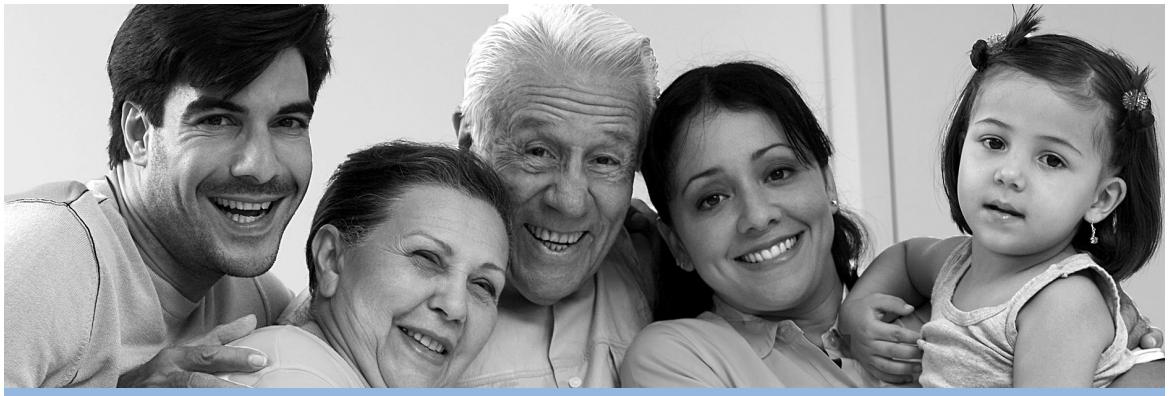
CareFirst

Group Hospitalization and Medical Services, Inc.

BluePreferred

Your Member Handbook

BOK5077-1S (6/12)



Welcome to BluePreferred

Thank you for choosing CareFirst BlueCross BlueShield's BluePreferred health plan. We are committed to providing our members and their families with the highest level of service possible and hope the information included in this handbook will assist you in understanding your BluePreferred benefits and options.

Please take a moment to review this information and then keep it in a safe place for future reference. This booklet, along with your Summary of Benefits and enrollment materials, gives you tips on how to receive the highest level of health care benefits. This guide is meant to be an overview and describes important features of BluePreferred. **However, it is not a contract. A detailed description of specific terms, as well as the conditions and limitations of your coverage, is included in your Evidence of Coverage/Agreement.**

As always, please contact Member Services at the telephone number listed on your member ID card if you have any questions regarding your coverage. We appreciate your business and look forward to serving you in the future.

Keep in a safe place for future reference.

➤ *You may also view this handbook online at www.carefirst.com in the **Plan Information** section.*

Important Information

Emergency Assistance and Medical Advice

In case of a medical emergency, call 911 or go to the emergency room. You should call your physician when you have a health problem. If you cannot reach your physician and have questions about your health, an illness or an urgent medical condition, FirstHelp™ is available to help you make a decision concerning the most appropriate level of care.

FirstHelp™ Health Care Advice Line – 24 hours a day, 7 days a week
Toll-free: (800) 535-9700

McKesson, Inc. is an independent company that provides 24-hour health care advice services under the name FirstHelp™. McKesson, Inc. does not provide CareFirst products or services. FirstHelp™ is solely responsible for the advice services.

Hospital Authorization/Utilization Management
Your BluePreferred Provider will obtain any necessary admission authorizations for in-area covered services. You are responsible for obtaining authorization for services rendered by non-participating facilities and out-of-area admissions.
Toll-free: (866) PREAUTH (773-2884)

Mental Health/Substance Abuse Care
Call the telephone number on your member ID card under the Mental Health/Substance Abuse Service and Authorization section. Assistance is available 24 hours a day, 7 days a week.

Additional Telephone Numbers

Pharmacy Benefits[1] (CVS Caremark)
(800) 241-3371

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

Vision Benefits[1] (Davis Vision)
(800) 783-5602

Davis Vision, Inc. is an independent company and administers the BlueVision Program on behalf of CareFirst.

Member Services

Please call the Member Services phone number listed on your member identification (ID) card.

TTY Telephone Numbers
Maryland Relay Program (toll-free)
(800) 735-2285

National Capital Area TTY
(202) 479-3546

Multi-lingual translators are available for assistance through Member Services.

Contact Member Services for benefit and contract information.

When writing to CareFirst, always include your Member Identification Number. Please address your correspondence to:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

[1]*Your coverage may not include these benefits. Refer to your Evidence of Coverage/Agreement for details.*

➤ ***Please refer to your Evidence of Coverage/Agreement for specific terms, conditions, limitations and exclusions.***

Contents

Your BluePreferred ID Card

In-Network

In-Network benefits for covered services rendered by providers in the CareFirst BluePreferred Provider Network or any Blue Cross and Blue Shield Preferred Provider Network while traveling.

Out-of-Network

Out-of-Network benefits for covered services rendered by any other provider that CareFirst recognizes as a covered provider of care.

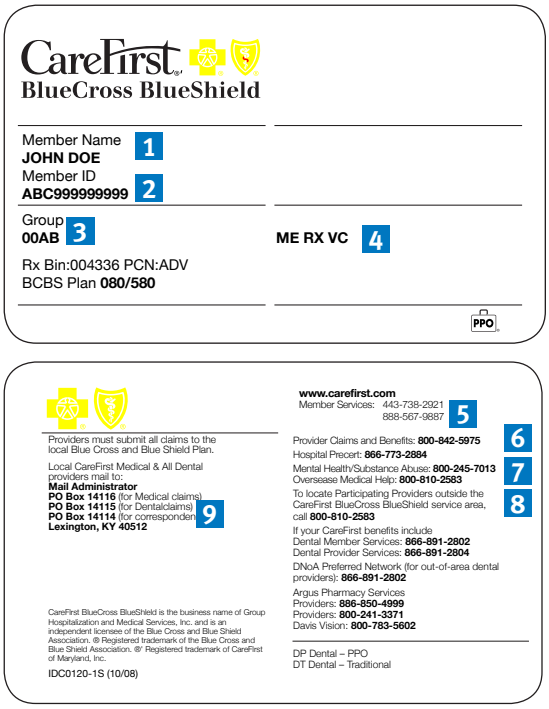
If you choose to see a non-participating provider, you may need to pay for the services at the time of the visit and file a claim for reimbursement. You will be responsible for a percentage of the allowed benefit and any provider charge above that amount.

Your Member ID Card

By now you should have received your BluePreferred member ID card. Your card identifies you as a BluePreferred member and contains important information about you, and some of the benefits for which you are eligible. This is the card that you present to your provider, a specialist or a hospital to receive care. Always carry your member ID card with you.

If your member ID card is lost or stolen, please contact Member Services immediately for a replacement. Remember to destroy any old cards and always present your current member ID card when receiving services.

The diagram to the right explains the information on your card. Please take a moment to review your card. If any of the information is incorrect, please contact Member Services immediately at the number listed on your member ID card.



This is a sample member ID card. Please review your actual card for your ID number and information specific to your coverage.

1. Member's Name
2. Your Membership Identification Number
3. Group Number
4. Type of Plan and Dental and Vision Coverage if Applicable
5. Member Services Telephone Numbers
6. Hospital Precertification/Utilization Management
7. Mental Health/Substance Abuse
8. BlueCard® Program
9. Claims & Correspondence Address

Frequently Asked Questions

What kind of information can I find on "*My Account*"?

You can view your health information online 24/7 with My Account. Signing up is easy! Just go to www.carefirst.com and, under "Log in to My Account," click the "Register Now" tab. Once you register for My Account, you will be able to:

- Review claims
- View your Explanation of Benefit (EOB) statements online
- Locate in-network providers in your area
- Order member ID cards
- Check the status of your deductible
- And more!

What kind of information can I find on www.carefirst.com?

At **www.carefirst.com** you can:

- Find out the latest member news and updates.
- Download claim forms and privacy forms.
- Learn how to get discounts on alternative therapies, vision and hearing services, fitness centers and more through the Options and Blue365 discount programs.
- Find a doctor who participates in your plan using our searchable provider directory.
- Look up health and wellness information at My Care First.
- Get Member Services phone numbers.
- Read answers to more of your frequently asked questions.
- Find benefit and eligibility information on My Account.
- Order a new member ID card on My Account.
- Research a doctor or hospital.

How can I find out if a certain doctor is a BluePreferred Provider with CareFirst?

You can access our Provider Directory on our web site at **www.carefirst.com/doctor**. Call Member Services at the number listed on your member ID card to request a BluePreferred Provider Directory or a Member Services Representative can access this information for you.

How do I know which specialists I can use? Can I use any specialist listed in the BluePreferred Provider Directory?

You may choose from the practitioners listed by specialty in the BluePreferred Provider Directory. Please note that the directory may include specialists whose services are not included in your coverage. You may contact Member Services at the number listed on your member ID card to verify your coverage for the specialty care. If you choose to see a non-BluePreferred Provider specialist, benefits will be considered out-of-network.

Do I need a referral for care?

You do not need a referral to seek care from any CareFirst BluePreferred Provider. You may receive treatment from any provider. When the provider is in the CareFirst BluePreferred Provider network or the Preferred Provider Network of any Blue Cross and Blue Shield (BCBS) plan when you are traveling, in-network benefits will apply to covered services. When the provider is not in the CareFirst BluePreferred Provider Network or the Preferred Provider Network of another BCBS plan, out-of-network benefits will apply to covered services.

How can I find out if I have a particular benefit?

Your benefits are detailed in the Evidence of Coverage/Agreement. You may also contact Member Services at the number listed on your member ID card to obtain specific information on contract benefits such as medical care, vision care, dental care, prescription benefits, etc.

TIP: **Always carry your member ID card with you at all times and present your card when you receive care.**

TIP: **You may find a doctor any time in our online Provider Directory at www.carefirst.com/doctor.**

I will be traveling out of town. What coverage do I have?

When you are outside of the CareFirst service area (Maryland, District of Columbia and Northern Virginia), in-network benefits are available for emergency or urgent care and for covered services rendered by covered practitioners participating in the Preferred Provider Network of another BCBS plan. Out-of-network benefits are applied when non-emergency/urgent treatment is received from providers who are not in a BCBS Preferred Provider Network. The hospital or practitioner should bill CareFirst directly. However, if an up-front payment is requested, contact Member Services when you return to obtain a claim form for consideration and reimbursement of the charges.

I have a dependent who will be going away to college. What coverage does he/she have?

If the college is outside of the CareFirst service area, in-network benefits are available for covered services rendered by practitioners participating in the Preferred Provider Network of another BCBS plan. Out-of-network benefits are applied when non-emergency/urgent treatment is received from providers who are not in a BCBS Preferred Provider network. The hospital or practitioner should bill CareFirst directly. However, if an up-front payment is requested, contact Member Services to obtain a claim form for consideration and reimbursement of covered charges.

