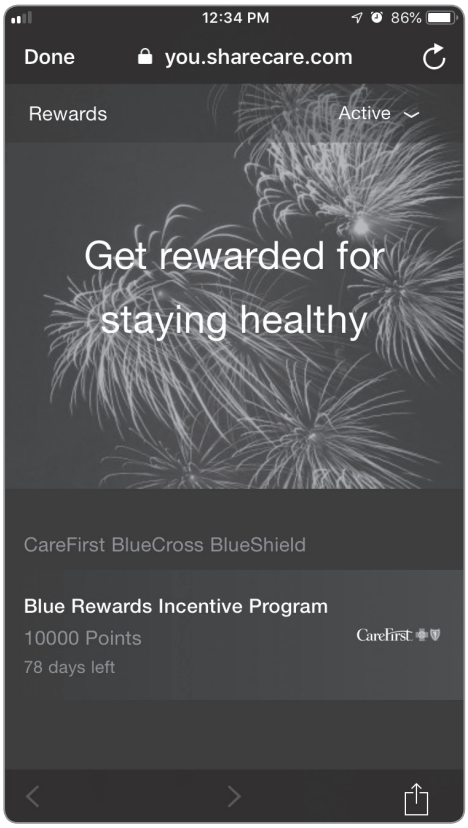
Learn how to take small steps toward big improvements in your financial situation. Whether you want to stop living paycheck to paycheck, get out of debt, or send a child to college, our financial well-being program can help.

To get started, visit **carefirst.com/sharecare**. You'll need to enter your CareFirst account username and password and complete the one-time registration with Sharecare to link your CareFirst account information. This will help personalize your experience.

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

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**.



SUM4585-1P (3/19) ■ Wellness Self-Insured

Mental Health Support

Well-being for mind and body

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

It's common to face some form of mental health challenge during your life. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) are here to help. Our support team is made up of specially trained service representatives, registered nurses and licensed behavioral health clinicians, 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

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

CareFirst members have access to specialized services and programs for depression, anxiety, drug or alcohol dependence, eating disorders, and other mental health conditions.

If you are in crisis, help is available 24/7 at 800-245-7013.

Like the privacy and convenience of Video Visit? You can now see providers for therapy and psychiatry services. These special services have fees associated with them, and your specific cost will be shown before the visit begins.

If you or someone close to you needs support or help making an appointment, call our support team at 800-245-7013, Monday-Friday 8 a.m.–6 p.m. ET. Or for more information, visit **carefirst.com/mentalhealth.**

SUM3223-1P (5/19)_C

BlueVision Plus

A plan for healthy eyes, healthy lives

BlueVision Plus—the stand alone vision program

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

Healthy eyes are an important part of your overall health. Routine eye examinations not only keep your eyewear current; they can also detect high-risk health issues such as diabetes and glaucoma before symptoms occur. Whether you have 20/20 vision or 20/200 vision, you should have a routine eye examination on a regular basis to keep your eyes healthy.

That's why we are pleased to offer BlueVision Plus, giving you complete eye health as part of your medical plan. BlueVision Plus makes eye health easy, offering a large network of optometrists, ophthalmologists and opticians from which to choose.

To administer your group's vision benefits, CareFirst and CareFirst BlueChoice have selected Davis Vision, Inc.—one of the nation's leading managed vision and eye care providers.

How the plan works

How do I find a provider?

BlueVision Plus offers a national network consisting of optometrists, ophthalmologists and opticians. To find a provider, go to **carefirst.com** and utilize the *Find a Doctor* 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?

BlueVision Plus is as easy to use as it is effective. Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueCross BlueShield or 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.

What if I go out-of-network?

Staying in-network gives you the best benefit, but BlueVision Plus does offer an out-of-network allowance schedule as well. In this case, you may see any provider you wish, but you will be responsible for all payments up-front. You will also be responsible for filing the claim with Davis Vision for reimbursement and paying any balances over the allowed benefit to the non-participating provider. You can find the claim form by going to **carefirst.com**, locate *Plan Information*, then click on F*orms*, *Vision*, *Davis Vision*.

May I use my benefit at different times?

Of course there will be times when you choose not to select your eyeglasses at the same time you receive your examination. You may "split" your benefits by getting your examination and your eyewear at different times. You don't even need to go to the same provider, but your care will be most effective when you stay with the same provider. When bringing an outside prescription to any provider, please confirm in advance that the provider will fill an outside prescription.

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

With BlueVision Plus, the benefit covers one pair of eyeglasses or a supply of contact lenses per benefit period. You are entitled to one pair of eyewear or a supply of contact lenses per benefit period.

Mail order replacement contact lenses

Free membership and access to a mail order replacement contact lens service, Lens 1-2-3®, provides a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 800-LENS-123 (800-536-7123) or visit **Lens123.com**.

