CareFirst
Family of health care plans

Patient-Centered Medical Home (PCMH) Program Description & Guidelines

2025

Adult Medicine

Table of Contents

Key Terms and Definitions

Collaborative Panel	A CareFirst made Panel for PCPs who are unable to find their own Panel
Credits	A Panel's Performance Year budget, or expected cost of care of their attributed Members
Debits	Allowed amount of healthcare spend for Members attributed to a Panel in the Performance Year
Designated Provider Representative (DPR)	Primary Care Prover (PCP) lead for the Panel who has certain administrative responsibilities
Episode of Care Debit Overlap	50% of the shared savings earned by specialists in an Episode of Care value-based model that is applied back to a Panel's Patient Care Account
Identification Stratification Population	Group of CareFirst Members who meet specific criteria related to care coordination needs
Individual Stop Loss	Portion of Gross Debits representing 80% of costs Per Member Per Year (PMPY) above $100,000 debited back to the Patient Care Account
Member	CareFirst beneficiary of Medical and Pharmacy Benefits
Member Months	The number of individual months a CareFirst Member is attributed to a PCMH Panel
Outcome Incentive Award	Portion of shared savings awarded to eligible Panels and practices who meet savings to budget, quality score, engagement and attribution requirements
Overall Medical Trend	Change in the total cost of care over time for CareFirst Members with the CareFirst Medical Benefit
Overall Pharmacy Trend	Change in the total cost of pharmacy claims for the CareFirst Members with the CareFirst Pharmacy Benefit
Panel	Group of Primary Care Providers formed for participation in the PCMH Program
Panel Governance	CareFirst committee that reviews Panel structure, appeals and exceptions
Participation Incentive	12 percentage point increase to standard base fee schedule for PCPs participating in the PCMH Program
Patient Care Account	A report that presents a Panel's budget and total healthcare spend in a Performance Year
Performance Year	The measurement period for PCMH ranging from January 1 through December 31 of any given year
Persistency	Increase in Outcome Incentive Award total for Panels who earn an Outcome Incentive Award multiple years in a row; awarded at levels of 2 or 3+ years in a row
Provider Directory	A list of providers contracted to participate in the CareFirst network available to CareFirst Members

Panel Size

A Panel, or group of Primary Care Providers (PCPs), is the basic performance unit of the PCMH Program, forming a team where one otherwise may not exist. PCMH Participation Incentives and Outcome Incentive Awards (OIAs) are based on the performance of Panels.

To form a Panel, PCPs must organize into a group of five to 15 PCPs. A Panel may be formed by an existing group practice, small independent group practices and/or solo practitioners that agree to work together to achieve Program goals. When a Panel is between five and 15 PCPs, it is large enough to reasonably pool member experience for the purpose of pattern recognition and the generation of financial incentives, yet small enough for each PCP's contribution to be perceived as meaningful. The idea is to tie rewards as directly as possible to individual PCP performance while providing enough experience to support sound conclusions about overall performance for each Panel.

Nurse Practitioners (NPs) are considered to be Primary Care Providers and count towards the minimum of five PCPs required to comprise a Panel.

Practices that exceed 15 PCPs but practice in the same location may request in writing to CareFirst an exception to form one Panel. This request will be reviewed by Panel Governance to determine the appropriateness of the exception based on the following criteria.

1. Panel Viability
2. Geography
3. Panel Cohesion/Accountability
4. Point in the Performance Year of the Request

CareFirst reserves the right to deny the addition of PCPs beyond 15.

If the termination of a practice or individual PCP within the Panel causes a Panel to fall below minimum participation requirements of five PCPs, the Panel will have up to one year to restore itself to the minimum participation level of five PCPs.

Panel Viability

For performance results to be credible, a Panel must have a minimum level of 15,000 attributed Member Months over the course of the Performance Year, or an average of 1,250 attributed Members per month. This is the point at which a Panel is considered viable and therefore eligible to earn an OIA.

There may be some instances when Panels are not able to reach the number of attributed Members needed to be viable while staying within the permissible range of five to 15 PCPs per Panel. For example, a Panel located in a geographic area with a low volume of CareFirst Members may not have enough Members to be considered viable. In these instances, the Panel may request, in writing to add additional PCPs, with the approval of CareFirst, to exceed the 15 PCP maximum and achieve a viable Panel size.

In some circumstances, a PCP may have difficulty finding a Panel to join. In these instances, CareFirst will assign a PCP to a PCMH Collaborative Panel. Practices joining the PCMH Program without a prospect to become a viable Panel that meets the Program requirements are agreeing to be placed in a Collaborative Panel. The Collaborative Panels will be constructed to ensure viability requirements are met. As such, CareFirst may construct a Panel that exceeds the 15 PCP maximum and may be geographically spread.

CareFirst reserves the right to deny the addition of PCPs beyond 15 and addition of any PCP to a Collaborative Panel.

Panel Composition

A PCP is eligible for this Program if (s)he is a healthcare provider who: (i) is a full-time, duly licensed medical practitioner; (ii) is a participating provider, contracted to render primary care services, in both the CareFirst BlueChoice Participating Provider Network (HMO) and the CareFirst Regional Participating Preferred Network (RPN); and (iii) has a primary specialty in:

1. Internal Medicine
2. Family Practice (Adult Members Only)
3. General Practice
4. Geriatrics
5. Family Practice/Geriatric Medicine
6. Doctors of Osteopathy–Primary Care
7. Nurse Practitioners–Primary Care (Adult Health, Family and Gerontology)

No partial group practices are accepted into the PCMH Program. All practitioners who function as a PCP must join the Program or the practice will not be accepted. In addition, all providers in the same practice must participate in the same provider networks. Those who do not function as a PCP–such as those who are "floaters" or see urgent care/sick care–should not enroll in the PCMH Program.