If I need in-area emergency care, what should I do?

If your situation is a medical emergency, call 911 or seek help immediately at the nearest emergency or urgent care facility. In an urgent situation, we recommend that you contact your health care provider for advice. If you are unable to reach your health care provider, you may contact FirstHelp™, our 24-Hour Emergency Assistance and Medical Advice Service at (800) 535-9700.

➤ *For more information, see "Emergency and Urgent Care" on page 14 of this handbook.*

What is Health + Wellness?

Health + Wellness is CareFirst's Care Management program that provides you with the tools and resources that will help you stay healthy or make you well.

Our prevention tools are designed to help you stay strong and healthy. Utilization Management helps ensure you receive the right care at the right time in the right place. Case Management provides support to members when it is needed most.

➤ *For more information and to learn how Health + Wellness can work for you, see ""Health + Wellness" on page 9 in this handbook.*

What can I do to ensure I pay the lowest copay for my prescription?

To ensure that you are paying the lowest copay for a prescription, you can check our Preferred Drug List by visiting the CareFirst BlueCross Pharmacy section at **www.carefirst.com/rx**. You can also:

- Talk with your doctor about a refill or a change in your medication.
- Call the pharmacy to order a refill.
- Order a prescription through mail order.

➤ *This information applies only to members whose prescription drug program is based on the CareFirst Preferred Drug List.*

When You Need Care

You should take the time to meet with your provider and establish a relationship because you cannot predict when you may become ill or require hospitalization. In an emergency, you may find it more comforting to see a doctor whom you already know.

In order to get the most out of your benefits, you should call your provider first when you have a medical problem. If your provider is with another patient, leave a brief message describing your problem or symptoms, and the provider will return your call as soon as possible.

In-Network Benefits

In-network care can be provided by a CareFirst BluePreferred Provider or any Blue Cross and Blue Shield Preferred Provider while traveling. By using a BluePreferred provider, you will receive a higher level of benefits, your out-of-pocket expense is less, and you will not have to fill out any claim forms. Your provider will obtain any authorizations you may need.

Out-of-Network Benefits

You coordinate your own medical care when you receive out-of-network benefits. You may go to any provider of service. Use of your out-of-network benefits will usually result in greater out-of-pocket expenses to you. However, you can limit your out-of-pocket costs by choosing CareFirst participating providers.

CareFirst Participating Providers

If you use a provider, specialist or hospital that participates in the CareFirst network, the provider will file the claim for you. Once the claims are processed, we will send payment directly to the participating provider. You will receive an explanation of benefits form showing how much the provider was paid and how much you owe the provider.

At the time of the service, the provider may collect any amount of your deductible that you have not yet satisfied, any applicable coinsurance, as well as those charges specifically excluded under your contract (example: cosmetic surgery). Participating providers cannot bill you for balances above the Allowed Benefit. Also, participating providers cannot bill you or collect for services that are, in the judgment of CareFirst, not medically necessary.

Non-CareFirst Participating Providers (within or outside of the CareFirst service area — MD, DC, Northern VA)

Your out-of-network coverage allows you and your family members to seek treatment from any provider of your choice. At the time you receive treatment from a provider who does not participate with CareFirst, you may need to provide payment in full to the hospital, doctor or other covered provider.

> You should always present your member ID card whenever you seek care at your provider's office or the hospital.

Medical Records

Each provider's office keeps a copy of your medical records. If you are a new member, we encourage you to transfer your previous medical records to your current provider's office. Transferring your records to your provider's office will give your provider easier access to your medical history. Your previous provider may charge you a fee for this transfer of records. Your medical records are kept in confidence and will only be released as authorized by law.

Scheduling Appointments

CareFirst BluePreferred Providers see patients in their own offices. Always call for an appointment before visiting your provider and identify yourself as a BluePreferred member. Don't forget to bring your member ID card to your appointment and present the card to the receptionist. You should always present your member ID card whenever you seek care at your provider's office or the hospital.

CareFirst has set goals for providers in our participating networks regarding appointment availability and office waiting times. For appointments for non-symptomatic visits, such as preventive care or routine wellness, we expect the doctor to schedule the appointment within four weeks.

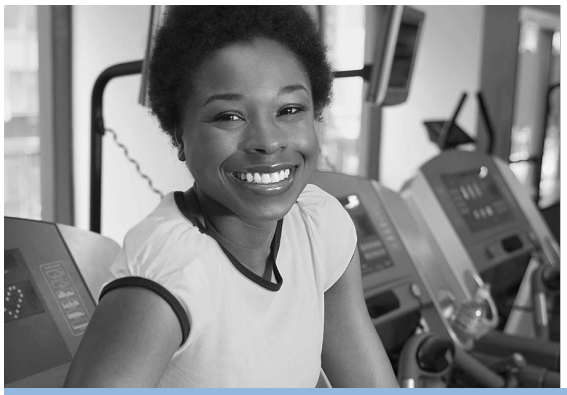
If you have an urgent problem, call your provider as soon as possible, and the office staff will arrange an appropriate time for you to be seen. For a symptomatic (acute) problem, most offices try to schedule you within 24 hours or less, depending on the urgency of the problem. The nurse or the appointment staff at your doctor's office will help you determine how quickly you need to be seen.

Canceling Appointments

If you are unable to keep a scheduled appointment, call the provider's office as soon as possible. Our providers prefer at least 24 hours notice so they can offer your appointment time to another patient. Some providers may charge you a fee if you miss an appointment and have not called to cancel.

Exclusions

Please refer to your Evidence of Coverage/ Agreement for specific information regarding exclusions from your coverage.



health+wellness

take charge.

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

With our Health + Wellness Program, you can:

- Stay healthy by identifying habits that could put your health at risk.
- Get healthy with programs that target specific health or lifestyle issues.
- Deal with unexpected health issues or medical emergencies with help from our case management program.
- Live with a condition with the support of a coordinated health care team, by participating in our Patient-Centered Medical Home program.
- Access online tools and services to help you get healthy and stay healthy.

Health and wellness programs and resources help you and your family live a healthy life.

Staying Healthy

Health Assessment

Get an immediate picture of your health status with our confidential, online questionnaire. You'll be asked about lifestyle choices including nutrition, physical activity and tobacco use. The survey takes about 15 minutes to complete and, based on your health status, you'll receive recommendations for improving your health. To take the Health Assessment, log into My Account at **www.carefirst.com**, click on the tab *Manage My Health* and then click on the *Health Assessment and Coaching.*

Getting Healthy

Health Advising

After completing the Health Assessment, a Health Advisor may contact you to discuss your results.

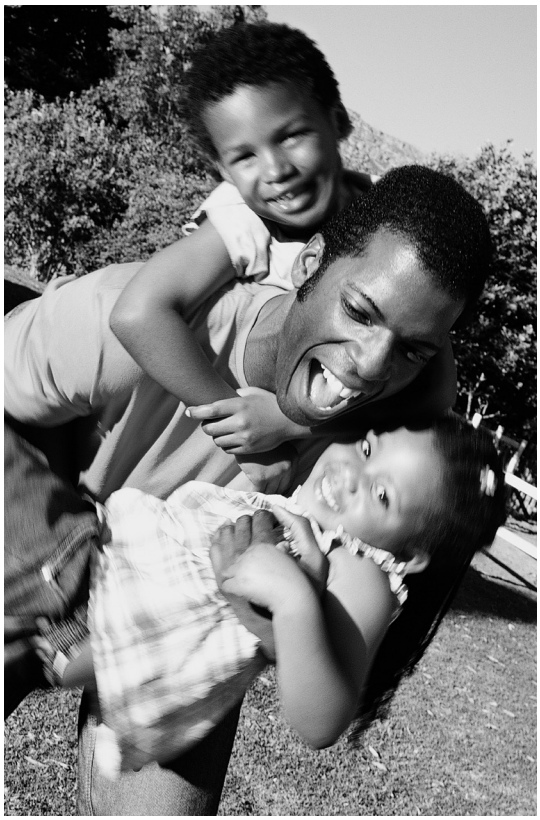
The Health Advisor will refer you to the appropriate resources, tools, care management and Health Coaching programs that can guide you toward better health.

Online Health Coaching

You may participate in a variety of free, confidential Online Health Coaching programs to help improve your health in the following areas:

- Weight management
- Stress management
- Smoking cessation
- Physical activity
- Overcoming depression
- Care for your back

These programs include access to an online health library, healthy recipes, exercise planners, enhanced goal-setting capabilities, quizzes, videos and links to relevant health information. You can also download most of the tools to an iPod™.



Don't forget to take your Health Assessment to get an immediate picture of your health.

Telephonic Health Coaching

Depending on your Health Assessment results, you may also qualify for Telephonic Health Coaching programs related to physical activity, healthy eating, smoking cessation, or stress management. You may interact with your coach through a private, secure Web-based message board or by phone.

You'll work together to develop a personal health action plan and your coach will monitor your progress and provide guidance and support as needed.

Utilization Management

Our program ensures you'll receive the most appropriate care when you need it. If you have to be hospitalized, or need therapy, our team will review your case, help coordinate care with your provider and assist with discharge planning. If necessary, our team will also approve additional inpatient hospital days.

Dealing with the Unexpected

Case Management

If you have a serious illness or injury, our Case Management program can help you navigate through the health care system and provide support along the way.

Our Case Managers, who are registered nurses, will:

- Work closely with you and your doctors to develop a personalized treatment plan.
- Coordinate necessary services.
- Contact you regularly to see how you're doing.
- Answer any of your questions.
- Suggest available community resources.

Our Case Management program is voluntary and confidential. To enroll or for more information, call (888) 264-8648.

Living with a Condition

Patient-Centered Medical Home (PCMH)

Our PCMH program promotes higher quality health care, while striving to control health care costs over time. PCMH was designed to provide your PCP with a more complete view of your health needs, as well as the care you receive from other providers. This enables the PCP to better manage your health risks, while encouraging you to maintain better health and ultimately produce better outcomes. To participate in PCMH, talk to your PCP.

Health and Wellness Tools

Health Education

Take an active role in managing your health by visiting My Care First at **www.mycarefirst.com**. Find nearly 300 interactive health-related tools, a multi-media section with more than 400 podcasts, and recipes to search by food group or dietary restrictions. Plus, there are videos and tutorials on chronic diseases and an encyclopedia with information on more than 3,000 conditions.

FirstHelp™

Speak with a FirstHelp™ nurse any time, day or night. Registered nurses are available to answer your health care questions and help guide you to the most appropriate care. Simply call (800) 535-9700 and a registered nurse will ask about your symptoms and help you decide on the best source of care.