BlueVision Plus—the stand alone vision program

Summary of Benefits

(12-month benefit period)

In-Network	You Pay
EYE EXAMINATIONS[1]	
Routine Eye Examination with dilation (per benefit period)	No copay
FRAMES *(once per 24 month benefit period)*	
Davis Vision Frame Collection	Fashion and designer frames from the Davis Vision Collection included—$25 copay for premier level frames
Non-Collection Frame	Plan pays up to $70, you pay balance minus 20% discount[3]
SPECTACLE LENSES *(once per 12 month benefit period)*	
Basic Single Vision	$10* or $30 copay
Lenticular (post-cateract)	$10* or $30 copay
Basic Bifocal	$10* or $30 copay
Basic Trifocal	$10* or $30 copay
CONTACT LENSES *(initial supply; once per 12 month benefit period in lieu of spectacle lenses)*	
Davis Vision Contact Lens Collection**	No copay
Medically Necessary Contacts	No copay with prior approval
Other (Non-Collection) Contact Lenses	Plan pays up to $105, you pay balance minus 15%[3] discount
Contact Lens EVALUATION, FITTING AND FOLLOW-UP CARE (once per 12 month benefit period)	
Davis Vision Collection, Standard Contact Lenses and Medically Necessary Contact Lenses	$30 copay
Other (non-collection) contact lenses	15% discount
Lens Options[1] **(add to spectacle lens prices above)**	
Standard Progressive Lenses	$50
Premium Progressive Lenses (Varilux®, etc.)	$90
Polarized Lenses	$75
High Index Lenses	$55
Polycarbonate Lenses for children, monocular and high prescription	No copay
Polycarbonate Lenses for all other patients	$30
Intermediate Vision Lenses	$30
Scratch-Resistant Coating	No copay
Scratch Protection Plan	Single Vision $20 Multifocal $40
Standard Anti-Reflective Coating	$35
Premium Glare Resistant Anti-Reflective Coating	$48
Ultra Anti-Reflective Coating	$60
Ultraviolet (UV) Coating	$12
Tinting	No copay
Plastic Photosensitive Lenses	$65
Oversized Lenses	No copay

In-Network	You Pay
CONTACT LENSES[1] *(mail order)*	
Lens 1-2-3® Mail Order Contact Lens Replacement Program	Up to 40% off Retail Prices
LASER VISION CORRECTION	
Laser Vision Correction[1]	Up to 25% off allowed amount or 5% off any advertised special[2]

Out-of-Network	You Pay
Routine Eye Examination with dilation (per benefit period)	Plan pays $40, you pay balance
Frames	Plan pays $20, you pay balance
Single Lenses	Plan pays $40, you pay balance
Bifocal Lenses	Plan pays $60, you pay balance
Trifocal Lenses	Plan pays $80, you pay balance
Lenticular (post-cataract) Eyeglass Lenses	Plan pays $130, you pay balance
Medically Necessary Contacts	Plan pays $230, you pay balance
Elective Contact Lenses	Plan pays $105, you pay balance

[1] These services or supplies are not considered covered benefits under the Plan. This portion of the Plan is not an insurance product.

[2] Please note that some providers have flat fees that are equivalent to these discounts.

[3] Discounts not available at Walmart and Sam's Club.

* The $10 copayment applies toward spectacle lenses when members receive services at an Eye Care Centers of America retail location such as Visionworks and Hour Eyes.

** The Davis Vision contact lens Collection offers a wide variety of covered-in-full contact lenses from today's top manufacturer's, including CooperVision® and Vistakon®, in both traditional and silicone hydrogel materials. The Collection is inclusive of disposable, planned replacement and select torics and multifocals. The Collection is updated regularly to reflect industry trends.

Exclusions

The following services are excluded from coverage:

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

Benefits issued under policy form numbers:
MD CFMI: CFMI/51+/GC (R. 7/10) • CFMI/EOC/D-V (R. 10/11) • CFMI/VISION DOCS (R. 10/11) • CFMI/VISION SOB (R. 10/11) • CFMI/ELIG/D-V (7/09) • and any amendments.

MD GHMSI: MD/CF/GC (R. 7/10) • MD/CF/EOC/D-V (R. 10/11) • MD/CF/DOCS-V (R. 10/11) • MD/CF/SOB-V (R. 10/11) • MD/CF/ELIG (R. 1/08) • and any amendments.

Ridered: CFMI/VISION RIDER (10/11) • MD/BCOO/VISION (R. 10/11) • MD/CF/VISION (R. 10/11).

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

Coordination of Benefits

If you're covered by more than one health plan

As a valued CareFirst member, we want to help you maximize your benefits and lower your out-of-pocket costs. If you're insured by more than one health insurance plan, our Coordination of Benefits program can help manage your benefit payments for you, so that you get the maximum benefits.

What is Coordination of Benefits (COB)?

It's a way of organizing or managing benefits when you're covered by more than one health insurance plan. For example:

- You and your spouse have coverage under your employer's plan.
- Your spouse also has coverage with another health insurance plan through his or her employer.

When you're covered by more than one plan, we coordinate benefit payments with the other health care plan to make sure you receive the maximum benefits entitled to you under both plans.

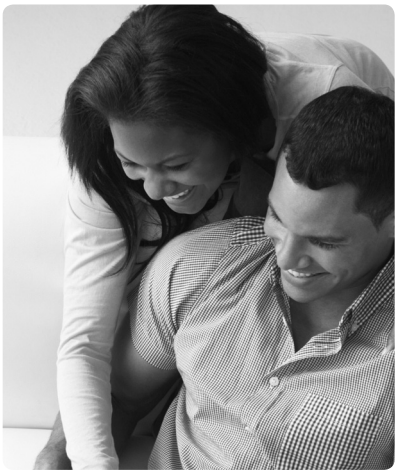
How does COB work?

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) and most commercial insurance carriers follow the primary-secondary rule. This rule states when a person has double coverage, one carrier is determined to be the primary plan and the other plan becomes the secondary plan.

