

Individual BluePreferred-Saver Application

OFFICE USE ONLY:

(Maryland Residents)



Group Hospitalization and Medical Services, Inc.

ID #:	CLASS/PLAN #:
GROUP #:	EFF DATE:

INSTRUCTIONS

- Please fill out all applicable spaces on this application. Print or type all information.
- Sign and return this application in the postage-paid return envelope.

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. If incomplete, the application will be returned and delay your coverage.

FAX COMPLETED APPLICATION TO:
1-877-877-5801 OR 1-410-796-7456

OR MAIL TO:
APPLICATION PROCESSING
5965 SANDY RIDGE
ELKRIDGE, MD 21075

YOU WILL RECEIVE A CONFIRM E-MAIL WITHIN 24-48 HOURS

1. APPLICANT INFORMATION

Last Name		First Name		Initial	Social Security #
Residence Address (Number and Street, Apt. #)			(City and State)	Zip Code (9-digit, if known)	
Billing Address, if different from Residence Address: (Number and Street)			(City and State)	Zip Code (9-digit, if known)	
Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married/Partner		Height	Weight
Home Phone ()	Work Phone ()	E-mail Address			

2. COVERAGE SELECTION (Check one)

- Individual** - Provides coverage for one person
- Individual & Child(ren)** - Provides coverage for an individual and eligible dependent(s)
- Individual & Adult** - Provides coverage for two eligible adults
- Family** - Provides coverage for two eligible adults and eligible dependent(s)

COVERAGE LEVEL DESIRED:

CHECK ONE:	Deductible		Coverage Level		Out-of-Pocket Limit	
	(In-Network)	(Out-of-Network)	(In-Network)	(Out-of-Network)	(In-Network)	(Out-of-Network)
<input type="checkbox"/>	\$2,500	\$5,000	70%	60%	\$5,000	\$10,000
<input type="checkbox"/>	\$5,000	\$10,000	100%	80%	\$5,000	\$12,500
<input type="checkbox"/>	\$10,000	\$12,500	100%	80%	\$10,000	\$15,000

MATERNITY BENEFITS: Check this box if you wish to include benefits for maternity services (additional cost). Yes

FOR BROKER USE ONLY:	Name:	SSN/Tax ID #:	CareFirst-Assigned ID#:
Contracted Broker:	Pinion Financial Services LLC	75-306-9661	48E
Sub-Agent/Sub-Agency:	J. Motsco		
Writing Agent:	J. Motsco		

3. ENROLLING FAMILY MEMBER(S) – Complete only if you select Individual & Child(ren), Individual & Adult or Family Coverage

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX	HT (in.)	WT (lbs.)
Spouse/Partner						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 4						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 5						<input type="checkbox"/> M <input type="checkbox"/> F		

4. OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

		YES	NO
1. Is anyone listed on this application eligible for Medicare?	<input type="checkbox"/>		<input type="checkbox"/>
If yes, please provide the following:			
Name of family member(s) _____ Medicare No. _____ Effective Date _____			
2. Is anyone listed on this application covered by other health insurance, including other Blue Cross and Blue Shield coverage?	<input type="checkbox"/>		<input type="checkbox"/>
If yes, please provide the following:			
Name of family member(s) _____ Insurance Company _____			
Policy Number and Type _____ Effective Date _____			
If you are accepted, will your new CareFirst BlueCross BlueShield coverage replace your existing policy?	<input type="checkbox"/>		<input type="checkbox"/>
3. Has anyone listed on this application been without health insurance for the past 12 months or longer?	<input type="checkbox"/>		<input type="checkbox"/>
If yes, please list name(s): _____			

5. HEALTH EVALUATION

PLEASE COMPLETE SECTIONS A, B, AND C. CHECK EACH ITEM “YES” OR “NO”. Answering yes will not necessarily result in the rejection of your application.

		YES	NO
Have you or any family member named in the accompanying application had a physical examination within the past five years?	<input type="checkbox"/>		<input type="checkbox"/>
<hr/>			
SECTION 5A — To the best of your knowledge or belief, has any person named in this application had within the last five years, or does such person now have, any of the following:		YES	NO
1. Cancer, tumor or other growth (malignant or benign)	<input type="checkbox"/>		<input type="checkbox"/>
2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test)	<input type="checkbox"/>		<input type="checkbox"/>
3. Kidney stones, kidney or bladder condition, urinary frequency or burning	<input type="checkbox"/>		<input type="checkbox"/>