Ask Our Nurses

Our Ask Our Nurses program lets you email questions about conditions, symptoms, treatments or diagnostic tests to our registered nurses through a secure and confidential email system. Simply log on to *My Account* at **www.carefirst.com** and click on *"Ask Our Nurses"* to submit your question. You'll receive a personalized response within 24 hours.

Vitality Magazine

Our member magazine has the tools to help you achieve a healthier lifestyle. Vitality provides you with updates to your health care plan and a variety of health and wellness topics, including food and nutrition, physical fitness and preventive health. All issues are available online at **www.carefirst.com/vitality**.

Support During Your Pregnancy

Our Case Managers strive to help you and your baby stay healthy during pregnancy. Once enrolled, the Case Manager will provide education and information on prenatal care and pregnancy. For more information, call (888) 264-8648.

Wellness Discount Program

You have access to discounts on fitness centers, acupuncture, massages, chiropractic care, nutritional counseling, and more. To learn more, visit **www.carefirst.com/options.**

Health News

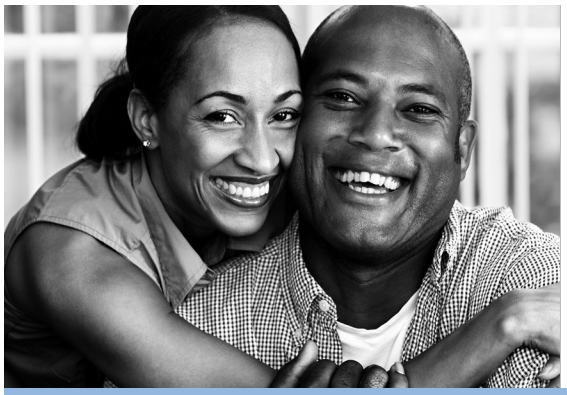
Get the latest information to help you, and your family, maintain a healthy lifestyle. Sign up for our monthly electronic member newsletter by visiting **www.carefirst.com/healthnews** to receive health-related articles and recipes.

Symptom Checker App

Find out when to manage symptoms at home and when to seek medical care, locate the nearest emergency room, or look up the prescribed dosage of common over-the-counter medicines. This free iPhone™ app can be downloaded at **www.carefirst.com/socialmedia.**

Pedometer App

Count your steps, distance traveled, and calories burned for each workout with the CareFirst *Ready, Step, Go!* app. This free app is available to anyone who has an iPhone™, iPod Touch™, or Android™ smartphone. Visit your favorite app store and search for *"Ready, Step, Go!"*.



Coverage When Traveling

Coverage when Traveling in the United States with BlueCard®

As a BluePreferred member, you have access to participating Blue Cross and Blue Shield providers and hospitals anywhere in the United States. The BlueCard® Program allows members who receive care outside of the CareFirst service area (MD, DC and Northern VA) to benefit from most claims filing and hold-harmless agreements that other Blue Cross and Blue Shield Plans have with their local participating providers.

Here's How It Works

- When you're outside of the CareFirst service area, call BlueCard® Access at (800) 810-BLUE (2583) to locate the nearest Blue Cross and Blue Shield preferred doctors and hospitals. You can also search for in-network providers electronically with the BlueCard® Provider Finder at **www.bcbs.com**.
- When you arrive at the doctor's office or hospital, present your current CareFirst ID and the preferred doctor or hospital will verify your membership and coverage.
- After you receive medical attention, your claim is electronically routed to CareFirst for processing.
- All participating and preferred doctors and hospitals are paid directly, relieving you of any hassle or worry. You are only responsible for any out-of-pocket expenses (non-covered services, deductibles, copayments or coinsurance). In-network benefits will be applied to covered Preferred Provider services. Out-of-network benefits will be applied to covered Participating Provider and non Participating Provider services.
- CareFirst will send you a detailed Explanation of Benefits advising you of the payments that were made and your liability to the provider of care.

You are responsible for obtaining all necessary authorizations for out-of-area services. Prior Authorization may be required for certain services including, but not limited to, hospital admission; home health care; skilled nursing facilities and hospice services. Failure to do so may result in a reduction or denial of benefits.

➤ ***Please refer to your Evidence of Coverage/ Agreement for specific information regarding Prior Authorization for out-of-area services.***

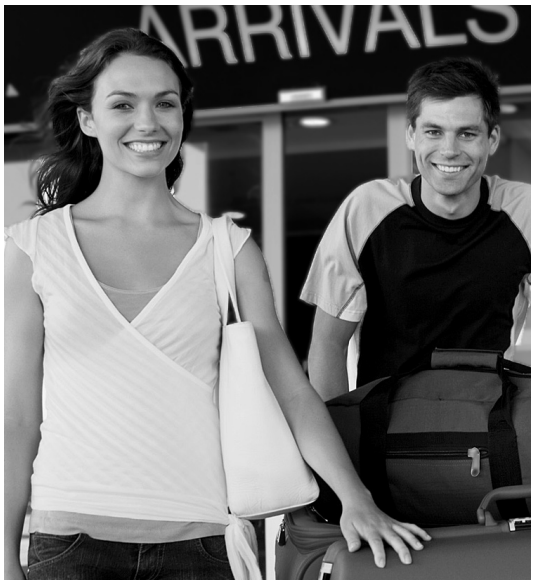
BlueCard Worldwide®

Care When Traveling Outside of the United States — BlueCard Worldwide®

Some policies only cover benefits for Emergency Care when traveling outside of the United States. Please refer to your policy for more information. Your member ID card may give you more access to health care services when you're traveling or living outside the U.S. For some policies, the BlueCard Worldwide® program enables you to receive inpatient and outpatient hospital care and physician services when you're traveling or living outside the United States.

The BlueCard Worldwide® program includes medical assistance services and an expanded network of health care providers throughout the world. For more information on BlueCard Worldwide®, call Member Services at the telephone number on your member ID card or log onto **www. bcbs.com.**

➤ *AT&T Direct is a registered trademark of AT&T. BlueCard® and BlueCard Worldwide® are registered service marks of the Blue Cross and Blue Shield Association, an association of independent, locally-owned Blue Cross, and Blue Shield Plans.*



How BlueCard Worldwide® Works

- Before you leave for your next international trip, pack your member ID card.
- When you're seeking information on available local physicians and hospitals in your travel destination, pull out your member ID card and log onto **www.bcbs.com/already-a-member-traveling-outside-of-the.html** or call the BlueCard Access line at (800) 810-BLUE (2583). (You can use the toll-free number outside of the U.S. by using an AT&T® Direct Access Number).
- If you require medical attention while you're traveling or living outside the U.S., call BlueCard Access at (800) 810-BLUE (2583). A medical assistance coordinator, in conjunction with a nurse, will arrange hospitalization, if necessary, or make an appointment with a physician. In an emergency, you should bypass this step and go directly to the nearest hospital.
- Once you arrive at the hospital, show them your member ID card. In doing so, you can avoid paying up front for your inpatient participating hospital services, other than any out-of-pocket expenses (deductible, copayment, coinsurance and non-covered services). You will not need to complete a claim form; the hospital will do that for you. For outpatient hospital care or physician services, you will pay the hospital or physician, complete an international claim form and send it to the BlueCard Worldwide® Service Center. To receive an international claim form, call (800) 810- BLUE (2583) or download one from **www.bcbs.com**.
- If you are admitted to the hospital, your care will be monitored throughout your hospital stay.

Emergency and Urgent Care

TIP: **Remember, urgent care centers do not take the place of your provider. Your provider should be your first contact whenever you need non-emergency medical care.**

Emergency and Urgent Care

When you have a medical emergency, your health care coverage is not the first thought that comes to mind. We encourage you to become familiar with this section so you'll know how to get the maximum benefits available under the policy if you should have a medical emergency.

Medical Emergencies

Emergency Services means, with respect to an Emergency Medical Condition:

A. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

B. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Emergency Medical Condition means the sudden and unexpected onset of a medical condition of sufficient severity, including severe pain, when the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

A. Serious jeopardy to the mental or physical health of the individual; or

B. Danger of serious impairment of the individual's bodily functions; or

C. Serious dysfunction of any of the individual's bodily organs or parts; or

D. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

➤ ***Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as CareFirst determines.***

Urgent Care

An "Urgent Condition" is a condition that is not a threat to life or limb, but does require prompt medical attention.

If the situation is urgent:

- Contact your physician. If your physician is unavailable or if you are unsure about the meaning or seriousness of the symptoms, you can call FirstHelp™ at (800) 535-9700 for medical advice.
- Go directly to an urgent care center if you need urgent care in Maryland, Washington, DC or Northern Virginia. A list of participating BluePreferred Provider urgent care centers can be found in the BluePreferred Provider Directory or on our web site at **www.carefirst.com**.

➤ ***Please refer to your Evidence of Coverage/ Agreement for specific information regarding the coverage of urgent care benefits.***

Urgent Care Centers

Urgent care centers are walk-in medical facilities equipped to handle minor emergencies. Most centers have evening and weekend hours should a condition require immediate attention and you are unable to reach your physician. Urgent care centers are typically conveniently located and often allow you to be seen more quickly than in an emergency room.

If your condition requires follow-up care after your initial visit to an urgent care center or hospital emergency room, you should seek care from a Preferred Provider. Out-of-Network benefits may apply to follow-up care received from a Non-Preferred Provider.

You may refer to the list of urgent care centers in your BluePreferred Provider Directory for a participating urgent care center near you or visit the online Provider Directory at **www.carefirst.com**.

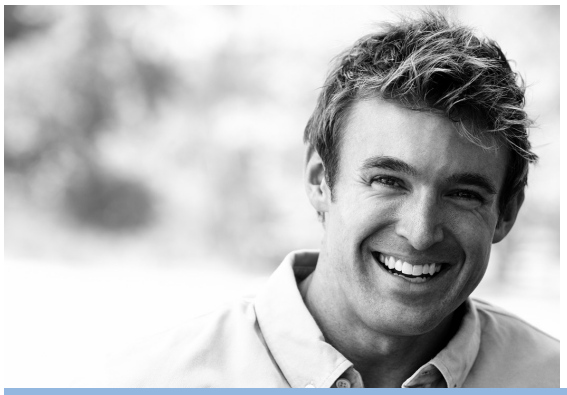
FirstHelp™

24-Hour Emergency Assistance and Medical Advice

If you believe a situation is a medical emergency, call 911 immediately or go to the nearest emergency facility. In an urgent situation, contact your physician for advice. If your physician is not available and you have symptoms and don't know exactly what they mean or how serious they are, CareFirst BluePreferred provides you with FirstHelp™, a 24-Hour Emergency Assistance and Medical Advice hotline. Here's how it works:

1. If you are unable to reach your physician, call FirstHelp™, our 24-Hour Medical Advice/ Emergency Assistance Service at (800) 535-9700. Your call will be answered promptly by an experienced registered nurse.
2. If the nurse determines that your situation is a medical emergency, he or she will advise you to seek immediate medical care.
   NOTE: If taking the time to call FirstHelp™ would seriously jeopardize your health, call 911 directly or go to an emergency facility immediately.
3. If your condition is not an emergency situation, the nurse will ask you about your symptoms. The nurse will then make recommendations to help you decide the safest and most appropriate course of action, whether it's a participating urgent care center, an appointment at your physician's office, or self-care.
4. If the nurse recommends self-care, he or she will educate you about your condition, explain what to do for pain or symptom relief and tell you what to expect or watch for. The nurse may also call you the next day to check on your condition.