Multi-specialty groups may also join the Program, but for the purposes of Panel formation and enhanced payments, only the PCPs in such practices may participate. If a PCP who is part of a multi-specialty group practice seeks to join the Program, all qualifying PCPs within the practice must agree to join in order to qualify for Program participation.

CareFirst considers NPs to be critical providers of primary care services and an option for enhanced access for CareFirst Members, and NPs are encouraged to participate in the PCMH Program. NPs who bill for professional services in their own name will have Members attributed to them, just as any other PCP, earning the 12% Participation Incentive and OIA if eligible. Alternatively, NPs who bill "incident to" a physician in the practice will not have any attributed Members, as these Members will appear under the name of the physician under whom the NP is billing.

NPs must comply with all statutory and regulatory obligations to collaborate with or operate under the supervision of a physician pursuant to applicable state and local laws. The inclusion of NPs is intended to provide Members with an expanded choice of providers. Physicians collaborating with NPs participating in the Program must also participate in the PCMH Program.

NPs may also form a Panel of their own, independent of physicians.

Panel Types

There are five types of Panels participating in the PCMH Program

Virtual Panel: A Virtual Panel is a voluntary association of small, independent group and/or solo practices formed by contract with CareFirst. The PCPs in the Panel agree to work together to provide services to CareFirst Members, use each other for coverage and work as a team in improving outcomes for their combined CareFirst population. CareFirst reviews and approves the formation of all Virtual Panels. PCPs in these Panels should practice within a reasonably proximate geographic distance from each other to ensure meaningful interactions among PCP Panel members.

Independent Group Practice Panel: An Independent Group Practice Panel is an established group practice of PCPs who can qualify as is, because the practice falls within the required size range of five to 15 PCPs.

Multi-Panel Independent Group Practice: A Multi-Panel Independent Group Practice is a practice with more than 15 PCPs that is not employed by a Health System. All such practices are required to identify segments of five to 15 PCPs that constitute logical parts of the larger practice–for example, pediatric or adult, and/or by location. CareFirst reviews and approves the division of the practice into constituent Panels.

Multi-Panel Health System: A Multi-Panel Health System is under the ownership of a hospital or Health System and consists of more than 15 PCPs. All such systems are required to identify segments of five to 15 PCPs that constitute logical parts of the larger system–typically by location and population served. CareFirst reviews and approves the division of the system into constituent Panels.

Collaborative Panel: Collaborative Panels are formed at CareFirst's sole discretion. In these instances, CareFirst will assign a PCP to a PCMH Collaborative Panel in order to meet a Member attribution count of 1,250 or greater. As CareFirst will assign PCPs to these Panels, the PCPs of a Collaborative Panel may not decide to remove a PCP from the Panel. These Panels are not required to meet in person and may participate in Panel meetings by teleconference. All other Program requirements will remain the same for Collaborative Panels, including Quality Scorecard, engagement and savings to budget requirements to earn an OIA.

Panel Peer Types

To ensure more meaningful and consistent comparisons in Panel performance and data reporting, Panels are assigned to an Adult or Pediatric peer group, effective in 2019. Separate, customized programs have been established for Adult and Pediatric Panel Peer Types. Mixed Panels have been eliminated. PCPs caring for Members of all ages will only be measured on their Members in the corresponding peer type.

PCP Access

PCPs must be accessible to all CareFirst Members. However, there are times when a practice or an individual PCP is "closed" (not accepting new Members) due to capacity limits. A practice or individual PCP within the PCMH Program is required to have an open practice unless they are closed to all payers. If a practice is open to any other payer for any of its networks, it must be open to all CareFirst Members. However, a practice/PCP may have an open practice for CareFirst and a closed practice for other payers.

Concierge Practices

PCPs who require CareFirst Members to participate in a private fee-based program on a concierge basis or require Members to pay any type of retainer, charge, payment, private fee or purchase additional benefits in order to receive services from the PCP, other than the deductibles, copays and coinsurance under the terms of the Member's CareFirst benefit contract, do not qualify for the Program.

PCPs who charge any fees for supplemental services beyond those covered by CareFirst, and who warrant that the fees charged are strictly voluntary and not required, must agree to and comply with the following conditions, in writing, before acceptance into the Program:

1. The Panel PCPs must make it clear that no fee, charge or payment of any kind is required of a CareFirst Member in order to become and/or remain a Member attributed to the PCP or medical practice (other than the payment of ordinary deductibles, copays and coinsurance under the Member's CareFirst benefit contract);

2. There must be no differences in the treatment, care, access, responsiveness, engagement, communications, etc., provided to CareFirst Members who do not pay the fee compared to those who pay the fee;
3. The Panel PCPs must set up office procedures and processes in such a way that a Member could not misconstrue a voluntary fee for supplemental services as a requirement to receive covered services; and
4. The Panel PCPs must recognize and agree that CareFirst maintains the right to audit compliance with these assurances, which may include a survey of the PCPs and medical practices' members who are CareFirst Members.

If CareFirst determines that any PCP or medical practice has not abided by these requirements, the PCP, medical practice and/or Panel will be subject to immediate termination from the Program and will forfeit any additional reimbursements or incentives they may otherwise be entitled to.

Exceptions to the rules regarding concierge practices may be negotiated on a case by case basis according to CareFirst's need for access in a particular geography or to meet particular market needs.