The **primary plan** has the initial responsibility to consider benefits for payment of covered services and pays the same amount of benefits it would normally pay, as if you didn't have another plan.

The **secondary plan** then considers the balances after the primary plan has made their payment. This additional payment may be subject to applicable deductibles, copay amounts, and contractual limitations of the secondary plan.

With the COB between your primary and secondary plans, your out-of-pocket costs may be lower than they would've been if you only had one insurance carrier.



Covered by more than one health plan? Contact Member Services at the number listed on your ID card.

What if I have other coverage?

Contact Member Services at the number listed on your ID card, so we can update your records and pay your claims as quickly and accurately as possible. Let us know when:

- You're covered under another plan.
- Your other coverage cancels.
- Your other coverage is changing to another company.

We may send you a routine questionnaire asking if you have double coverage and requesting information regarding that coverage, if applicable. Complete and return the form promptly, so we can continue to process your claims.

How do I submit claims?

When CareFirst is the primary plan

You or your doctor should submit your claims first to CareFirst, as if you had no other coverage. The remaining balance, if any, should be submitted to your secondary plan. Contact your secondary plan for more information on how to submit the claims for the remaining balance.

When CareFirst is the secondary plan

Submit your claim to the primary plan first. Once the claim has been processed and you receive an Explanation of Benefits detailing the amount paid or denial reasons, the claim can be submitted to CareFirst for consideration of the balances. Mail a copy of the Explanation of Benefits from the primary carrier and a copy of the original claim to the address on the back of your CareFirst ID card.

When CareFirst is the primary and secondary plan

You don't need to submit two claims. When a claim form is submitted, write the CareFirst ID number of the primary plan in the subscriber ID number space. Then complete the form by indicating the CareFirst secondary plan ID number under *Other Health Insurance.* In most cases, we'll automatically process a second claim to consider any balances.

Which health plan is primary?

There are standard rules throughout the insurance industry to determine which plan is primary and secondary. It's important to know these rules because your claims will be paid more quickly and accurately if you submit them in the right order. Keep in mind that the primary-secondary rule may be different for different family members.

Here are the rules we use to determine which plan is primary:

- If a health plan doesn't have a COB provision, that plan is primary.
- If one person holds more than one health insurance policy in their name, the plan that has been in effect the longest is primary.
- If you're the subscriber under one plan and a covered dependent under another, the plan that covers you as the subscriber is primary for you.
- If your child(ren) are covered under your plan and your spouse's plan, the Birthday Rule applies. This rule states the health plan of the parent whose birthday occurs earlier in the year is the primary plan for the children.
  - For example, if your birthday is May 3 and your spouse's is October 15, your plan is primary for your children. But, if the other insurer does not follow the Birthday Rule, then its rules will be followed.
  - When parents are separated or divorced, the family plan in the name of the parent with custody is primary unless this is contrary to a court determination.
  - For dependent coverage only, if none of the above rules apply, the plan that's covered the dependent longer is primary.

BRC5823-1P (8/17)

Notice of Privacy Practices

As a participant in a health plan offered by Prince George's County Public Schools (PGCPS), you are entitled under federal law to receive a privacy notice that describes how the health plan may use and disclose your health information. The privacy notice describes how a health plan is permitted and required to use and disclose your health information and provides a description of your rights and the health plan's obligations under federal and state privacy laws.

A privacy notice for the PGCPS Benefits Plan, available to each PGCPS employee and retiree covered by the PGCPS Board Sponsored benefits plan, follows. A summary of the provision in the notice is outlined below:

How a health plan may use and disclose your health information

A health plan is permitted to use and disclose your health information for a number of different purposes. In some cases, you are entitled to object to such uses and/or disclosures and in other cases you are not entitled to object to certain uses and disclosures of your health plan. If a health plan wants to use or disclose your health information for a purpose not stated in the privacy notice, it may obtain your written authorization before it can use or disclose your health information. A health plan may use and disclose your information

- to pay for your health care treatment,
- to perform business management and general administrative activities,
- to law enforcement officials,
- for health oversight activities, and
- to avert a serious threat to the health or safety of an individual

Please refer to the following privacy notice for a complete listing of the purposes for which health plan is permitted to use and disclose your health information.

Your Rights as a Participant in a Health Plan

Pursuant to federal law, you have a number of rights associated with your health information. Your rights include to:

- restrict or limit how a health plan uses or discloses your health information,
- request confidential communications, inspect and copy your health information,
- inspect and copy your health information,
- amend your health information,
- an accounting of disclosures, and
- receive a paper copy of the privacy notice.

Obligations of a Health Plan

A plan is required to provide you with a privacy notice and comply with its terms. However, a plan may amend the privacy notice and apply such amendment to all of the health information it maintains.

Contact Information

A detailed privacy notice follows. Please read it carefully. If you have any questions or require additional information about the privacy notice, please contact the Benefits Services Department at 301-952-6200 or **pgcps.benefits@pgcps.org**.

Privacy notice for Prince George's County Public Schools Employee Benefits Plan

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.

This Privacy Notice describes how the self-insured components of the PGCPS Benefits Services Department, may use and disclose your health information to carry out treatment, payment and health care operations and for the other uses that are required or permitted by law. The self-insured components include the health, dental, prescription drug, and vision benefits for which PGCPS is the plan sponsor. Each of these self-insured components is referred to in this Privacy Notice as a "Health Plan". Additionally, this Privacy Notice explains the rights you have with respect to your health information, and certain obligations the Benefits Services Department must abide by in accordance with the law.