➤ ***If your urgent condition is related to mental health or substance abuse, see "Seeing Mental Health Specialists" on page 16 of this handbook.***



Seeing Mental Health & Substance Abuse Specialists

Your health coverage includes mental health and substance abuse benefits. CareFirst contracts with a Mental Health & Substance Abuse administrator to coordinate the BluePreferred inpatient, partial hospitalization and outpatient benefits for mental health & substance abuse services. Mental health and substance abuse benefits may be subject to day and/or visit limitations. Also, certain conditions may be excluded. Please refer to your Evidence of Coverage/Agreement for specific information about your particular coverage, or call Member Services for more information.

In-Network Mental Health and Substance Abuse Care

Outpatient*

If you think you need mental health or substance abuse care, you may choose to seek in-area treatment from any of the mental health & substance abuse providers listed in the BluePreferred Provider Directory under the specialties of Psychiatric Social Work, Psychiatry or Psychology.

➤ ***It is your responsibility to contact our Mental Health & Substance Abuse administrator at the phone number on your ID card when using any out-of-area provider. Failure to do so may result in a reduction or denial of benefits.****

Inpatient

Inpatient mental health & substance abuse services must be coordinated through our Mental Health & Substance Abuse administrator. Please refer to your Evidence of Coverage/Agreement to identify your specific mental health & substance abuse benefits.

Your BluePreferred Provider will handle precertification requirements with CareFirst. It is your responsibility to contact our Mental Health & Substance Abuse administrator when using the inpatient services of any out-of-area provider. Failure to do so may result in a reduction or denial of benefits. Your BluePreferred Provider or a representative may contact our Mental Health & Substance Abuse administrator on your behalf by calling the Mental Health & Substance Abuse Service and Authorization telephone number on the back of your member ID card.

If you receive ongoing care from a mental health or substance abuse provider, whether outpatient or inpatient, we suggest that you have this provider send regular reports regarding your treatment directly to your physician. This is especially important if you are receiving medications. Your physician will be aware of your situation and can monitor for potential interactions related to any other medications that may be prescribed for you. By working in partnership with your physician and other providers, you can provide for continuity and effective coordination of your health care.

Out-of-Network Mental Health and Substance Abuse Care

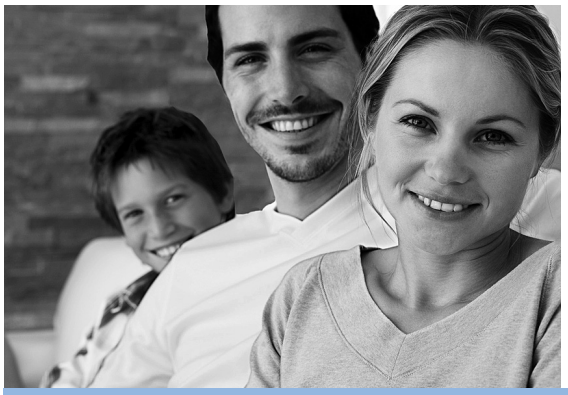
Outpatient

You may choose any covered provider for covered outpatient out-of-network services. Please see your Evidence of Coverage/Agreement for benefit details.

Inpatient

Inpatient mental health services must be authorized through our Mental Health & Substance Abuse administrator. It is your responsibility to contact our administrator at the telephone number on the back of your member ID card. Failure to do so may result in a reduction or denial of benefits. Your physician or a representative may contact our administrator on your behalf. Please see your Evidence of Coverage/Agreement for benefit details.

**Note: If you are enrolled in your health coverage through your employer, and your employer has 51 or more full-time employees, prior authorization may not be required. To be in compliance with the Federal Mental Health Parity Enforcement Act, CareFirst does not require prior authorization for outpatient mental health services for groups with 51 or more full-time employees. If you have any questions, please see your Human Resources representative.*



Additional CareFirst Benefits

Dental Benefits

Your benefits may include dental coverage. Details about your dental coverage are located in your Evidence of Coverage/Agreement.

If you have dental benefits, you have access to the following services:

- Preventive care
- X-rays
- Fillings and restorative services
- Oral surgery and periodontal care
- Emergency care

Your dental coverage may also include orthodontia.

For information on dental coverage, please call the Member Services or the Dental Member Services number located on the back of your member ID card.

The following is a list of dental plans for which you may be eligible if you purchase coverage through your employer. If you purchased your dental policy directly from CareFirst, you have other plan options detailed in your enrollment brochure. You can also call (800) 544-8703 to learn more.

Traditional Dental

CareFirst's Traditional Dental allows you the freedom to seek dental care from any dentist and the opportunity to reduce out-of-pocket costs. When you visit a participating dentist, you have no claims to file and are only responsible for applicable deductibles and coinsurance. If you seek care from a non-participating dentist, you will be required to file claims yourself and you may incur higher out-of-pocket costs. More than 4,000 dentists participate with CareFirst – you may already be seeing a CareFirst participating dentist. You may also have access to a national network with 86,000 dentists.

Preferred (PPO) Dental

CareFirst's Preferred (PPO) Dental offers both savings and choice. CareFirst has developed a network of 3,700 preferred dentists who have agreed to provide care at a discount. You may also have access to a national network with 86,000 dentists. Once you meet your annual deductible, you can save money by paying a lower coinsurance amount when using a dentist in the Preferred network, and have no claim forms to file. If you receive care outside the Preferred network, you may have to file your own claim forms and pay more out-of-pocket for your care.

Dental HMO

As a Dental Health Maintenance Organization (DHMO) member, you choose a Primary Care Dentist (PCD) from a carefully selected network. All dental services are provided for the cost of a copay – there are no deductibles to meet, no claim forms to file and no annual maximums. If you have not selected a PCD or have questions about your DHMO dental coverage, please contact Dental Services at (410) 847-9060 or (888) 833-8464.

Pharmacy Benefits

Your coverage may include benefits for prescription drugs. Please review your Evidence of Coverage/Agreement to determine whether or not you have benefits for outpatient prescription medications under your CareFirst plan. BluePreferred members with individual coverage have prescription drug plans associated with their specific medical plan.

CareFirst uses a Preferred Drug List, which is a list of Generic and certain Preferred Brand drugs. Drugs that are not Preferred Drug List may be covered as part of your plan, although your payment may be more for these drugs.

If you are prescribed a drug that is not on the Preferred Drug List, discuss alternatives with your doctor.

How often does the Preferred Drug List change?

As often as needed, but usually no more than a few times each year. Drugs on the Preferred Drug List are selected by a committee of practicing physicians and pharmacists from the community and CareFirst and are chosen because of their quality, effectiveness, safety and cost. The Preferred Drug List also changes as new drugs enter the market and as Generic equivalents become available. For the most current Preferred Drug List, please visit **www.carefirst.com/rx**, or call (800) 241-3371 for a paper copy.

Prior authorization

Even if a drug is on our Preferred Drug List, it may still require advance approval, or prior authorization, before it can be filled. Your physician should begin the authorization process before you visit the pharmacy. If prior authorization is not obtained or is denied, the drug will not be covered. If you are already at the pharmacy and find that the drug needs prior authorization, you should have the pharmacist call the prescribing doctor and request that he/she begin the authorization process.

Questions

If you have any questions about your prescription drug coverage, call CareFirst Pharmacy Member Services at (800) 241-3371 or visit CareFirst BlueCross BlueShield Prescription Drug Solutions at **www.carefirst.com/rx**.

How to manage medication costs

Our prescription drug benefit already saves you money on prescription costs. However, you also may have other alternatives to lower your costs while getting medicines that treat your condition. Here are simple steps you can take:

1. Know your out-of-pocket costs. Use the price comparison tool in *My Account* to learn more about the costs of your medications.
2. Talk with your doctor. Print a copy of our current Preferred Drug List to bring to your next doctor's visit. Discuss the medicines you are taking and if they are on the Preferred Drug List. If your medicine is not on this list—ask if there are more affordable alternatives that may be right for you.
3. Use a participating pharmacy. There are more than 60,000 participating pharmacies nationwide that accept your prescription drug card. Choose one that's convenient, but remember to shop around. Some pharmacies charge more than others, and if you have a plan with coinsurance, those prices may affect how much you pay.
4. Don't forget your member ID card. To help ensure you receive proper service, the pharmacist will need your member ID card and a prescription from your doctor.
5. Be on the lookout for alternatives. New medicines become available often, so the price of your prescription may rise or fall as a result. Changes in the Preferred Drug List often happen because a new medicine is introduced to the marketplace or a Generic becomes available.

Some of these tips apply only to members whose prescription drug benefit is based on the CareFirst Preferred Drug List.

Vision Benefits

CareFirst is pleased to offer BlueVision and BlueVision *Plus* to meet your vision needs. These vision plans are administered by Davis Vision, Inc., a national provider of vision care services.

Your coverage may include benefits for vision care under BlueVision or BlueVision *Plus*. Please review your Evidence of Coverage/Agreement to determine if your coverage includes benefits for vision care.

BluePreferred members with individual coverage are only eligible for BlueVision coverage.

BlueVision

BlueVision provides a routine vision examination (including dilation) once per benefit period for a $10 copay when you visit a participating Davis Vision provider. Through Davis Vision, you also receive discounts on eyeglass lenses and frames or contact lenses, as well as laser vision correction surgery. Refer to your Evidence of Coverage/Agreement to find out what benefits you have under your plan.

BlueVision *Plus*

(Group Members Only)

BlueVision *Plus* provides an extended benefit that includes an eye examination (including dilation) and coverage for eyeglasses or contact lenses once per benefit period. Eyeglass frames are covered in full when you choose from the Davis Vision Collection of approximately 400 frames, or you can receive an allowance toward any other frame. You can also receive coverage for contact lenses in lieu of eyeglasses. The choice is yours! Additionally, Davis Vision offers discounts on laser vision correction surgery, additional lens treatments and coatings. Refer to your Evidence of Coverage/Agreement to find out what benefits you have under your plan.

With BlueVision *Plus* you may receive services from out-of-network providers in addition to in-network providers, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network.