Online Connectivity and Systems Requirements for PCPs

The PCMH Program is designed to empower PCPs with the tools and data to effectively manage the care of their members without placing a technology burden on the practice. The PCMH Searchlight System is available via CareFirst's provider website. Member-level detail is available in the Care Management Platform, Guiding Care via the PCP's Director of Regional Care Management.

To access the CareFirst Provider Portal, a valid User ID/Password is required, in addition to a computer meeting standard internet access with a current browser. Please contact CareFirst Help Desk (410-998-6400) or **ProviderCFDAccess@carefirst.com** for additional assistance.

Eligibility for PCMH Participation Incentive

A Panel or practice becomes effective in the PCMH Program 60 days following CareFirst's receipt of a complete PCMH application and signed network contract addendum from the whole Panel. Enrollment with a retroactive date is not allowed.

Once effective, CareFirst will add 12 percentage points to professional fees for all practices in the Panel as an incentive for participation in the Program, known as the Participation Incentive. The Participation Incentive continues for as long as PCPs in the Panel meet all engagement requirements and Quality Scorecard minimums, as discussed below in the Quality Measurement Program Requirements section. Participation Incentive and OIAs (if any) do not apply to time-based anesthesia, supplies and injectable drug fees/billings. These additional fees are advance payments intended to fund the practice's work on transformation, including time to meet with CareFirst staff, reviewing data, and redesigning workflow to achieve optimal outcomes and value in the Program. If Panels do not invest in a way that achieves outcomes and value, the Participation Incentive is at risk of reduction or elimination. More details can be found in the Eligibility for Participation Incentive section below.

One note to be clear: The 12 percentage point Participation Incentive is added to Base Fees, not multiplied against them, and may be reduced if certain conditions are not met.

The Participation Incentive is contingent upon meeting quality score and engagement requirements in the PCMH Program and will terminate upon the effective date of a practice's or Panel's termination from the

Program. In this event, the payments to the practice will revert to the then-current CareFirst HMO and RPN fee schedules applicable to the practice without any incentives or Participation Incentives.

Measuring a Panel's Total Cost of Care vs. Trend Target

Success in the PCMH Program is determined by a Panel's ability to keep the global spend within a yearly trend target. An expected budget is set each Performance Year, built from the Panel's global medical and pharmacy spend in a Base Period, and adjusted for changes in Overall Medical Trend and Overall Pharmacy Trend, the relative risk of the Panel's patient population, and the Panel's attributed Members.

Base Period

The Base Period for Panels is the average Per Member Per Month (PMPM) Medical and Pharmacy Costs from a two-year period prior to the Performance Year. In PY2019, CareFirst moved to a two-year rolling Base Period no more than three years prior to the Performance Year. The two-year Base Period reduces volatility and reflects the realities of changes in the local health market. At the start of each Performance Year, the Base Period will shift forward one year and will be restated using the Panel's current PCP composition, lessening the impact of market shifts and adjusting for provider movement across Panels.

For PY2021, 2022 and 2023, CareFirst moved away from the rolling Base Period to avoid using inappropriate Base Years affected by the COVID-19 pandemic. PY2025 will have a Base Period of 2022 and 2023. This Base Period put the PCMH Program back on track with changes made in PY2019. Overall Medical Trend, Pharmacy Trend and Illness Burden will be adjusted forward from 2022 and 2023, and all adjustment for changes in Panel composition will be applied as described above.

Risk Adjustment

Since the start of the PCMH Program, CareFirst has used the industry-leading DxCG Intelligence to calculate the Medical Illness Burden Score (IBS) for Medical Budget calculation. In an effort to further align with local and national value-based programs, the PCMH Program made plans in PY2020 to move to U.S. Department of Health and Human Services (HHS) Hierarchical Condition Category (HCC) Coding to measure risk. After a detailed analysis of both risk adjustment tools, it was determined that DxCG model captures a larger set of diagnosis and is a more precise risk adjustment tool for setting Panel budgets. DxCG will continue to be used to set PCMH Panel budgets in PY2025 and moving forward.

Although HHS-HCC risk scores are used in the ACA risk transfer program to offset the population risk differences between insurance carriers within a market, these scores were not intended to be applied for smoothing risk across smaller populations. The scores may not have the same level of precision when used for this purpose. The HHS-HCC risk score model focuses on adjusting for risk associated only with selected high-cost diagnoses, whereas the DxCG model captures many more diagnoses and reflects a more accurate risk level for individuals.

Pharmacy budgets will be risk adjusted independently for Pharmacy Benefit Members based on the industry standard Pharmacy Risk Grouper, which calculates Pharmacy Burden Scores (PBS). Panels' Performance Year budgets are adjusted based on changes in the risk of these two populations from Base Period to Performance Year.

Member Attribution

Attribution of Members will occur on a monthly basis using a 24-month claims lookback period. Plurality of PCP office visits will determine the attributed provider for each Member. Claims history is used to determine a plurality of visits first over the most recent 12 months and then, if necessary, over the preceding 12 months. In the case of a tie for either period, attribution is assigned to the provider with the most recent visit. Effective 2021, Member self-selection is no longer used to attribute Members to Panels. Therefore, in

the case of no visits in the 24-month period, a Member will remain unattributed until they visit a PCMH PCP. Attribution for Adult Panels is restricted to Members age 18 and older, while attribution for Pediatric Panels is restricted to ages 20 and younger.

PCMH Attribution will supersede attribution for all other CareFirst value-based programs.

A visit will only impact attribution if an evaluation and management code is submitted from a primary care place of service. Video and audio only calls may impact attribution if the appropriate evaluation and management codes are submitted. Vaccinations, such as COVID-19 and flu shots, or COVID-19 testing will not impact attribution unless an evaluation and management service is included.