Each health plan is required by law to maintain the privacy of your health information and provide you with this privacy notice outlining the health plan's legal duties and privacy practices with respect to your health information. Nothing contained in this privacy notice should be construed to supersede or limit any additional rights you may be entitled to under other applicable laws. Therefore, if an applicable law affords you greater rights or more protections other than as described herein, each health plan will comply with the law that gives you greater rights and/or procedures.

Each health plan is required to abide by the terms of this privacy notice, but reserves the right to make additional changes of this privacy notice and to make such changes applicable to all your health information that such health plan maintains. If the Benefits Services Department makes any material revisions to this privacy notice, it will provide you with a copy of the revised privacy notice, which will specify the date on which such revised privacy notice becomes effective.

I. Use and Disclosure of Your Health Information

A health plan in which you are enrolled may use your health information for treatment, payment, and health care operations. A health plan also may use your health information for other purposes that are permitted and/or required by law and pursuant to your written authorization. The following lists examples of how a health plan may use and/or disclose your health information. Any other uses not described in this privacy notice will only be made with your explicit written authorization, which authorization you may revoke at any time by providing written notice of your revocation.

II. Your Rights as a Participant in a Health Plan

As a participant in one or more of the health plans, you have a number of rights associated with your health information. The following describes your specific rights.

A. The Right to Request a Restriction or Limitation on the Use and Disclosure of Your Health Information

You have the right to request restrictions or limitations on how a health plan is allowed to use and/or disclose your health information; however, the health plan does not have to agree to your requested restriction or limitation. If you would like to request a restriction or limitation on a health plan's use or disclosure of your health information, please send your request in writing to the address listed at the end of this privacy notice. Your request must specify – (1) if you would like to restrict or limit health plan's use, disclosure, or both; (2) what information you would like to restrict or limit; and (3) to whom you want the limitation or restriction to apply (e.g., your spouse).

If a health plan agrees to a restriction or limitation of your health information, the restriction or limitation will not prevent such health plan from disclosing your health information as follows: (1) to you if you request access to your health information or if you request an accounting of disclosures; (2) for purposes required or permitted by law (e.g., to comply with laws relating to worker's compensation); or (3) in the case of an emergency, as described below.

If a health plan accepts your restriction or limitation regarding how such health plan may use or disclose your health information, the health plan may nevertheless disclose the restricted health information to a health care provider if you are in need of emergency care and your restricted health information is needed to provide emergency treatment to you. Before the health plan discloses your restricted health information to a health care provider during an emergency, the health plan will request that the health care provider that receives your health information not further use or disclose your health information.

If a health plan accepts your requested restriction or limitation, such health plan may terminate the restriction or limitation if – (1) you agree to the termination or request the termination in writing; (2) you orally agree to the termination and the oral agreement is appropriately documented; or (3) the health plan informs you that it is terminating the restriction or limitation provided, however, the health plan's termination would only be effective for health information the health plan creates or receives after the health plan informs you of the termination.

B. Right to Request Confidential Communications via Alternative Means or Locations

You have the right to request receipt of health information from a health plan by alternative means or via alternative locations provided that you clearly state that the disclosure of all or part of your health information could endanger you. For example, you may want to receive communications related to your health care at a different address other than your home address because you could be in danger of harm if someone at that address saw such health information. If you wish to receive confidential communications via alternative means or locations, please submit your request to the address listed at the end of this privacy notice and set forth the alternative means by which you wish to receive communications or the alternative location at which you wish to receive such communications. A health plan will accommodate all reasonable requests.

C. Right to Access your Health Information

You have the right of access to inspect and obtain a copy of your health information provided, however, you are not entitled to access health information that is: (1) contained in psychotherapy notes; (2) compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding; and (3) is either subject to the Clinical Laboratory Improvements Amendments of 1988 (CLIA) to the extent that the provision of access to the individual would be prohibited by law or is exempt from CLIA. To access your health information, please send your request in writing to the address listed at the end of this privacy notice. If a health plan does not have your health information in its possession, it will provide you with the appropriate contact information when your request is received. If you request a copy of your health information, you will receive a response to your request in a timely fashion but may be charged a reasonable, cost-based fee to cover copy costs and postage.

In some limited circumstances, a health plan may deny your request for access to health information. Unreviewable grounds for denial are: situations involving (i) psychotherapy notes, information compiled for use in legal proceedings, and certain information held by clinical laboratories; (ii) certain requests which are made by inmates of correctional institutions; (iii) information created or obtained during research that includes treatment if certain conditions are met; (iv) denials permitted by the Privacy Act, 5 U.S.C. § 524a; and (v) information obtained from non-health care providers pursuant to promises of confidentiality. See 45 C.F.R. 164.524(a)(2).

Reviewable grounds for denial are: (i) disclosures which would cause endangerment of the individual or another person; (ii) situations where the protected health information refers to another and disclosure is likely to cause substantial harm; and (iii) requests made by a personal representative where disclosure is likely to cause substantial harm. See C.F.R. § 164.524(a)(3). If access is ultimately denied, you will be entitled to written explanation of the reasons for the denial.

D. Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of disclosures of your health information made by a health plan, including disclosures to or by business associates of the health plan, for the period of six (6) years prior to the date on which you request an accounting of disclosures or such lesser period as you indicate provided, however, you are not entitled to receive an accounting of disclosures for disclosures that occurred prior to April 14, 2003. If you wish to receive an accounting of disclosures, please send your written request to the address listed at the end of this privacy notice. If a health plan does not have your health information in its possession, it will provide you with the appropriate contact information when it receives your request. You will receive a response to your request for an accounting of disclosures no later than 60 days after your request is received.

Notwithstanding the foregoing, your accounting of disclosures will not include any disclosures made – (1) to carry out treatment, payment, and/or health care operations; (2) directly to you; (3) incident to a use or disclosure otherwise permitted by law; (4) pursuant to your authorization; (5) to persons involved in your care; (6) for national security or intelligence purposes as permitted by law; (7) to correctional institutions or law enforcement officials as permitted by law; (8) as part of a limited data set in accordance with law; or (9) that occurred prior to April 14, 2003.

You will receive one request annually free of charge and, thereafter, a health plan may charge you a reasonable, cost-based fee for each subsequent request for an accounting of disclosures within the same 12 month period. A health plan will notify you of the cost for an accounting of disclosures and you may choose to withdraw or modify your request before you are charged any costs.

E. Right to Amend Your Health Information

If you believe a health plan has health information about you that is incorrect or incomplete, you may make a written request to the health plan stating the reasons to support your requested amendment. You have the right to request an amendment to your health information for as long as the health plan maintains your health information. If you would like to make a request to amend your health information, please send your request in writing to the address listed at end of this privacy notice. If the health plan does not have your health information in its possession, it will provide you with the appropriate contact information when your request is received. You will receive a response to your request for an amendment no later than 60 days after the health plan receives your request. However, a health plan may deny your request for amendment if, for example, the health plan determines your requested health information was not created by such health plan or is already accurate and complete. You may respond to the denial by filing a written statement of disagreement. The health plan has the right to rebut your disagreement. If this occurs, you have the right to request that your original request, the denial, your statement of disagreement, and the rebuttal be included in future disclosures of your health information.

F. Right to Receive a Paper Copy of Your Privacy Notice

You have the right at any time to obtain a paper copy of this privacy notice, even if you receive this privacy notice electronically. If you have received an electronic copy of tis privacy notice, but wish to obtain a paper copy of this privacy notice, please send your written request to the address listed at the end of this privacy notice.

III. Miscellaneous

A. Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. If you wish to file a complaint with the Benefits Services Department, please forward your written complaint to the address listed at the end of this privacy notice. If you choose to file a complaint, Prince George's County Public Schools is prohibited by law from retaliating against you for filing such complaint.

B. Effective Date

This notice is effective as of August 2014.

C. Contact Information

If you need any additional information about this privacy notice, please contact the EEO Advisor for Prince George's County Public Schools.

Continuation of Coverage (COBRA)

Prince George's County Public Schools
General Notice of Cobra Continuation Coverage Rights
Continuation Coverage Rights Under Cobra

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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." Specific qualifying events are listed later in this notice. 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.**

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;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated 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 parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Prince George's County Public Schools, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Plan Administrator has been notified in writing that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You must give written notice of some qualifying events

For the other qualifying events (**divorce** or **legal separation** of the employee and spouse or a **dependent child's losing eligibility for coverage** as a dependent child), you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must provide this notice to: PGCPS Benefits Administration Office, using the procedures specified in the box below. **If these procedures are not followed or if the notice is not provided in writing to the COBRA Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.**

Notice Procedures: Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail your notice to the COBRA Plan Administrator. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state the name of the Plans such as the medical, dental, vision, and health care reimbursement account, the name and address of the employee covered under the Plans, and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

How is COBRA coverage provided?

Once the COBRA Plan Administrator 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. **If you or your spouse or dependent children do not elect continuation coverage within this 60-day election period, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, 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, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, 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 Plan Administrator 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 follow the procedures specified in the box above, entitled "Notice Procedures." In addition, your notice must include the name of the disabled qualified beneficiary, the date that the qualified beneficiary became disabled, and the date that the Social Security Administration made its determination. Your notice must also include a copy of the Social Security Administration's determination. **If these procedures are not followed or if the notice is not provided in writing to the COBRA Plan Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE.**

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, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, 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. In all of these cases, you must make sure that the COBRA Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. You must follow the procedures specified in the box above, entitled "Notice Procedures." Your notice must also name the second qualifying event and the date it happened. If the second qualifying event is a divorce, your notice must include a copy of the divorce decree. **If these procedures are not followed or if the notice is not provided in writing to the COBRA Plan Administrator within the required 60-day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

Shorter maximum coverage period for Health Care Reimbursement Account (Health FSA)

COBRA coverage under the Health Care Reimbursement Account (Health FSA) is available to a qualified beneficiary provided the employee has not overspent their Health Care Reimbursement Account as of the time of the qualifying event. An employee that has overspent their account is not entitled to continue coverage under the Health Care Reimbursement Account. If applicable, the maximum COBRA coverage period for a Health Care Reimbursement Account maintained by the employer ends on the last day of the plan year in which the qualifying event occurs.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.
For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator 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 Plan Administrator.

Plan contact information

Name of group health plan:

PGCPS Group Health Plan

Contact Person:

Plan Administrator
Prince George's County Public Schools
Benefits Services
14201 School Lane, Room 132
Upper Marlboro, MD 20772

Telephone Number:

(301) 952-6200

Rights and Responsibilities

Notice of privacy practices

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) are committed to keeping the confidential information of members private. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to send our Notice of Privacy Practices to members of fully insured groups only. The notice outlines the uses and disclosures of protected health information, the individual's rights and CareFirst's responsibility for protecting the member's health information.