How to Access In-Network Vision Care

- Call (800) 783-5602 for a list of providers nearest you, or access the network through **www.carefirst.com/doctor** then select the *Vision* tab at the top of the page.
- Call the Davis Vision provider of your choice and schedule an appointment.
- Identify yourself as a BluePreferred member and a BlueVision plan participant.
- Provide the office with the member's identification number and the year of birth of any covered dependents needing services.
- The provider's office will verify your eligibility for services and no claim forms are required.

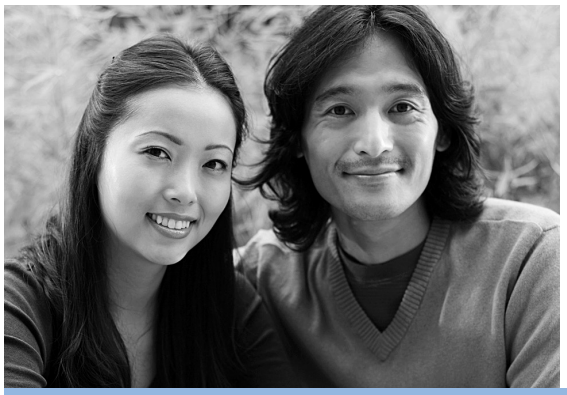
How to Access Out-of-Network Vision Care

Out-of-Network care varies according to plan. Some plans allow out-of-network care while others do not. Refer to your Evidence of Coverage/Agreement to find out what benefits you have under your plan.

If you choose an out-of-network provider, you will be required to pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

➤ ***Only one claim per service may be submitted for reimbursement each benefit period. To print claim forms, visit the "Members" section of www.carefirst.com and click on "Forms" or call (800) 783-5602 to request claim forms.***



Administration of Your Plan

Personal and Enrollment Changes

If you have group coverage and you wish to enroll or disenroll a dependent (including newborns) or change your marital status, you must notify your employer within the timeframe specified in your Evidence of Coverage/Agreement. Individual contract members must notify CareFirst in writing to make enrollment changes. Membership change request forms can be found online at **www.carefirst.com.** The appropriate address to write to is on your member ID card.

Filing a Claim for Reimbursement

An advantage of your BluePreferred coverage is that you do not have to file claims when treatment is performed by a Preferred Provider. BluePreferred Providers are required to submit claims on your behalf. All you have to do is pay any necessary copayment and/or deductible at the time of the visit.

If you do need to submit a claim for services rendered by a provider who does not participate in a BCBS Preferred Provider network, you may contact Member Services for a CareFirst Health Benefits Claim Form or download a claim form at **www.carefirst.com**. Be sure to attach a complete itemized bill prepared by the provider of service that includes the charges for each service along with the medical condition for which the treatment was performed. Submit the completed claim form and attachments to:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

Provider Reimbursement

BluePreferred Providers are paid on a fee-for-service basis. This means that BluePreferred Providers receive benefit payments according to a fee schedule for covered services they perform. The fee schedule is known as the Allowed Benefit. You may contact Member Services to obtain additional information about provider payment arrangements.

Out-of-Pocket Costs

Your out-of-pocket costs will depend on the type of provider you or your family members see when you need care:

- BluePreferred Provider or CareFirst Preferred Provider (in-network)
- Participating Provider (out-of-network)
- Any other covered provider (out-of-network)

Annual Deductible

For most in-network services and all out-of-network services, you must first meet an annual deductible before CareFirst begin to provide benefits. Your deductible will depend on the level of coverage you or your employer selected and whether services are rendered in or out of network. After you meet the deductible, you may also be responsible for copayments and coinsurance. (Refer to your Evidence of Coverage/Agreement or Individual Enrollment Agreement for your deductible amounts.)

Copayment

If you use an in-network provider (BluePreferred Provider), certain services are covered at 100% of the Allowed Benefit after you pay a set fee, called your copayment. Refer to your Evidence of Coverage/Agreement or Individual Enrollment Agreement for specific information about your plan's copayments.

Coinsurance

For all out-of-network and some in-network services, you are responsible for a percentage of the cost of services you receive, called coinsurance.

In-area BluePreferred Providers and most out-of area Preferred Providers agree to accept a fixed amount for each service offered by CareFirst, called the Allowed Benefit. For some in-network services, you will pay a percentage of the Preferred Provider Allowed Benefit.

If you go out-of-network to a CareFirst Participating Provider, the program will cover a percentage of the Allowed Benefit for covered services you or your covered family members receive.

If you go out-of-network to a Non-Participating Provider, CareFirst will pay a percentage of the cost for covered services, up to the Allowed Benefit. If your Non-Participating Provider charges more than the Allowed Benefit, you will be responsible for paying your percentage of the Allowed Benefit in addition to any charges above the Allowed Benefit. This additional amount is not counted toward your deductible or the annual out-of-pocket limit. (Refer to your Evidence of Coverage/ Agreement or Individual Enrollment Agreement for more information.)

Out-of-Pocket Limit

To protect you and your family from the cost of a catastrophic illness or accident, there is a limit on the amount of out-of-pocket medical expenses you will be expected to incur for covered services every benefit year.* This is called the out-of-pocket limit. After your costs reach the limit, CareFirst will pay 100 percent of the Allowed Benefit for covered medical costs for the remainder of the benefit year.

Other Insurance

When you or your dependents have additional coverage under another health plan or insurance program (for example, a plan through your spouse's employer, or Medicare) coordination of benefits (COB) may apply. COB eliminates duplicate payments for the same expense and plays an important role in controlling the price you pay for your health care coverage.

While it is important that you receive the health benefits for which you are eligible, it is just as important that payments are properly coordinated so that one health insurance carrier does not exceed its payment responsibility for your bill. The combined payment by CareFirst and the other plan should not be more than the total amount of the bill.

We update our COB information periodically; however should your other insurance change, please let us know so we can update our records. Even if you do not have other insurance, it is important that you provide that information to us so that we may keep your records current, which will ensure speedy processing of your claims. To supply this information, you may call our COB department at (866) 285-2611, or you may download a COB form in the Forms section of our web site at **www.carefirst.com**. Rules to determine how benefits are coordinated are outlined in your Evidence of Coverage/Agreement.

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

Virginia:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157, Richmond, VA 23218
(877) 310-6560 or (804) 371-9032
ombudsman@scc.virginia.gov

Office for Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1463
(800) 955-1819 or (804) 367-2104
Fax: (804) 367-2149

District of Columbia:

Office of Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th Street, NW
9th Floor
Washington, DC 20001
Phone: (877) 685-6391
Fax: (202) 535-1216

Maryland:

Maryland Insurance Administration
Inquiry, Investigation, Life and Health
200 St. Paul Place, Suite 2700, Baltimore, MD 21202-2272
(410) 468-2244 or (800) 492-6116
Fax: (410) 468-2270
www.mdinsurance.state.md.us

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

Office of Health Care Quality
Spring Grove Center, Bland-Bryant Building,
55 Wade Avenue, Catonsville, MD 21228
(877) 402-8218
Fax: (410) 402-8215
www.dhmh.state.md.us/ohcq

Member Satisfaction

CareFirst BlueCross BlueShield requires that your concerns and/or complaints be heard and 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 to do:

- If your comment or concern is regarding the quality of service received from a CareFirst representative or 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 identification 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. Members may also send an e-mail complaint directly to Quality Improvement at **quality.care.complaints@carefirst.com**.

- 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. If you send your comments to us in writing, please include your identification 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. Our Quality Improvement 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/Agreement.

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

Appeals Process

CareFirst's appeal procedure is designed to enable you to have your concerns regarding a denial or reduction of benefits, or a denial of authorization for services, heard and resolved. By following the steps outlined below, you can ensure your appeal is quickly and responsively addressed.

Please note that state mandates may alter the steps below. Refer to your Evidence of Coverage/Agreement for more specific information regarding the appeals process. The procedure for filing an appeal is also located on our website at ***www.carefirst.com****. In the Members & Visitors section, click on "Frequently Asked Questions" in the Solution Center. If you would like a paper copy of the appeals process, you may also contact CareFirst BlueChoice Member Services at the phone number located on your member ID card.*

Step 1: Inquiry and discussion of the problem

Often, Member concerns can be most effectively handled and resolved through informal discussions and information gathering. If your question or concern is regarding our handling of a claim or other administrative action, the member or the member's authorized representative should discuss the matter with the CareFirst BlueChoice Member Services Department. The CareFirst BlueChoice Member Services Department Customer Service Representative will contact the appropriate individuals and gather information needed to answer the question. In many instances, the matter can be quickly resolved.

Step 2: Appeal process

If your concern is not resolved through an informal discussion with a CareFirst BlueChoice Customer Service Representative, you or your authorized representative may make a formal request for an appeal.

This appeal request should be in writing, addressed to our Member Services Department and state the reason(s) for the request. In the event the member or the member's authorized representative cannot put the request in writing, a Customer Service representative can assist you. The request for an appeal must be made within six (6) months or at least 180 days from the date of receipt of denial of benefits. A decision by the Plan shall be made within 30 calendar days for a pre-service appeal, or 45 working days for a post service appeal.

The appeal of a medical necessity decision shall be reviewed, as appropriate, by a physician of the same or similar specialty as the treatment under review. The physician review of the appeal will be performed by a physician who was not part of the original denial.

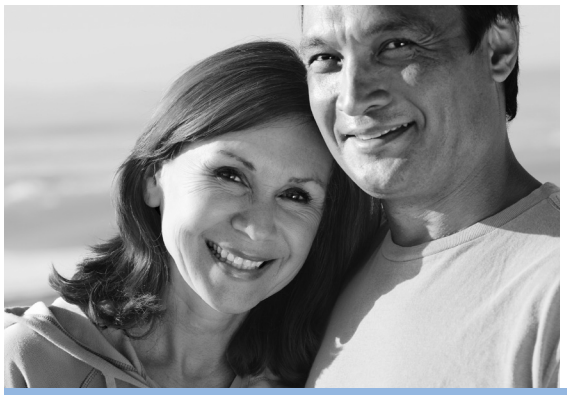
An expedited appeal process has been established in the event that a delay in a decision would be seriously detrimental to your health or the health of a covered family member. Expedited appeals involve care that has not yet occurred or is currently occurring (pre-service or concurrent care). In an expedited appeal, a decision shall be made within 24 hours of receipt. The physician review of the appeal will be performed by a physician who was not part of the original denial decision.

The expedited appeal review will be, as appropriate, reviewed by a physician in the same or similar specialty as the treatment under review.