5. HEALTH EVALUATION (Continued)

	YES	NO
4. Goiter, thyroid condition, diabetes	<input type="checkbox"/>	<input type="checkbox"/>
5. Seizure disorder, central nervous system disorder, multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
6. Substance abuse (drug or alcohol dependency, abuse or addiction)	<input type="checkbox"/>	<input type="checkbox"/>
7. Use of illicit drugs	<input type="checkbox"/>	<input type="checkbox"/>
8. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition	<input type="checkbox"/>	<input type="checkbox"/>
9. Cataract or other eye condition	<input type="checkbox"/>	<input type="checkbox"/>
10. Tuberculosis, lung condition, asthma, bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
11. Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition	<input type="checkbox"/>	<input type="checkbox"/>
12. Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)	<input type="checkbox"/>	<input type="checkbox"/>
13. (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition	<input type="checkbox"/>	<input type="checkbox"/>
14. (Female) Is currently pregnant; expected date of delivery: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
15. (Male) Prostate condition, reproductive system disorders, infertility	<input type="checkbox"/>	<input type="checkbox"/>
16. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder	<input type="checkbox"/>	<input type="checkbox"/>
17. Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
18. Anemia, blood disorders	<input type="checkbox"/>	<input type="checkbox"/>
19. Excluding physical examinations, consulted a physician, health care provider, or other individual or facility for medical or surgical treatment, advice, screening for any condition, or prescription medication for a medical condition NOT listed above in items 1-18?	<input type="checkbox"/>	<input type="checkbox"/>
20. Had any known departure from good health not previously mentioned in this questionnaire for which treatment or advice may or may not have been sought?	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: ALL QUESTIONS MUST BE CHECKED “YES” OR “NO” – Or your application will be returned.

SECTION 5B — If you have checked “YES” to any part of SECTION 5A, for each box checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgeries and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

Patient's First Name	Question Number	Diagnosis or Condition	Duration Dates	Explain treatment including all medications, hospitalizations, surgery and diagnostic test results and physician's/hospital's name.	Recovery (Check only one box.)
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL

NOTE: FAILURE TO DISCLOSE CONDITIONS MAY RESULT IN VOIDING OF MEMBERSHIP AND DENIAL OF BENEFITS.

5. HEALTH EVALUATION (Continued)

SECTION 5C — If any person included in this application is presently using medication or prescription drugs, please provide the following information.

Name of Family Member	Illness or Condition	Date of Last Treatment	Operation (Yes or No)	Attending Physician Name and Address

6. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request, from Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst).

This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for a CareFirst policy. I understand that a medically underwritten policy is only issued under the conditions that the health of all persons named on the application remains as stated above. I also understand that failure to enter accurate, complete and updated medical information may result in the denial of all benefits, cancellation or voiding of my policy.

I will update CareFirst if there have been any changes in health concerning any person listed in this application that occurs prior to acceptance of this application by CareFirst.

IF YOU HAVE ANY QUESTIONS CONCERNING THE BENEFITS AND SERVICES THAT ARE PROVIDED BY OR EXCLUDED UNDER THIS AGREEMENT, PLEASE CONTACT A MEMBERSHIP SERVICES REPRESENTATIVE BEFORE SIGNING THIS APPLICATION.

WARNING: It is a fraudulent insurance act for a person knowingly or willfully to make a false or fraudulent statement or representation in or with reference to this application for insurance.

Signature of Applicant 1: * X _____ Date: _____

Signature of Applicant 2: X _____ Date: _____

Re-sign and re-date below **only** if box is checked.

Signature of Applicant 1: **X** _____ Date: _____

Signature of Applicant 2: **X** _____ Date: _____

*Rates are based on the age of the Subscriber.

NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.

Parent or Legal Guardian's Signature: X _____ Date: _____

BluePreferred-Saver Underwritten – Maryland



In-Network: ■ **\$2,500 Deductible**, 70%/30% Coinsurance ■ **\$5,000 Out-of-Pocket**
 Out-of-Network: ■ **\$5,000 Deductible**, 60%/40% Coinsurance ■ **\$10,000 Out-of-Pocket**
 Prescription: \$15 Generic Copay, \$150 Deductible, \$1,500 Annual Maximum