To obtain a copy of our Notice of Privacy Practices, go to **www.carefirst.com** and click on *Privacy Statement* at the bottom of the page, click on *Health Information* then click on *Notice of Privacy Practices.* Or call the Member Services telephone number on your member ID card. Members of self-insured groups should contact their Human Resources department for a copy of their Notice of Privacy Practices. If you don't know whether your employer is self-insured, please contact your Human Resources department.

Member satisfaction

CareFirst wants to hear your concerns and/or complaints so that they may be resolved. We have procedures that address medical and non-medical issues. If a situation should occur for which there is any question or difficulty, here's what you can do:

- If your comment or concern is regarding the quality of service received from a CareFirst representative or related to administrative problems (e.g., enrollment, claims, bills, etc.) you should contact Member Services. If you send your comments to us in writing, please include your member ID number and provide us with as much detail as possible regarding any events. Please include your daytime telephone number so that we may contact you directly if we need additional information.

CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

- If your concern or complaint is about the quality of care or quality of service received from a specific provider, contact Member Services. A representative will record your concerns and may request a written summary of the issues. To write to us directly with a quality of care or service concern, you can:
  - Send an email to: **quality.care.complaints@carefirst.com**
  - Fax a written complaint to: **301-470-5866**
  - Write to:
    CareFirst BlueCross BlueShield
    Quality of Care Department
    P.O. Box 17636
    Baltimore, MD 21297

If you send your comments to us in writing, please include your identification number and provide us with as much detail as possible regarding the event or incident. Please include your daytime telephone number so that we may contact you directly if we need additional information. Our Quality of Care Department will investigate your concerns, share those issues with the provider involved and request a response. We will then provide you with a summary of our findings. CareFirst member complaints are retained in our provider files and are reviewed when providers are considered for continuing participation with CareFirst.

These procedures are also outlined in your Evidence of Coverage.

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

VIRGINIA:
Complaint Intake, Office of Licensure and Certification, Virginia Department of Health, 9960 Maryland Drive, Suite 401, Richmond, VA 23233-1463
Phone #: 800-955-1819 or 804-367-2106
Fax #: 804-527-4503

Office of the Managed Care Ombudsman, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218
Phone #: 1-877-310-6560 or 804-371-9032

DISTRICT OF COLUMBIA:
Department of Insurance, Securities and Banking, 801 1st Street, NE, Suite 701, Washington, DC 20002
Phone #: 202-727-8000

MARYLAND:
Maryland Insurance Administration, Inquiry and Investigation, Life and Health, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202
Phone #: 800-492-6116 or 410-468-2244

Office of Health Care Quality, Spring Grove Center,
Bland-Bryant Building, 55 Wade Avenue, Catonsville, MD 21228
Phone #: 410-402-8016 or 877-402-8218

For assistance in resolving a Billing or Payment Dispute with the Health Plan or a Health Care Provider, contact the Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General at:

Health Education and Advocacy Unit, Consumer Protection Division, Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202
Phone #: 410-528-1840 or 877-261-8807
Fax #: 410-576-6571
web site: www.oag.state.md.us

Hearing impaired

To contact a Member Services representative, please choose the appropriate hearing impaired assistance number below, based on the region in which your coverage originates.

Maryland Relay Program: 800-735-2258
National Capital Area TTY: 202-479-3546
Please have your Member Services number ready.

Language assistance

Interpreter services are available through Member Services. When calling Member Services, inform the representative that you need language assistance.

Please Note: CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

Confidentiality of subscriber/ member information

All health plans and providers must provide information to members and patients regarding how their information is protected. You will receive a Notice of Privacy Practices from CareFirst or your health plan, and from your providers as well, when you visit their office.

CareFirst has policies and procedures in place to protect the confidentiality of member information. Your confidential information includes Protected Health Information (PHI), whether oral, written or electronic, and other nonpublic financial information. Because we are responsible for your insurance coverage, making sure your claims are paid, and that you can obtain any important services related to your health care, we are permitted to use and disclose (give out) your information for these purposes. Sometimes we are even required by law to disclose your information in certain situations. You also have certain rights to your own protected health information on your behalf.

Our responsibilities

We are required by law to maintain the privacy of your PHI, and to have appropriate procedures in place to do so. In accordance with the federal and state Privacy laws, we have the right to use

and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We may disclose your protected health information to the plan sponsor/employer to perform plan administration function. The Notice is sent to all policy holders upon enrollment.

Your rights

You have the following rights regarding your own Protected Health Information. You have the right to:

- Request that we restrict the PHI we use or disclose about you for payment or health care operations.
- Request that we communicate with you regarding your information in an alternative manner or at an alternative location if you believe that a disclosure of all or part of your PHI may endanger you.
- Inspect and copy your PHI that is contained in a designated record set including your medical record.
- Request that we amend your information if you believe that your PHI is incorrect or incomplete.
- An accounting of certain disclosures of your PHI that are for some reasons other than treatment, payment, or health care operations.
- Give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice.

Inquiries and complaints

If you have a privacy-related inquiry, please contact the CareFirst Privacy Office at 800-853-9236 or send an email to privacy.office@carefirst.com.