All appeal decisions will be communicated in writing to the member, and include a detailed explanation as to the reason for the decision, and any supporting documentation to show how the decision was made. If the decision remains a denial of the benefits, a detailed explanation that references the rule, policy or guideline used in making the appeal decision will be included. Also included in this written appeal decision will be an explanation of the appropriate next steps a member or the authorized member representative may take if they are not satisfied with the appeal decision.

Members have a right to an independent external review of any final appeal determination.

If you wish, you may contact the insurance regulatory department in your area to file a complaint or an appeal regarding a denial or reduction of benefits. Refer to your Evidence of Coverage/ Agreement for more specific information regarding initiating an external review of a final appeal determination or a complaint.



Your Coverage

Ending Your Coverage

Your coverage or your dependent's coverage with CareFirst may automatically end for certain reasons. These reasons may include but are not limited to:

- you are no longer employed by the company that carries your CareFirst coverage;
- you are canceling an individual policy because you are now eligible for a group policy;
- your employer cancels coverage with CareFirst;
- divorce from a policyholder; or
- a dependent child who no longer meets the definition of a dependent child.

Please refer to your Evidence of Coverage/ Agreement or contact Member Services for more information.

TIP: If you are interested in receiving a conversion policy application, please contact Member Services at the phone number listed on your member ID card.

Continuing Your Coverage

If you are changing jobs or your dependents' status changes, please speak to your employer, your payroll office or Member Services about the options available to you and your eligible dependents to continue health care benefits.

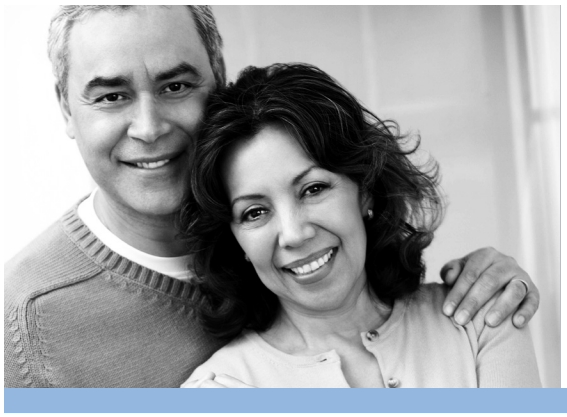
If you have group coverage, you and your dependents may be eligible under federal laws to continue your coverage with CareFirst at your own expense under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Your former employer is responsible for supplying eligible beneficiaries with the details about COBRA coverage. You and your dependents may be eligible for continuation under a state or federal district provision. See your Evidence of Coverage/ Agreement for more information. Another option may be a CareFirst conversion policy. A conversion policy is a non-group policy offered to members who are losing their group or individual benefits under certain conditions. A conversion policy is a contract that provides individual or family medical coverage.

Eligible members can enroll for conversion coverage after their eligibility for group coverage ends. You should check with your employer to see how soon you must enroll after your coverage ends. Members who end or lose their group coverage may be entitled to a conversion policy in the following situations:

- the policyholder's eligibility for his or her current group coverage ends;
- termination of spouse's and dependents' eligibility due to the policyholder's death;
- termination of marriage to the policyholder;
- termination of the group agreement if the group has not provided for continued coverage through another plan, and termination is not a result of the group's failure to pay premiums; or
- termination of dependent's eligibility due to reaching the age limit.

New Technology Assessment

To ensure that our members have access to safe and effective care, CareFirst has a formal process to review and make decisions regarding new developments in medical technology. We evaluate new medical technologies and the use of existing technologies for inclusion as a covered benefit through a formal review process. We refer to medical personnel, governmental agencies, and published articles about scientific studies in this process.



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, 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.

If a policyholder is eligible to receive credit for previous coverage, he or she must provide to his/her employer:

- a certificate of the prior (creditable) coverage, or
- other Evidence of Coverage/ Agreement, such as a pay stub or statement from the previous employer or insurer.

How to Request a Certificate of Creditable Coverage

- If you were covered through a CareFirst health insurance entity, call the Member Services telephone number on your member ID card. Please be prepared to provide information regarding your prior health care coverage, including your membership number and your most recent dates of coverage with CareFirst. A certificate of creditable coverage will be requested for you and mailed to your address within 14 days.
- For other health insurers, you should call the customer service telephone number for your previous health insurer. This phone number is usually located on your member ID card. Please be prepared to provide information regarding your prior health care coverage, including your membership number with that insurer and your most recent dates of coverage.
- If you are unable to obtain a certificate of creditable coverage from your prior health insurance carrier, CareFirst will accept a letter from the employer with whom you had prior health coverage. You should contact the Human Resources Department of your previous employer to request this type of letter. Please be sure this letter indicates your most recent coverage dates.
- If you are unable to obtain a letter or a certificate, CareFirst will accept copies of your member ID cards showing your effective coverage dates and CareFirst will assist you in obtaining a certificate of creditable coverage.

Confidentiality

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, whether oral, written, or electronic. Your confidential information includes Protected Health Information (PHI) 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. 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, and there are some requirements you will have to follow to allow other people to obtain your 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 payment activities and health care operations as explained in the Notice of Privacy Practices. This Notice is sent to all policyholders 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 records;
- request that we amend your information if you believe that your PHI is incorrect or incomplete;
- request and receive an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations; and
- give us written authorization to use your protected health information or disclose it to anyone not listed in this notice.

Member Rights and Responsibilities

Rights of Members

CareFirst promotes members' rights by providing mechanisms to ensure:

- Protection of confidential information.
- Accurate and understandable information about benefit plans, customer service and accessing health care services.
- Continuity and coordination of medical and/or behavioral health or substance abuse care by participating providers.
- Professional and responsive customer service.
- Timely and complete resolution of customer complaints and appeals.

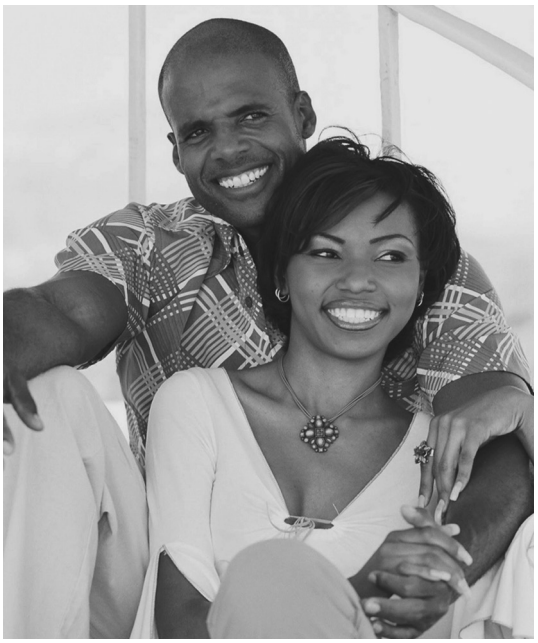
Members have a right to:

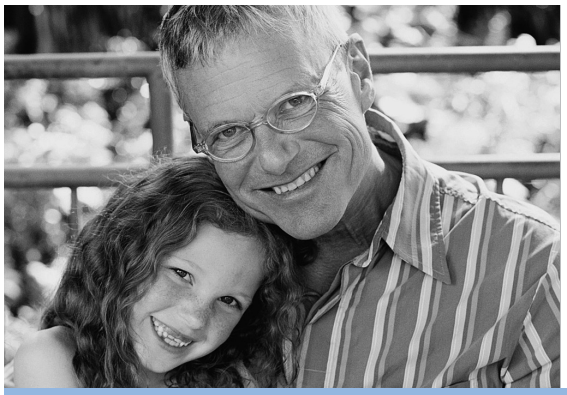
- Be treated with respect and recognition of their dignity and right to privacy.
- Receive information about the Health Plan, its services, its practitioners and providers, and members' rights and responsibilities.
- Participate with practitioners in decision making regarding their health care.
- Participate 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.

Responsibilities of Members

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.





HSA, HRA and Compatible Plans

The information provided in this section is specifically for members of CareFirst's BluePreferred HRA and HSA Compatible Plans. If you are unsure as to whether this information applies to you, please refer to your Evidence of Coverage/Agreement.

Health Savings Account (HSA)

Members of CareFirst's BluePreferred HSA and HSA Compatible health plans have the option to participate in a Health Savings Account to pay for qualified medical expenses with tax-free dollars. HSA and HSA Compatible health plans are always high deductible health plans (HDHPs).

How your HSA works

A Health Savings Account is a tax-free savings account that allows you to put aside pre-tax income, earn interest on the savings, and use the tax-free savings for eligible health care expenses. And, unlike other medical savings accounts (such as Flexible Spending Accounts) any money you don't spend stays in your account for future use.

Each year you, your employer (if applicable) or both make a contribution toward your HSA. You then use the money in your account to pay the full or discounted cost of covered services until you reach your benefit year deductible.

Once you meet your plan year deductible, your BluePreferred coverage begins. You then pay a copayment or coinsurance for all covered services, including prescription drugs.

The money in the HSA always belongs to you

Your HSA is your personal account and is entirely portable. If you are a member of an employer-based plan, this means that, should you leave your current employer, you can take the money with you.

An HSA can be an excellent way to put money aside for any qualified health care expenses that might not be covered by your plan today. And if you don't spend it, it's also a tax-free way to prepare for future expenses – such as the need to cover retiree health premiums (excluding Medicare Supplement plans) or to pay for future non-covered health care expenses.

While your HSA was designed to fund your health care, now and in the future, HSA funds can be "cashed out" at any time. The money will be subject to income tax and a 10 percent penalty if you close the account before you turn 65. Of course, you can always use the money for qualified health care expenses with no penalty and no taxes.

Funds rollover from year to year

Depending on the amount of qualified health care expenses you incur in a given year, you may not need to use all of the funds in your HSA. In this event, the remaining balance in your HSA will automatically roll over to the following benefit year.

HSAs are available to members of employer-based health plans, as well as members who purchase a qualifying high deductible health plan on their own.

How your deductible works

With your BluePreferred HSA or HSA Compatible Plan, CareFirst has combined your medical and prescription drug coverage into one easily managed benefit year deductible. This means that until you meet your combined deductible, you will be responsible for the covered expenses associated with your health care services, as well as your prescription drugs. These expenses can be funded through the money in your Health Savings Account. See your contract, benefit summary or contact Member Services if you are unsure of the type of deductible in your plan.

Because you have a combined deductible, you also have a combined out-of-pocket maximum. This means your eligible health care and prescription drug out-of-pocket expenses will be applied towards meeting your out-of-pocket

maximum. Should you reach your out-of-pocket maximum, CareFirst will pay 100% of the applicable Allowed Benefit for most covered services for the remainder of the benefit year.

Preventive Care

There is an old saying that "an ounce of prevention is worth a pound of cure." That's why CareFirst covers the cost of certain preventive care in full, or for a predictable copayment or coinsurance, regardless of the level of your deductible.