Setting Budget Targets

Budgets for the 2025 Performance Year will be calculated using the Base Period (2022 and 2023) PMPM Medical and Pharmacy costs. Those PMPMs are then risk adjusted and trended forward to create the budget for the 2025 Performance Year population. In 2025, CareFirst will use actual Medical and Pharmacy trends specific to CareFirst's adult population. At the start of the Performance Year, a trend target will be established to set the Panel's budget and will be adjusted to match the actual trend at the end of the Performance Year. Trends will be set based on the portion of healthcare spending controlled by the owner of the Panels, as described below. Trend targets will adjust each year to bring growth in healthcare costs in line with wage inflation.

- Independent Panels
  - Medical: CareFirst Medical trend minus 1 percentage point
  - Pharmacy: CareFirst Rx trend minus 1 percentage point
- Health System Panels
  - Medical: CareFirst Medical trend minus 2 percentage points
  - Pharmacy: CareFirst Rx trend minus 2 percentage points

Pediatric Panels participating in the PCMH Program will have a trend factor based on the CareFirst trend specific to the pediatric population. See the Pediatric Program Description & Guidelines for details on the Pediatric Program.

Calculating Savings to Budget

Savings compared to expected is calculate at the end of the Performance Year for each Panel. Panels that have less net Debits than Credits may be eligible to share in the savings in the form of an Outcome Incentive Award (OIA). The net Debits is the total allowed amount for the attributed patient population of the Panel in the Performance Year minus the Individual Stop Loss and Episode of Care Debit Overlap.

Individual Stop Loss Reduction

All Panels are protected against "shock claims" for extremely high costs cases that could distort their Debits and Credits and, therefore, Panel results. The Program includes an Individual Stop Loss (ISL) protection limit Per Member Per Year (PMPY) against these type of claims with respect to amounts shown as Debits in each Panel's Patient Care Account.

In PY2025, ISL is set at $100,000 PMPY. Only 20% of any costs above $100,000 in the calendar year are debited against the Patient Care Account of a Panel. The ongoing 20% Debit is designed to keep the PCPs actively interested in their most complex Members.

The ISL threshold is examined on an annual basis and adjusted, if necessary, to maintain a constant percentage of costs subject to the ISL. Since Program inception, the target percentage of total cost above

the ISL level has been in the 7.5 to 8.0 percent range (of total cost). Accordingly, total costs above the ISL are constantly measured to assure that this portion of total claim costs remain subject to ISL protection.

Episode of Care Debit Overlap

In 2021, CareFirst launched new value-based programs for specialties that manage Episodes of Care for Members attributed to PCMH Panels. Since these models operate in parallel, CareFirst Members attributed to PCMH may have discrete episodes with multiple providers operating in episode-based incentive agreements independent of one another. Reductions in overall cost of specialist-driven episodes benefit PCMH providers. For this reason, any incentives paid to specialists will count toward the total cost of care budget for PCMH Panels, but it should be noted that incentives are only paid when a specialty practice makes measurable improvement in the management of episodes vs. their prior history. CareFirst will notify practices with an update to the Program Description & Guidelines (PD&G) as new specialty driven value-based programs become available.

Quality Measurement Program Requirements

In addition to cost savings to budget, Panels must achieve clinical quality measures to be successful in the PCMH Program. CareFirst has selected quality measures that drive the most impactful health outcomes and align with those of other payers' programs where possible to maximize provider focus and minimize conflicting coding burdens.

CareFirst Core Quality Measures

Clinical Quality Scores will be a composite of measures based on NCQA and HEDIS recommendations. Measures include process-based and outcomes-based measures collected through claims, and may require attestation, clinical data sharing and survey responses in order for a Panel to achieve all Quality Scorecard points. Details of the inclusion and exclusion criteria for each measure can be found in the CareFirst Core10 Playbook, located in the appendix of this document. The 2025 CareFirst Core Quality Measures for Adult Panels are shown below.

PCMH Clinical Quality Scorecard	Source	Measure Point Value
1. Optimal Care for Diabetic Population	CareFirst Custom Measure	
Optimal Care for Diabetes Composite	CareFirst Custom Measure	5
HbA1c Control (<8%)	NCQA	3
Blood Pressure Control (<140/90)	NCQA	3
Retinal Eye Exam	NCQA	3
Kidney Health Evaluation for Patients With Diabetes	NCQA	3
Statin Therapy (80% adherence)	NCQA	3
2. Controlling High Blood Pressure	NCQA	15
3. Colorectal Cancer Screening	NCQA	10
4. Use of Imaging Studies for Low Back Pain	NCQA	5
5. Depression Screening	NCQA	10
6. Acute Hospital Utilization	NCQA	10
7. All-Cause Readmission	NCQA	5
8. Emergency Department Utilization	NCQA	10
9. Clinical Experience Survey	CareFirst Custom Measure	15
Overall Clinical Score		100

PCMH Clinical Quality Scorecard (Observation Measures—0 points)	Source
Depression Screening—Follow-Up	NCQA
Social Needs Screening (SNS-E) Food Screening	NCQA
Social Needs Screening (SNS-E) Housing Screening	NCQA
Social Needs Screening (SNS-E) Transportation Screening	NCQA

Scores are awarded in tiers based on national and peer benchmarks. No points will be awarded for Panels failing to meet the first tier of each measure, roughly the 25th percentile. Scoring is done at the PCP level and rolled up to the Panel level for final Panel scores at the end of the Performance Year. Optimal Care for Diabetic Population Composite Measure requires Members to meet all five measures to be compliant. Panels can also earn points for compliance on the individual HEDIS diabetes measures. Population Health Measures are scored for the Members attributed to the Panel at the end of the Performance Year. Event-Based and Risk-Adjusted Measures are scored for Members attributed to the Panel at the time of the event, even if these Members are no longer attributed to the Panel at the end of the Performance Year. Survey Measures are scored for Members attributed to the Panel at the time of the survey. The Clinical Quality Scorecard with tiered quality score benchmarks is detailed below.