Monthly Premium Rates Effective: January 1, 2008

AGE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$56	-	-	-
6-17	\$50	\$97	\$100	\$132
18-20	\$73	\$141	\$144	\$192
21	\$74	\$143	\$146	\$196
22	\$75	\$145	\$150	\$199
23	\$77	\$151	\$154	\$205
24	\$78	\$153	\$156	\$208
25	\$79	\$155	\$158	\$211
26	\$81	\$159	\$163	\$218
27	\$82	\$162	\$166	\$220
28	\$84	\$165	\$168	\$223
29	\$87	\$168	\$172	\$230
30	\$88	\$170	\$175	\$233
31	\$90	\$175	\$180	\$239
32	\$91	\$177	\$182	\$243
33	\$93	\$182	\$187	\$248
34	\$94	\$184	\$189	\$252
35	\$97	\$189	\$194	\$258
36	\$98	\$191	\$196	\$261
37	\$100	\$196	\$201	\$267
38	\$103	\$201	\$205	\$274
39	\$104	\$203	\$207	\$277
40	\$106	\$207	\$213	\$283
41	\$111	\$216	\$221	\$295
42	\$117	\$228	\$233	\$311
43	\$121	\$237	\$243	\$323
44	\$127	\$248	\$255	\$340
45	\$133	\$259	\$266	\$355
46	\$139	\$271	\$278	\$370
47	\$144	\$282	\$290	\$386
48	\$152	\$296	\$304	\$405
49	\$158	\$309	\$318	\$424
50	\$166	\$323	\$332	\$443
51	\$173	\$338	\$346	\$461
52	\$181	\$353	\$362	\$484
53	\$189	\$369	\$379	\$505
54	\$198	\$385	\$395	\$526
55	\$207	\$403	\$414	\$551
56	\$216	\$422	\$432	\$577
57	\$227	\$442	\$454	\$606
58	\$236	\$460	\$472	\$630
59	\$248	\$484	\$495	\$661
60	\$258	\$504	\$517	\$689
61	\$270	\$528	\$540	\$720
62	\$283	\$552	\$566	\$755
63	\$295	\$576	\$592	\$789
64	\$308	\$602	\$617	\$824
65	\$322	\$629	\$645	\$862
66 and over	\$338	\$659	\$675	\$901

*To include a maternity benefit, add \$126 to the monthly premium rate.

The actual premium rate may be either 25% or 50% higher than above premium rates based on the Medical Underwriting results.

Policy Form Numbers:

IEA/OE DP MD • DOCS-PPO/M • MD/CF/IND DRUG (1/05) • MD/CF/Low Cost 70% Option SOB (1/05) and any amendments.

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association.
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 CUT6655-1S (11/07)

BluePreferred-Saver

Underwritten – Maryland



In-Network: ■ **\$5,000 Deductible**, 100%/0% Coinsurance ■ **\$5,000 Out-of-Pocket**
 Out-of-Network: ■ **\$10,000 Deductible**, 80%/20% Coinsurance ■ **\$12,500 Out-of-Pocket**
 Prescription: \$15 Generic Copay, \$150 Deductible, \$1,500 Annual Maximum

Monthly Premium Rates Effective: January 1, 2008

AGE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$52	-	-	-
6-17	\$47	\$92	\$95	\$125
18-20	\$69	\$133	\$136	\$182
21	\$70	\$135	\$138	\$185
22	\$71	\$137	\$141	\$188
23	\$73	\$142	\$145	\$194
24	\$74	\$144	\$147	\$197
25	\$75	\$146	\$149	\$199
26	\$77	\$150	\$154	\$206
27	\$78	\$153	\$156	\$208
28	\$80	\$155	\$158	\$211
29	\$82	\$158	\$162	\$217
30	\$83	\$160	\$165	\$220
31	\$85	\$165	\$169	\$226
32	\$86	\$167	\$171	\$229
33	\$88	\$171	\$176	\$234
34	\$89	\$173	\$178	\$238
35	\$92	\$178	\$183	\$243
36	\$93	\$181	\$185	\$246
37	\$95	\$185	\$190	\$252
38	\$97	\$190	\$194	\$258
39	\$98	\$192	\$196	\$261
40	\$100	\$196	\$201	\$267
41	\$105	\$204	\$209	\$278
42	\$110	\$215	\$220	\$293
43	\$114	\$224	\$229	\$305
44	\$120	\$234	\$240	\$321
45	\$125	\$244	\$251	\$335
46	\$131	\$255	\$262	\$349
47	\$136	\$266	\$273	\$364
48	\$143	\$279	\$286	\$382
49	\$149	\$291	\$300	\$399
50	\$156	\$305	\$313	\$418
51	\$163	\$319	\$326	\$435
52	\$170	\$333	\$341	\$456
53	\$179	\$348	\$357	\$476
54	\$187	\$363	\$372	\$496
55	\$195	\$380	\$390	\$519
56	\$204	\$397	\$407	\$544
57	\$214	\$417	\$428	\$571
58	\$223	\$434	\$445	\$594
59	\$234	\$456	\$467	\$623
60	\$243	\$475	\$487	\$649
61	\$254	\$497	\$509	\$679
62	\$266	\$520	\$534	\$712
63	\$278	\$543	\$558	\$743
64	\$290	\$568	\$582	\$777
65	\$304	\$593	\$608	\$812
66 and over	\$319	\$621	\$636	\$849

*To include a maternity benefit, add \$126 to the monthly premium rate.