Questions and Answers

How do I contribute to my HSA?

If you are a member of an employer group plan, your HSA contributions can be made through payroll deductions. If you purchased your health plan on your own and have set-up your own HSA, you can make contributions to your HSA at anytime, up to the allowable amount determined by the IRS.

Are there limits to how much I can contribute to my HSA?

The IRS stipulates that your plan year HSA funding cannot exceed $3,300*, if you have individual coverage, and $6,550*, if you have family coverage. For additional information, you can visit the IRS web site at: **www.IRS.gov** or call (800) 829-3676.

**This amount applies to year 2014 only.*

How are my medical and prescription drug claims paid?

When visiting your doctor, lab or urgent care facility, you will likely be charged your normal per visit copayment or any portion of your benefit year deductible that has not yet been satisfied. Your provider will then submit a claim to CareFirst for benefits consideration. If you have not already met your benefit year deductible, the claim will be processed and a benefit determination will be sent to you and to the provider. The provider will in turn seek any remaining payments from you. You will be responsible for the cost of your medical services until you meet your deductible.

These expenses can be paid out of your HSA by using your HSA debit card or fund checks. By seeking services from Preferred Providers, your responsibility will be limited to the discounted amount or plan allowance that our Preferred Providers agree to accept as payment in full.

Your pharmacist will charge you CareFirst's discounted cost for prescription drugs until you reach your benefit year deductible. These expenses can also be paid directly from your HSA using your debit card or fund checks.

Since prescription deductible information is automatically transmitted to CareFirst so that we may efficiently track your deductible balances, it is important for you to pick up your prescription drugs from the pharmacy as soon as possible. Pharmacies have their own guidelines for returning medications to their inventory stock. If the pharmacy returns your prescription drugs to their inventory stock, any applicable deductible will be retracted. Each of these deductible and retracted deductible transactions will be recorded on your HSA account.

What happens when HSA funds have been exhausted?

If you use all the money in your HSA before meeting your annual deductible, you will then be responsible for a limited out-of-pocket amount, called the "Bridge." The Bridge is the difference between the amount in your HSA and your deductible.

The amount of money you and/or your employer have contributed to your HSA will determine how much of a "bridge" you have before your BluePreferred coverage becomes available.

Who administers the Health Savings Account?

This depends on the type of coverage that you have. There are three possible scenarios:

1. You are a member of an employer group and your employer has chosen CareFirst's preferred financial institution to administer your Health Savings Account. In this case, you will receive your account information, as well as your HSA debit card and/or personal checks directly from CareFirst's preferred financial institution.
2. You are a member of an employer group and your employer has chosen another financial institution to administer your Health Savings Account. In this case, you will receive information regarding your HSA directly from your employer or your employer's preferred financial institution.

3. You have purchased an HSA Compatible Health Plan on your own and plan to set up a Health Savings Account at your chosen financial institution. In this case, you will receive information regarding your HSA directly from the preferred bank affiliated with CareFirst.

Who is eligible to participate in an HSA?

To be eligible to enroll in a Health Savings Account, you must be covered by a high deductible health plan (HDHP), such as BluePreferred HSA or BluePreferred HSA Compatible.

To enroll in a health savings account you cannot be:

- covered by any medical plan other than a high deductible health plan (dental and vision are not included in this restriction);
- enrolled in Medicare Part A or Part B; or
- claimed as a dependent on another individual's tax return.

How can I track my health benefits?

The more you know, the better you can manage your health care needs. With a CareFirst BluePreferred HSA or HSA Compatible Plan, you can tap into the power of the Internet to help you manage your benefits.

CareFirst online tools, available at **www.carefirst.com**, allow you to:

- Keep track of your HSA balance
- Check the status of a claim
- Compare hospitals
- Compare prescription drug costs
- Request a member ID card
- Confirm or review eligibility
- Find a doctor
- Access health and wellness information

Your HSA funds are available to pay for qualified health care expenses covered under your CareFirst BlueCross BlueShield BluePreferred coverage.

What is the definition of a "Qualified Medical Expense"?

Qualified expenses are those permitted by Section 213(d) of the Internal Revenue Tax Code and that are otherwise permissible under the IRS regulations. When you use the account to pay for qualified expenses, you pay with tax-free dollars.

Qualified expenses include but are not limited to:

- Prescription Drugs
- Certain over-the-counter medications with a prescription
- Doctor's visits, lab, x-ray and other diagnostic and treatment services
- Routine health care, including prenatal care, smoking cessation, obesity weight loss programs
- Qualified long-term care services and qualified long-term care insurance
- COBRA premiums
- Health insurance for those on unemployment compensation

➤ *For a complete list of qualified and unqualified HSA expenses, visit the IRS web site at **www.IRS.gov** or call (800) 829-3676.*

➤ *Please Note: HSA funds can also be spent on qualified expenses that are not covered by your BluePreferred plan. These expenses will not be applied toward your benefit year deductible. Only covered expenses will be applied toward your benefit year deductible.*

Health Reimbursement Arrangement (HRA) Group Plans Only

Group members of CareFirst's BluePreferred HRA and HRA Compatible Plans may have the option to participate in a Health Reimbursement Arrangement, where your employer deposits funds into your spending account to pay for qualified medical expenses.

How your HRA works

An HRA is a medical savings account that allows you to use funds provided by your employer to pay for eligible medical expenses. Each year, your employer makes a contribution toward your HRA. You then use the money in your account to pay the full or discounted cost of qualified services until you reach your benefit year deductible or exhaust the fund contributions, whichever is less.

Once you meet your plan year deductible, your BluePreferred coverage begins. You then pay a copayment or coinsurance for all covered services, including prescription drugs.

Funds rollover from year to year

Depending on the amount of qualified health care expenses you incur in a given year, you may not need to use all of the funds in your HRA. Depending on your plan design, in this event, your employer may allow the remaining balance in your HRA to roll over to the following benefit year.

Available to members of employer-based group plans

Because HRAs are funded by the employer, HRAs are only available to members of employer-based health plans. HRAs are not available to members who wish to purchase this health plan on their own.

How Your Deductible Works

Some HRA plans have a medical-only deductible while others have a combined or integrated medical and prescription drug deductible. This means that until your medical-only or your integrated benefit year deductible has been met, you will be responsible for covered expenses associated with your health care services and prescription drugs. See your contract, benefit summary or contact Member Services if you are unsure of the type of deductible in your plan.

If you have a combined deductible, you also have a combined out-of-pocket maximum. This means your eligible health care and prescription drug out-of-pocket expenses will be applied towards meeting your out-of-pocket maximum. Should you reach your out-of-pocket maximum, CareFirst will pay 100% of the applicable Allowed Benefit for most covered services for the remainder of the benefit year.

Questions and Answers

How do I contribute to my HRA?

Funds in your HRA account can only be deposited by your employer. You are not eligible to make any additional contributions toward your HRA.

What happens when HRA funds have been exhausted?

If you use all the money in your HRA before meeting your annual deductible, you will then be responsible for a limited out-of-pocket amount, called the "Bridge." The Bridge is the difference between the amount in your HRA and your deductible.

The amount of money your employer has contributed to your HRA will determine how much of a "bridge" you have before your BluePreferred coverage becomes available.

What happens if I leave my employer?

Should you leave your current employer, all funds that remain in your HRA will revert to the employer.

How are my medical and prescription drug claims paid?

When visiting your doctor, lab or urgent care facility, you will likely be charged your normal per visit copayment or any portion of your benefit year deductible that has not yet been satisfied. Your provider will then submit a claim to CareFirst for benefits consideration. If you have not already met your benefit year deductible, the claim will be processed and a benefit determination will be sent to you and to the provider. The provider will in turn seek any remaining payments from you. You will be responsible for the cost of your medical services until you meet your deductible. Remember, by seeking services from Preferred Providers, your responsibility will be limited to the discounted amount or Allowed Benefit that our Preferred Providers agree to accept as payment in full.

These deductible, coinsurance and copayment amounts will be automatically transferred to your HRA account and eligible expenses will automatically be reimbursed to you on a weekly basis.

Reimbursement

Reimbursement checks have a minimum reimbursement value of $25. Therefore, if the deductible, coinsurance or copayment reimbursement totals for that processing week do not reach the $25 minimum, your reimbursement will be delayed until additional reimbursement is available from your incurred claims.

Prescription drug deductible

If you have a combined medical and prescription drug deductible, your prescription deductible and copayment amounts will also be automatically transferred to your HRA account and reimbursement for these amounts will be included with your medical reimbursements. Your pharmacist will charge you CareFirst's discounted cost for prescription drugs until you reach your benefit year deductible.

Since prescription deductible information is automatically transmitted to CareFirst so that we may efficiently track your deductible balances, it is important for you to pick up your prescription drugs from the pharmacy as soon as possible. Pharmacies have their own guidelines for returning medications to their inventory stock. If the pharmacy returns your prescription drugs to their inventory stock, any applicable deductible will be retracted. Each of these deductible and retracted deductible transactions will be recorded on your HRA account.

What is the definition of "Qualified Medical Expense"?

Your HRA funds are available to pay for qualified medical services covered under your BluePreferred plan, as well as any additional health care expenses deemed acceptable by your employer.

Please note: Some HRA funds allow reimbursement for additional qualified expenses, determined by your employer, that are not covered by your BluePreferred plan. These expenses will not be applied toward your benefit year deductible. Your employer will have a complete list of eligible expenses. Only covered medical expenses under your BluePreferred plan will be applied toward your benefit year deductible.

How can I obtain HRA reimbursement for qualified healthcare expenses not covered by my CareFirst BluePreferred plan?

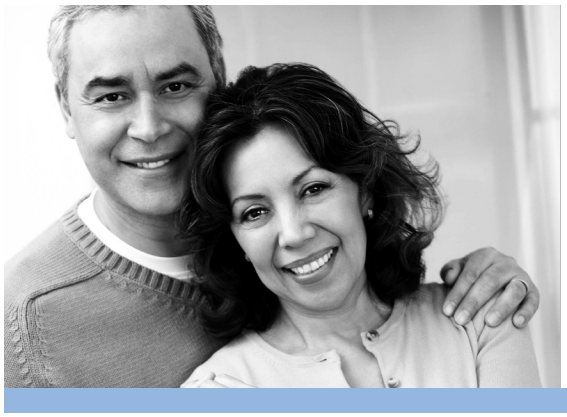
Qualified health care services and items not covered by your CareFirst BluePreferred plan can be reimbursed through your HRA by faxing or mailing a claim along with the supporting documentation to our BlueFund Administration office. You can obtain an HRA Reimbursement Claim form from our web site at **www.carefirst.com**. Complete the form and fax or mail it along with any necessary documentation to:

BlueFund Administration
13511 Label Lane
Suite 201
Hagerstown, MD 21740
Fax: (301) 564-5192

➤ ***You will have 90 days from the end of your benefit year to submit claims or have claims automatically processed for reimbursement through your HRA for services received during the ending benefit year. Be sure to contact your health care provider and request that he/she submit their claims to CareFirst BlueCross BlueShield before the 90 days expire for services that need to be processed through your BluePreferred coverage. Any claims for the ending benefit year posted to your HRA after this 90-day period will not be reimbursed to you. You'll be able to see exactly where your money goes, so you can make the best decision. Visit the CareFirst web site at www.carefirst.com for more information.***

How can I track my health benefits?