In PY2025, Panels will again have an opportunity to earn bonus points for demonstrating improvement in member compliance rate year over year for certain measures. Two bonus points will be available for each core measure* in the Population Health and Risk-Adjusted Measure categories, totaling 16 available bonus points. Bonus points are added to clinical attainment rate as a percentage point increase (i.e., Clinical attainment plus 2 percentage points for each measure where improvement is earned). In order to receive two bonus points for a measure, a Panel must demonstrate a one percent or greater change in the compliance rate [(# of Compliant Members / # of Member Opportunities) x 100] from PY202 4 to PY2025. Bonus point achievement will be displayed in the Clinical Quality Scorecard and is detailed below.

*Bonus points will only be available for the Optimal Care for Diabetic Composite measure, not individual sub measures (HbA1c control, Blood Pressure Control, Retinal Eye Exam, Kidney Health Evaluation for Patients with Diabetes and Statin Therapy).

2025 PCMH Clinical Quality Scorecard

Measures	Panel Summary					Benchmarks				
						Not Tiered (No Points)	Tier 4 (50% Points)	Tier 3 (65% Points)	Tier 2 (80% Points)	Tier 1 (100% Points)
	Points Available	Points Obtained	# Members Compliant	# Members Opportunities	% Compliance	% COMPLIANCE TO ACHIEVE EACH TIER				
POPULATION HEALTH MEASURES	**50**									
Optimal Care for Diabetic Population*	25									
▪ Optimal Care for Diabetes Composite	5									
▪ HbA1c Control (<8%)	4									
▪ Blood Pressure Control (<140/90)	4									
▪ Retinal Eye Exam	4									
▪ Kidney Health Evaluation for Patients With Diabetes	4									
▪ Statin Therapy (80% adherence)	4									
2. Controlling High Blood Pressure	15									
3. Colorectal Cancer Screening	10									
EVENT-BASED MEASURES	**20**		Compliant Events	# Events	% Compliance	% COMPLIANCE TO ACHIEVE EACH TIER				
4. Depression Screening for Adults —Screening	15									
5. Use of Imaging Studies for Low Back Pain	5									
RISK-ADJUSTED MEASURES	**15**		Observed # Events	Expected # Events	Observed to Expected	OBSERVED TO EXPECTED RATIO TO ACHIEVE EACH TIER (Lower ratio is better)				
6. Acute Hospital Utilization	10									
7. All-Cause Readmissions	5									
SURVEY MEASURES	**15**		Average Score	Denominator	Sucess Rate	RATE TO ACHIEVE EACH TIER				
9. Clinical Experience Survey**	15									
Overall Clinical Score	100									
Overall Clinical Attainment Rate										
Improvement Bonus Points	16									
Total Clinical Quality Score										

** Minimum response rate will be applied for CAHPS-like survey

Improvement Bonus Points 2 points available for each measures below if change in rate from PY2024 to PY2025 is greater than or equal to 1% change					
Measure	Previous Year's Rate	Current Year's Rate	% Change	Points Available	Points Earned
1. Optimal Care for Diabetes Composite*					
2. Controlling High Blood Pressure					
3. Colorectal Cancer Screening					
4. Depression Screening for Adults - Screening					
5. Use of Imaging Studies for Low Back Pain					
6. Acute Hospital Utilization**					
7. All-Cause Readmissions**					
8. Clinical Experience Survey					
Total Bonus Points				16	

Panels must achieve at least 65% of the total clinical quality points available to receive the full Participation Incentive and to be eligible for an OIA. This represents the 50th percentile in total Clinical Quality Scorecard points.

For 2025, two observational measures (Social Needs Screening and Depression Screening Follow-Up) will be reported in Searchlight. No points will be attributed to these measures.

Engagement Program Requirements

Engagement in the PCMH Program is a requirement for Participation Incentive and OIA eligibility. In PY2025, engagement will again be measured with a set of Panel, practice and provider requirements. Failure to meet these requirements may results in the provider, practices or Panel becoming ineligible to receive an OIA and/or retain the full Participation Incentive.

PCP Engagement Requirements include:

1. Each practice completes PCMH Practice Survey in Q1 of the Performance Year.
2. Each Panel identifies a Designated Provider Representative (DPR) who helps set Panel's expectations, co-leads PCMH discussion and signs off on changes to Panel structure.
3. All PCMH providers in a practice complete CareFirst Health Equity Training by July 1, 2025 (more details below).

Care Management Expectations

While Care Management is no longer an engagement requirement for OIA eligibility, engagement with care coordination continues to be critical for success in the PCMH Program. CareFirst will continue to offer care coordination services for medical, behavioral health and social drivers of health (SDOH) support. This allows for more comprehensive care plans with access to home health, community resources and SDOH support programs.