Members' rights and responsibilities statement

Members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Receive information about the health plan, its services, its practitioners and providers, and members' rights and responsibilities.
- Participate with practitioners in decision-making regarding their health care.
- Participate in a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities.
- Voice complaints or appeals about the health plan or the care provided.

Members have a responsibility to:

- Provide, to the extent possible, information that the health plan and its practitioners and providers need in order to care for them.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the plans and instructions for care that they have agreed on with their practitioners.
- Pay copayments or coinsurance at the time of service.
- Be on time for appointments and to notify practitioners/providers when an appointment must be canceled.

Eligible individuals' rights statement wellness and health promotion services

Eligible individuals have a right to:

- Receive information about the organization, including wellness and health promotion services provided on behalf of the employer or plan sponsors; organization staff and staff qualifications; and any contractual relationships.
- Decline participation or disenroll from wellness and health promotion services offered by the organization.
- Be treated courteously and respectfully by the organization's staff.
- Communicate complaints to the organization and receive instructions on how to use the complaint process that includes the organization's standards of timeliness for responding to and resolving complaints and quality issues.

Habilitative services

CareFirst provides coverage for habilitative services to members younger than the age of 19. This includes habilitative services to treat congenital or genetic birth defects, including a defect existing at or from birth, a hereditary defect, autism or an autism spectrum disorder, and cerebral palsy.

Habilitative services include speech, physical and occupational therapies. CareFirst must pre-approve all habilitative services. Any deductibles, copayments and coinsurance required under your contract apply. Policy maximums and benefit limits apply. Habilitative services are not counted toward any visit maximum for therapy services.

Please note that any therapies provided through the school system are not covered by this benefit. This coverage applies only to contracts sold to businesses based in Maryland. Check your contract coverage to determine if you are eligible to receive these benefits. If you have questions regarding any of these services, contact Member Services at the telephone number on your member ID card.

Mastectomy-related services

CareFirst provides coverage for home visits to members who undergo a mastectomy (the surgical removal of all or part of the breast as a result of breast cancer) or the surgical removal of a testicle. Coverage includes one home visit that occurs within 24 hours after discharge from the hospital or outpatient facility and an additional home visit if prescribed by the member's doctor. To be eligible, the member must be in the hospital less than 48 hours or have the procedure performed on an outpatient basis. This coverage applies only to contracts sold to businesses based in Maryland. Please check your contract coverage to determine if you are eligible for these surgical procedure benefits.

CareFirst offers other benefits for mastectomy-related services, including:

- All stages of reconstruction of the breast that underwent the mastectomy.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis (artificial breast) and treatment of the physical complications that occur at all stages of the mastectomy, including lymphedema (swelling).

You and your physician will determine the appropriate plan to treat your condition. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits covered under your health plan. Please refer to your Benefit Guide or Evidence of Coverage for more details or call Member Services at the telephone number on your member ID card.

Care for mothers, newborns

Under the Newborns' and Mothers' Health Protection Act, CareFirst offers coverage for inpatient hospitalization services for a mother and newborn child for a minimum of:

- 48 hours of inpatient hospitalization care after an uncomplicated vaginal delivery.
- 96 hours of inpatient hospitalization care after an uncomplicated cesarean section.

If the mother and newborn remain in the hospital for at least the length of time provided, coverage includes:

- A home visit if prescribed by the attending physician.
- The mother may request a shorter length of stay if, after talking with her physician, she decides that less time is needed for her recovery.

If the mother and newborn have a shorter hospital stay than listed above, coverage includes one home visit scheduled to occur within 24 hours after hospital discharge and an additional home visit if prescribed by the attending physician.

CUT6623-1P (8/17)

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within "30 days" after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "30 days" after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

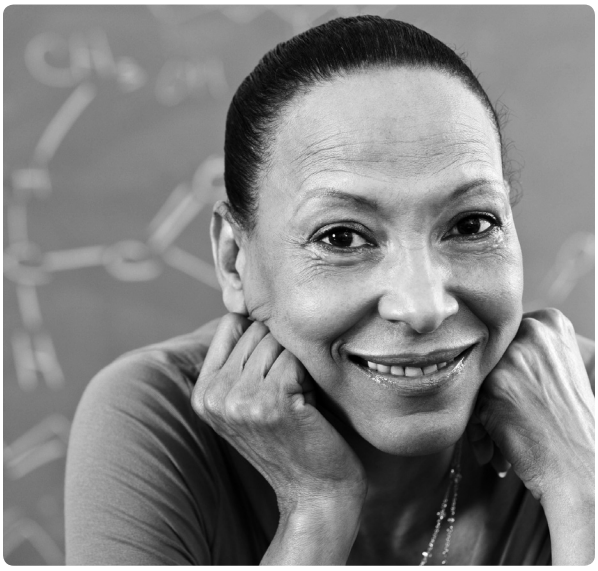
If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Benefits Services Department, Prince George's County Public Schools, 301-952-6200.

Portability (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) ensures that individuals who have health insurance do not experience a gap in coverage due to termination or departure from their current job. A member terminating coverage with an insurance carrier will receive a Certificate of Creditable Coverage indicating the length of time they have had health insurance coverage. This Certificate of Creditable Coverage is used to reduce any waiting time for pre-existing conditions that may be part of subsequent health insurance coverage, as long as there has not been a break in coverage for more than 63 days.