The more you know, the better you can manage your health care needs. With a Carefirst BluePreferred HRA plan, you can tap into the power of the Internet to help you manage your benefits.



Definition 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 authorized representative under CareFirst'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.

BluePreferred Provider
A covered practitioner or facility that contracts with CareFirst to render covered services to eligible members in accordance with the terms and conditions of the Preferred Provider Plan.

Certificate of Creditable Coverage
A document necessary to waive any waiting periods, exclusionary amendments or medical underwriting for a person with a pre-existing condition.

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

Coinsurance
A percentage of the Allowed Benefit that the member pays for a covered service (e.g., 20% for lab services or X-rays).

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

Complaint
A protest filed with the regulatory department involving an adverse benefit determination, appeal decision or grievant decision.

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

Covered Expenses
Amounts that are eligible for benefits by CareFirst, as described in your Evidence of Coverage/ Agreement.

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

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

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

Health Care Provider
An individual who is licensed or otherwise authorized in the State where services are provided in the ordinary course of business or practice of a profession, and is a treating practitioner of the member; or a health care facility.

Health Reimbursement Arrangement (HRA)
An employer funded medical savings account that provides you with first dollar coverage for all of your eligible health care expenses.

Health Savings Account (HSA)
A tax-free savings account that allows you to put aside pre-tax income, earn interest on your savings, and use your tax free savings for eligible medical expenses.

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.

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 freedom to seek treatment from any covered provider.

Individual Enrollment Agreement
A document reflecting an individual's enrollment agreement with CareFirst.

Member
An individual who meets all applicable eligibility requirements stated in Part 2 of the Evidence of Coverage/Agreement or Individual Enrollment Agreement, 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 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.

Prior Authorization
The contractual requirement that the provider or member should obtain approval from CareFirst before certain services are covered for a member. Prior Authorization is required for services such as, but not limited to, hospitalizations, physical, speech and occupational therapy, skilled nursing care, home health care, and hospice services.

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

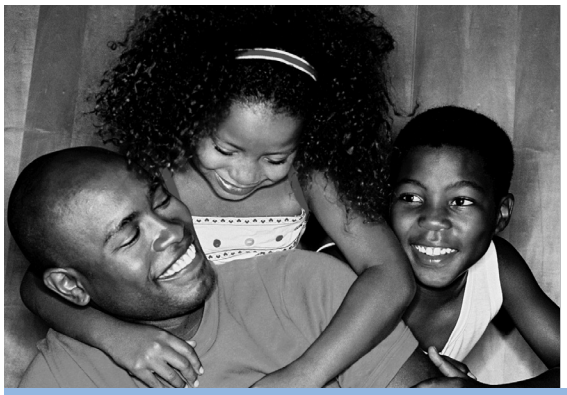
Preventive Health Care
Care provided to prevent disease or its consequences. It includes programs aimed at warding off illnesses (e.g., immunizations), early detection of disease and inhibiting further deterioration of the body. This includes the promotion of health through altering behavior, especially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

Primary Provider
The plan provider 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.

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

Summary of Benefits
A list of the available benefits for a Preferred Provider Plan. A benefit summary is for benefit comparison only and does not create rights not given through the contract.



Index

Policy Form Numbers

DC:
BluePreferred: DC/CF/GC (R. 10/07); DC/CF/BP/EOC (7/08); DC/GHMSI/DOL APPEAL (3/06); DC/CF/BP/DOCS (7/08); DC/CF/BP/SOB (7/08); DC/CF/ATTC (R. 1/10); DC/CF/RX3 (R. 7/11) and any amendments or riders.

BluePreferred CDH: DC/CF/GC (R. 10/07); DC/CF/BP/EOC (7/08); DC/GHMSI/DOL APPEAL (3/06); DC/CF/BP/DOCS (7/08); DC/CF/SOB/HDHP (R. 7/08); DC/CF/ATTC (R. 1/10) and any amendments or riders.

MD:
BluePreferred (GHMSI): MD/CF/GC (R. 7/10); MD/BP/EOC (10/07); MD/GHMSI/DOL APPEAL (R. 7/11); MD/BP/DOCS (10/07); MD/CF/BP/SOB (R. 4/08); MD/CF/ATTC (R. 7/09); MD/CF/RX (R. 1/09) and any amendments or riders.

BluePreferred CDH (GHMSI): MD/CF/GC (R. 7/10); MD/BP/EOC (10/07); MD/GHMSI/DOL APPEAL (R. 7/11); MD/BP/DOCS (10/07); MD/CF/BP/SOB (R. 4/08); MD/CF/ATTC (R. 7/09); MD/CF/RX (R. 1/09) and any amendments or riders.

BluePreferred (CFMI): CFMI/51+/GC (R. 7/10); CFMI/51+/EOC (4/09); CFMI/DOL APPEAL (R. 7/11); CFMI/51+/DOCS (4/09); CFMI/51+/PPO SOB (4/09); CFMI/51+/ELIG (R. 1/10) and any amendments or riders.

BluePreferred CDH (CFMI): CFMI/51+/GC (R. 7/10); CFMI/51+/EOC (4/09); CFMI/DOL APPEAL (R. 7/11); CFMI/51+/DOCS (4/09); CFMI/51+/PPO SOB (4/09); CFMI/51+/ELIG (R. 1/10) and any amendments or riders.

Consumer Direct:
Consumer Direct BluePreferred PPO (GHMSI):
MD/BP/DB/IEA (10/07)
MD/GHMSI/DOL APPEAL (R. 9/11)
MD/CF/BP IEA DOCS (4/08)
MD/CF/DB/EXT MAT (4/08)
MD/CF/DB/MU SOB (4/08)
MD/CF/DB/NGF/RX4 (10/11)
MD/CF/VISION (R. 1/06)
MD/CF/DB/ELIG (R. 11/09)
and any amendments

Consumer Direct BluePreferred Saver (GHMSI):
MD/BP/DB/IEA (10/07)
MD/GHMSI/DOL APPEAL (R. 9/11)
MD/CF/BP IEA DOCS (4/08)
MD/CF/DB/EXT MAT (4/08)
MD/CF/DB/SAVER SOB (4/08)
MD/CF/NGF/IND DRUG (10/11)
MD/CF/VISION (R. 1/06)
MD/CF/DB/ELIG (R. 11/09)
and any amendments

Consumer Direct BluePreferred HSA (GHMSI):
MD/BP/DB/IEA (10/07)
MD/GHMSI/DOL APPEAL (R. 9/11)
MD/CF/BP IEA DOCS (4/08)
MD/CF/DB/EXT MAT (4/08)
MD/CF/DB/HSA SOB (4/08)
MD/CF/DB/ELIG (R. 11/09)
MD/CF/DB/NGF/RX HSA (10/11)
and any amendments

Consumer Direct BluePreferred PPO (CFMI):
CFMI/DB/BP/IEA (1/11)
CFMI/DOL APPEAL (R. 9/11)
CFMI/DB/BP/DOCS (1/11)
CFMI/DB/BP/EXT MAT (1/11)
CFMI/DB/BP/MU SOB (1/11)
CFMI/DB/BP/ELIG (1/11)
CFMI/DB/RX4 (10/11)
CFMI/DB/BP/VISION (1/11)
and any amendments

Consumer Direct BluePreferred Saver (CFMI):
CFMI/DB/BP/IEA (1/11)
CFMI/DOL APPEAL (R. 9/11)
CFMI/DB/BP/DOCS (1/11)
CFMI/DB/BP/EXT MAT (1/11)
CFMI/DB/BP/SAVER SOB (1/11)
CFMI/DB/GEN DRUG ONLY (R. 10/11)
CFMI/DB/BP/VISION (1/11)
CFMI/DB/BP/ELIG (1/11)
and any amendments

Consumer Direct BluePreferred HSA (CFMI):
CFMI/DB/BP/IEA (1/11)
CFMI/DOL APPEAL (R. 9/11)
CFMI/DB/BP/DOCS (1/11)
CFMI/DB/BP/EXT MAT (1/11)
CFMI/DB/BP/HSA SOB (1/11)
CFMI/DB/BP/ELIG (1/11)
CFMI/DB/HSA/RX4 (10/11)
and any amendments

MSGR:
GHMSI
MD/CF/MSGR/GC (R. 9/09); MD/CF/MSGR/GS (9/09); MD/CF/MSGR/COC (R. 7/08); MD/CF/MSGR/DOCS/RPN (R. 12/11)
MD/CF/MSGR/SOB/PPO/CORE (R. 7/07); And any amendments or riders.

CFMI
MD/CFMI/MSGR/GC (9/09); MD/CFMI/MSGR/GS (R. 9/09)
MD/CFMI/MSGR/COC (4/09); MD/CFMI/MSGR/DOCS/RPN (R. 12/11); MD/CFMI/MSGR/SOB/PPO/CORE (4/09); And any amendments or riders.

VA:
BluePreferred: VA/CF/GC (R. 7/10); VA/CF/BP/EOC (7/08); VA/GHMSI/DOL APPEAL (R. 7/11); VA/CF/BP/DOCS (7/08); VA/CF/BP/SOB (7/08); VA/CF/ATTC (R. 1/10); VA/CF/RX3 (R. 7/11) and any amendments or riders.

BluePreferred CDH: VA/CF/GC (R. 7/10); VA/CF/BP/EOC (7/08); VA/GHMSI/DOL APPEAL (R. 7/11); VA/CF/BP/DOCS (7/08); VA/CF/SOB-CDH (7/08); VA/CF/ATTC (R. 1/10) and any amendments or riders.

Dental Policy Form Numbers
DC: DC/CF/DENTAL RIDER (R. 1/12)
MD: MD/CF/DENTAL RIDER (R. 4/08)
VA: VA/CF/DN RDR (R. 1/12)

Vision Policy Form Numbers
DC: DC/CF/VISION (R. 1/12)
MD: MD/CF/VISION (R. 10/11)
VA: VA/CF/VISION (R. 1/12)

For more information, call Member Services at the telephone number on your member ID card.

840 First Street, NE
Washington, DC 20065

www.carefirst.com

BOK5077-1S (6/12)