Effective in 2024, referrals for any CareFirst Member (Commercial, Maryland Medicaid, Medicare Advantage and Dual-Eligible Special Needs) may be submitted via a single direct phone line (888-264-8648), secure email (**CareManagement@carefirst.com**) or through the referral link. Referrals can be made 24/7 via direct phone or secure email for any CareFirst Member, regardless of insurance policy. The referral should include the following information:

- Member name (first, last)
- Date of birth
- Member phone number
- CareFirst Member ID
- Reason for referral
- Provider/office name and contact information for ongoing communication

A Care Management Coordinator will review the referral and match Members to the most appropriate suite of clinical support programs tailed to the patient's needs. The Care Management Triage team will acknowledge receipt of the referral and verify the Member benefit for Care Management. If the Member is not eligible, the triage team will notify the office/provider. If eligible, the Member will be assigned to the next available Care Manager, who will make three attempts to connect with the Member over the following 14 days. When needed, a larger multidisciplinary team including a lead care manager, pharmacist, social worker and behavioral health care manager can be engaged to support social drivers of health (SDOH), gaps in care, pharmacy, behavioral health, and follow-up appointments with PCP and specialists.

Confirmation of Care Management will occur, as well as communication from care teams through the duration of the care plan, including care plan activation, graduation and acute event follow-ups.

Health Equity Training

As racial and ethnic disparities in health continue to grow, CareFirst is committed to advancing health equity to all residents in the jurisdictions we serve. Patient-centered care must accommodate an increasingly diverse patient population. In 2025, all PCPs in PCMH Panels will be expected to complete one of the CareFirst Health Equity Trainings found online at the CareFirst Learning and Engagement Center: **carefirst.com/learning/health-equity/health-equity.html**

As part of CareFirst's health equity strategy to reduce barriers to good health both in and out of clinical settings, CareFirst has created the "Understanding Implicit Bias" training course for providers. The course is offered free of charge to any clinicians contracted in all CareFirst networks and was recently recognized and approved by the Maryland Department of Health Office of Minority Health & Health Disparities for 2024. The course was created with the intent to further support the provider community, allowing them to use CareFirst training to apply for and renew their licensure in the state of Maryland as well as receiving Continuing Medical Education (CME) Credit.

Failure to complete the three engagement requirements detailed above will result in the practice becoming ineligible to receive an OIA and a reduction in Participation Incentive as described in Eligibility for Participation Incentive section of the PD&G.

Eligibility for Outcome Incentive Awards

The PCMH Program pays substantial incentives to those Panels that demonstrate favorable outcomes and value for their Members. These incentives are called Outcome Incentive Awards (OIAs). All such incentives are expressed as add-ons to the professional fees paid to PCPs who comprise Panels who earn an OIA.

Practices must meet the conditions below to be eligible for an OIA:

1. The practice must be in a PCMH Panel that joined the Program on or before July 1 of the Performance Year. If the Panel joins after this date, it will not be eligible for an OIA until the following Performance Year.
2. The practice must be in a PCMH Panel that meets viability requirements by having at least 15,000 Member Months for the Performance Year.
3. The practice must be in a PCMH Panel that has a cost savings to budget in their Patient Care Account (i.e., Credits must exceed Debits).
4. The practice must be in a PCMH Panel that achieved a minimum of 65% of the quality points available (50th percentile compared to national benchmarks) on the Clinical Quality Scorecard.
5. The practice must meet all three engagement requirements.

OIAs are effective August 1 of the year following the Performance Year (e.g., August 1, 2025, for Performance Year—2024) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2026). In order to be paid an OIA, the practice must participate in the PCMH Program throughout the incentive payout period (August 1–July 31) following each Performance Year.

All OIAs earned by each practice are added on top of Base Fees and Participation Incentives.

OIAs are always calculated at the Panel level based on savings, quality score, Panel size and date of Panel formation. Individual practices within a Panel will be ineligible for an OIA if any or all providers in the practice do not meet the three PCP Engagement Requirements. All other practices in a Panel that meet conditions one through five above will be eligible for an OIA.

Panels that are part of a larger entity may request to be paid their OIA at the entity level. The entity may elect to be paid this aggregated OIA amount based on combined, weighted results for all Panels (including non-viable and ineligible Panels) or be paid separate OIAs for each winning Panel. A group may alter this choice in advance of each Performance Year upon 60 days written request to CareFirst before the start of each Performance Year.

For a Panel that joins the Program within the first six months of the Performance Year, any earned OIA will be prorated based on effective date of Panel's entry into the Program as shown below.

Proration of Outcome Incentive Award (OIA)

Effective Date	Prorated Percentage
1/1	100
2/1	92
3/1	83
4/1	75
5/1	67
6/1	58
7/1	50

OIAs and Participation Incentives will cease immediately upon termination of a practice's participation in the Program and/or termination of a Panel from the Program.

Outcome Incentive Award Calculation

The OIA is the intersection of cost savings to budget and PCMH Clinical Quality Scorecard results. The incentive awarded back to the Panel is designed to be roughly one third of the Panel's savings. Panels can achieve a higher OIA by earning a higher Clinical Quality Score, winning multiple years in a row and having a larger Panel attribution. The OIA formulas are described below. Quality Score represents the Panels clinical attainment rate on the PCMH Clinical Quality Scorecard plus any improvement bonus points.