When a member terminates with CareFirst BlueChoice, they receive a Certificate of Health Plan Coverage that indicates how long the member was covered. The member should then present the certificate to the new insurance carrier. This will reduce or eliminate waiting periods for pre-existing conditions under the member's new policy.



Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at **askebsa.dol.gov** or by calling toll-free 1-866-444- EBSA (3272).

If you live in Delaware, Maryland, Pennsylvania or Washington, D.C., you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility.

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1-877-267-2323, Menu Option 4, ext. 61565

ONLINE	PHONE
DELAWARE—MEDICAID	
http://www.dhss.delaware.gov/dss/dhcp.html	1-800-996-9969
MARYLAND—MEDICAID	
https://mmcp.dhmh.maryland.gov/chp/ SitePages/Home.aspx	1-800-456-8900
PENNSYLVANIA—MEDICAID	
http://www.dpw.state.pa.us/hipp	1-800-692-7462
VIRGINIA—MEDICAID AND CHIP	
Medicaid Website: **http://www.dmas.virginia.gov/rcp-HIPP.htm** CHIP Website: **http://www.famis.org/**	Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-866-873-2647
WASHINGTON D.C.—MEDICAID	
http://dhcf.dc.gov/node/151012	1-877-685-6391

Glossary of Terms

Allowed Benefit

The maximum dollar amount allowed for services covered, regardless of the provider's actual charge. A provider who participates in the network cannot charge the member more than this amount for any covered service.

Appeal

A protest filed by a member or a health care provider under CareFirst BlueCross BlueShield/ CareFirst BlueChoice's internal appeal process regarding a coverage decision.

Authorization

The contractual requirement that the provider or member notify and obtain approval from the plan before certain services are covered for a member. Authorization is required for services such as, but not limited to, non-emergency hospitalizations, certain outpatient hospital services, skilled nursing care, home health care, outpatient surgical services, and durable medical equipment.

Claim Form

A form obtained from Member Services for reimbursement of covered services paid by the member.

Coinsurance

A percentage of the plan allowance that the member pays for a covered service (e.g., 20 percent for lab services or x-rays).

Complaint

A protest filed with the regulatory department involving an adverse decision, coverage decision, appeal decision, or grievance decision.

Coordination of Benefits

A provision which determines the order of benefit determination when a member has health care coverage under more than one plan.

Copayment

A specified amount that the member pays for a covered benefit (e.g., $10 per office visit to a primary care physician).

Covered Expenses

Amounts that are eligible for benefits by CareFirst BlueChoice, as described in your Evidence of Coverage.

Covered Provider

A type of provider from whom you are eligible to receive care under the benefits described in your Evidence of Coverage.

Deductible

The dollar amount of incurred covered expenses that the member must pay before CareFirst BlueChoice makes payment.

Dependent

A member who is covered under the Plan as the spouse or eligible child of a Subscriber.

Evidence of Coverage

A document reflecting an individual's or group's enrollment agreement with CareFirst BlueChoice.

Exclusions

Specific conditions, treatments, services or circumstances listed in the contract for which CareFirst BlueChoice will not provide benefits.

Health Care Provider

An individual who is licensed or otherwise authorized in this State to provide health care services in the ordinary course of business or practice of a profession, and is a treating provider of the member; or a hospital.

Health Maintenance Organization (HMO)

An organization that provides a wide range of health care services through a PCP who renders or coordinates all of your care to provide you with quality service while reducing medical costs.

HIPAA

Health Insurance Portability and Accountability Act. This Act addresses many tenets of health insurance coverage including the handling of Personal Health Information (PHI) and the Member's ability to receive credit towards his or her waiting period.

Glossary of Terms

Indemnity

Traditional insurance plans under which the health plan reimburses the provider and the member on a fee-for-service basis after the patient has satisfied any applicable deductible. These plans typically have the highest out-of-pocket expenses, but they give you the flexibility to seek treatment from any covered provider.

Member

An individual who meets all applicable eligibility requirements stated in Part 2 of the Evidence of Coverage, is enrolled for coverage, and for whom we receive the premiums and other required payments. A member can be either a subscriber or a dependent.

Network

A group of multi-specialty medical groups and individual practice doctors who are contracted to provide services to members of a health plan.

Participating Provider

A covered provider that contracts with CareFirst BlueCross BlueShield/CareFirst BlueChoice to be paid directly for rendering covered services to eligible members of this plan.

Practitioner

Professionals who provide health care services. Practitioners are required to be licensed as defined by law.

Preferred Provider

A covered practitioner or facility that contracts with CareFirst BlueCross BlueShield/ CareFirst BlueChoice (or with another Blue Cross and Blue Shield plan) to render covered services to eligible members in accordance with the terms and conditions of the Preferred Provider Plan.

Preventive Health Care

Care provided to prevent disease or its consequences. It includes programs aimed at warding off illnesses (e.g., immunizations), early detection of disease and inhibiting further deterioration of the body. This includes the promotion of health through altering behavior, especially by health education.

Primary Care Physician

The Plan physician selected by or on behalf of, the member to provide primary care to the member and to coordinate and arrange other required services.

Provider

An individual, institution or organization that provides medical services. Examples of providers include physicians, therapists, hospitals and home health agencies.

Referral

A written authorization by the PCP for the member to see a specialty provider.

Specialist

A licensed health care provider to whom a member can be referred to by a PCP.

Subscriber

A member who is covered under the Plan as an eligible employee or member of the group, rather than as a dependent.

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

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

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

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

Foreign Language Assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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