OIA Formulas Based on Panel Size and Win Years

Duration*	Average Members	Outcome Incentive Award	
Adult Panels			
1	3,000+	Fee Increase = [(Quality Score + 30)/100] * 9.00 * % Savings	
1	2,000-2,999	Fee Increase = [(Quality Score + 30)/100] * 7.59 * % Savings	
1	1,250-1,999	Fee Increase = [(Quality Score + 30)/100] * 6.75 * % Savings	
2	3,000+	Fee Increase = [(Quality Score + 30)/100] * 9.00 * %Savings	* 1.10
2	2,000-2,999	Fee Increase = [(Quality Score + 30)/100] * 7.59 * %Savings	* 1.10
2	1,250-1,999	Fee Increase = [(Quality Score + 30)/100] * 6.75 * %Savings	* 1.10
3+	3,000+	Fee Increase = [(Quality Score + 30)/100] * 9.00 * %Savings	* 1.20
3+	2,000-2,999	Fee Increase = [(Quality Score + 30)/100] * 7.59 * %Savings	* 1.20
3+	1,250-1,999	Fee Increase = [(Quality Score + 30)/100] * 6.75 * %Savings	* 1.20

Eligibility for Participation Incentive

Participation Incentives are intended to fund the providers' time and attention to the Program and to assure frontline providers are properly informed of utilization, savings to budget and Quality Scorecard results necessary to drive transformation leading to better outcomes and value for the CareFirst population.

Practices can earn their 12 percentage point Participation Incentive by engaging in practice transformation and by sharing all PCMH utilization, budget, Quality Scorecard and OIA data with PCPs. Practices who do not complete the three PCP Engagement Requirements will lose all or portions of their Participation Incentive based on market size category as shown below. Panels that do not meet a minimum of 65% of the points available on the Clinical Quality Scorecard, and do not achieve a savings, will also lose all or portions of their Participation Incentive based on market size category. Panels and practices that save compared to expected and meet PCP Engagement Requirements but fall below 65% on the Clinical Quality Scorecard will retain the full 12% Participation Incentive but will not be eligible for an OIA. Adjustments for practices losing all or part of the 12 points will go into effect in August of 2026 based on 2025 Performance.

The amount of the Participation Incentive at risk is dependent upon the size of the practices within Panels and their influence over the larger healthcare market. Six points will be at risk for independent, primary care centric practices, and for Panels part of independent, multi-specialty practices and 12 points for Panels part of multi-hospital Health Systems.

Determining market size category:

- **Entrepreneurial and Corporate** (6pts): All virtual Panels, single-site independent Panels and multi-site independent Panels
- **Health System (12pts)**: Multi-Hospital Health Systems and/or hospitals that employ a comprehensive range of specialties

Entrepreneurial and Corporate Panels who fail to meet eligibility for the Participation Incentive two years in a row will risk the remaining six points, bringing the Participation Incentive to 0%, and will remain at 0% until engagement and Clinical Quality Scorecard minimums are met. Panels who lost all or a portion of the Participation Incentive are eligible to receive the full 12 percentage point Participation Incentive upon meeting all eligibility requirements in the next Performance Year.

Changes in Participation Incentive will be effective on August 1 of the year following the Performance Year (e.g., August 1, 2025, for Performance Year #15—2024) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2026).

Please note that any practices transitioning from PCMH to an Accountable Care Organization (ACO) may be eligible to retain their OIA and Participation Incentive. CareFirst recommends that you contact your Practice Consultant to determine any potential impacts before making any decisions.

OIA For Strong Cost Efficiency and Quality

Adult Panels can also be rewarded for demonstrating strong cost efficiency and high, Quality Scores even if they do not produce a saving compared to expected in their Patient Care Account. Panels finishing the Performance Year in the top 10% of Risk Adjusted Total PMPM spend and in the top 10% of total Clinical Quality Scorecard points, compared to all Adult PCMH Panels, will be awarded a 15-point OIA as long as all other OIA-eligibility criteria is met. The top 10% represents the best performance in the respective category.

Changes in Panel Composition

A variety of circumstances may arise over time that may impact PCP membership of a Panel or practice. Panels or practices may dissolve, change their PCP membership via attrition or termination, or allow PCPs to leave and join other Panels.

A PCP may change Panels for any reason, including a change in their practice location or a change in their affiliation with a particular practice. In this case, the PCP may join another Panel in the new location, or another practice that is part of Virtual Panel.

The following rules govern these Panel changes:

1. If a Panel's participation falls below five PCPs it must, within one year, increase its membership to five or more or the Panel will lose OIA eligibility for the Performance Year. If the Panel participation falls below five PCPs for a full year, the Panel will be terminated from the Program. Exceptions may be granted with written request through Panel Governance.
2. A Panel may request an exception to the upper limit of 15 PCPs in writing. For an exception to be granted, the Panel must demonstrate that the Panel practices as a cohesive unit and must provide compelling justification as to why such larger size would not unduly diminish the contribution of each PCP to overall Panel performance.

3. Multi-Panel Independent Group Practices and Multi-Panel Health Systems may choose to have an OIA paid at the entity wide tax identification number (TIN) level, notwithstanding the fact that all OIAs are determined at the Panel level as a Program requirement. In the situation, all Panels under the same TIN will receive a single OIA, determined by the weighted average of each Panel, weighted on size of Panel Debits.
4. If a new PCP or practice joins an existing practice, the reimbursement level of the existing practice will be assumed by the new PCP or practice, including the Participation Incentive and OIAs (if any), once the new PCP has signed on to the PCMH Program. A new PCP joining an existing practice will only be considered to be a member of the Panel on a prospective basis. No retroactive enrollment is allowed.
5. If a PCP leaves a Panel but remains in the CareFirst HMO and RPN networks without participating in another Panel, the PCP will lose the Participation Incentive and OIA at the point they terminate from the Panel.
6. If a Panel changes ownership or tax ID, but the actual PCPs making up the Panel remain the same, the Panel will be treated as having continuous participation in the PCMH Program for the purposes of OIA and persistency awards.
7. Any practice that joins a Panel is required to be an active PCMH participant of that Panel during the last two complete calendar quarters of the current Performance Year to be eligible for an OIA. That is, only practices that actively participate in the Program by July 1 of the Performance Year are eligible for an OIA for that Performance Year. If a practice joins a Panel after July 1, that practice is excluded from the OIA for that Performance Year. A practice will be considered active in the PCMH Program once the practice has signed both a Panel contract and the PCMH Addendum to their network agreement with CareFirst. A retroactive enrollment date is not allowed for practices that are new to PCMH.
8. Acceptance of a practice into an existing Panel requires unanimous agreement by the Panel, communicated in writing to CareFirst by the Panel's Designated Provider Representative (DPR).
9. If a practice leaves a Panel after the end of a Performance Year, joins another Panel and remains in good standing with the Program, the practice will keep the OIA earned in the previous Panel.

Appeals

Any PCP or Panel as a whole may submit a letter to CareFirst requesting review of any aspect of the calculation of an OIA that they believe to be made in error. CareFirst will promptly (within two weeks) contact the PCP and Panel to discuss the information submitted with the request as well as any other pertinent information. Following a thorough review, CareFirst will notify the appealing PCP and/or Panel of its response in writing within 90 days of the receipt of complete information from the PCP and/or Panel.

CareFirst will make corrections in Panel results if any errors are found. In carrying out corrections, CareFirst may provide a correction on a prospective basis or on a retrospective basis, depending on the circumstances of the particular case.

The deadline to submit an appeal for the 2025 Performance Year is September 1, 2025.

Signing on with PCMH

Participation in the Program is entirely voluntary. There is no penalty or negative impact on existing CareFirst fee payments for network RPN and HMO PCPs or practices who elect not to participate.

Each PCP (or the practice to which they belong) will be required to sign an Addendum to its CareFirst RPN and HMO Participation Agreements.

If a PCP applying for participation in the Program is in an established large group practice that contains more than 15 PCPs, the practice and CareFirst will agree on the way the practice will be divided into Panels prior to the effective date of Program participation.

If a PCP applicant is in a solo practice or a small practice and wishes to participate in the Program by joining another Panel(s) or practice(s) as part of a Virtual Panel, then all of the PCPs who would make up the Virtual Panel must sign a PCMH enrollment form indicating that they are voluntarily forming a Virtual Panel for the purposes of the Program and are attesting to their commitment to work individually and collectively toward Program goals. If a Virtual Panel is not formed, the practice will be added to a Collaborative Panel at CareFirst's sole discretion.

All PCPs within a practice who submit claims to CareFirst for payment under a single tax ID number must join so that all participate in the Program. Any division of the practice into Panels made for performance tracking purposes as described above does not affect this participation requirement.

Each Panel must designate a lead provider called a Designated Provider Representative (DPR) to act as a primary point of contact between the Panel and CareFirst.

As stated above, practices receive formal PCMH Recognition by CareFirst immediately upon execution of the Participation Agreements, as defined by PCMH designation in the CareFirst Provider Directory.

Termination from PCMH

A practice may terminate its participation in the Program upon ninety (90) calendar day's prior written notice to CareFirst for any reason.

A Panel may terminate participation in the Program with ninety (90) calendar day's prior written notice to CareFirst for any reason. This will terminate all participants within such Panel from the Program unless they join another Panel. If a PCP in a practice terminates participation in the Program, but does not terminate from the practice, the practice will be terminated from the Program. Notwithstanding this requirement, in the case of a PCP who is recalcitrant with Program engagement, an individual PCP may be terminated from the PCMH Program. Once the PCP is terminated, they will no longer receive the participation fee or OIA.

A Virtual Panel may change its self-selected team of PCPs at any time if it continues to meet the minimum size requirements of the Program and notifies CareFirst. The consent of at least three-fifths (3/5) of the PCPs in the Virtual Panel is required to forcibly remove a practice from the Panel. A letter from the Panel's Designated Provider Representative is required to be sent to the practice that was voted to be removed informing them of the Panel's decision. CareFirst may choose to remove PCPs whose lack of participation and cooperation with Panel goals is harming Panel performance, at its option.

In a Collaborative Panel, as CareFirst will assign PCPs to these Panels, the PCPs of a Collaborative Panel may not decide to remove a PCP from the Panel. CareFirst may immediately terminate a practice or PCP that has been deemed by CareFirst to be detrimental to the success of the Collaborative Panel.

CareFirst may immediately terminate a practice, PCP and/or Panel from the Program under the following circumstances with written notice, unless the termination is related to the discontinuance of the entire Program, which requires 90 calendar day's prior written notice:

1. The practice, PCP and/or Panel repeatedly fails to comply with the terms and conditions of the Program.
2. The practice, PCP and/or Panel has substantial uncorrected quality of care issues.

3. Termination of either the Master Group Participation Agreement, or the Primary Care Physician Participation Agreement which terminates the Group's, PCP's and/or Panel's participation in CareFirst's RPN or HMO networks.
4. Any other termination reason set forth in the termination provisions of the underlying Participation Agreements within the applicable notice periods set forth therein.

The payment of the Participation Fee and any OIA will immediately terminate upon the effective date of the PCP's, Group's or Panel's termination from the Program regardless of the reason for termination.

Disqualification of Participants

In the event that a CareFirst PCMH practice does not meet the participant qualifications as defined above in the Panel Composition section of the Program Description and Guidelines, it must provide immediate notice to CareFirst whereupon the practice will be disqualified from participation in the Program. All PCMH-related financial incentives will cease for claims with dates of service on or after the PCP's, Practice's or Panel's termination date.

2025 Quality Provider Toolkit is coming soon.

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

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**.

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

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their 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.