The actual premium rate may be either 25% or 50% higher than above premium rates based on the Medical Underwriting results.

Policy Form Numbers:

IEA/OE DP MD • DOCS-PPO/M • MD/CF/IND DRUG (1/05) • MD/CF/Low Cost 100% Option SOB (1/05) and any amendments.

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BluePreferred-Saver

Underwritten – Maryland



In-Network: ■ **\$10,000 Deductible**, 100%/0% Coinsurance ■ **\$10,000 Out-of-Pocket**

Out-of-Network: ■ **\$12,500 Deductible**, 80%/20% Coinsurance ■ **\$15,000 Out-of-Pocket**

Prescription: \$15 Generic Copay, \$150 Deductible, \$1,500 Annual Maximum

Monthly Premium Rates Effective: January 1, 2008

AGE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$40	-	-	-
6-17	\$36	\$70	\$72	\$95
18-20	\$52	\$101	\$103	\$137
21	\$53	\$102	\$104	\$139
22	\$53	\$104	\$107	\$141
23	\$55	\$107	\$110	\$146
24	\$56	\$109	\$111	\$148
25	\$56	\$110	\$113	\$150
26	\$58	\$113	\$117	\$155
27	\$58	\$116	\$118	\$157
28	\$60	\$117	\$119	\$159
29	\$62	\$119	\$122	\$163
30	\$62	\$121	\$125	\$166
31	\$64	\$125	\$128	\$170
32	\$65	\$126	\$129	\$173
33	\$66	\$129	\$133	\$176
34	\$67	\$131	\$135	\$179
35	\$69	\$135	\$138	\$183
36	\$70	\$136	\$139	\$185
37	\$71	\$139	\$143	\$190
38	\$73	\$143	\$146	\$194
39	\$74	\$144	\$147	\$197
40	\$75	\$147	\$151	\$201
41	\$79	\$153	\$157	\$209
42	\$83	\$162	\$165	\$221
43	\$86	\$169	\$172	\$229
44	\$90	\$176	\$181	\$241
45	\$94	\$184	\$189	\$252
46	\$99	\$192	\$197	\$262
47	\$102	\$200	\$206	\$274
48	\$108	\$210	\$215	\$287
49	\$112	\$219	\$225	\$300
50	\$117	\$229	\$235	\$314
51	\$123	\$240	\$245	\$326
52	\$128	\$250	\$256	\$342
53	\$134	\$261	\$268	\$357
54	\$140	\$273	\$279	\$372
55	\$146	\$286	\$293	\$390
56	\$153	\$298	\$306	\$408
57	\$160	\$313	\$321	\$428
58	\$167	\$325	\$334	\$446
59	\$176	\$342	\$350	\$467
60	\$182	\$356	\$365	\$487
61	\$191	\$373	\$382	\$509
62	\$200	\$390	\$400	\$534
63	\$209	\$407	\$418	\$557
64	\$218	\$426	\$436	\$582
65	\$227	\$445	\$456	\$609
66 and over	\$239	\$466	\$477	\$636

*To include a maternity benefit, add \$126 to the monthly premium rate.

The actual premium rate may be either 25% or 50% higher than above premium rates based on the Medical Underwriting results.

Policy Form Numbers:

IEA/OE DP MD • DOCS-PPO/M • MD/CF/IND DRUG (1/05) • MD/CF/Low Cost 100% Option SOB (1/05) and any amendments.



BluePreferred-Saver *Maryland*

More to feel good about.

Maryland

Leaving more money in your hands

BluePreferred-Saver is a product for people like you:

people who know they need health coverage, but don't want to spend a lot of money for it. With BluePreferred-Saver's design, you save money, even if you don't visit the doctor very often.

- **Save with lower monthly premiums**, and rest assured: you're covered for life's sudden health emergencies.
- **Save at the doctor's office.** Your expense is limited to a small copay for the first two visits each year (excluding preventive care). All of your preventive care visits in-network are covered with a small copay and no deductible.
- **Save on prescription drugs.** After meeting a lower deductible, you pay only a \$15 copay for generic drugs, and get discounts on brand name prescriptions.

Save your hard-earned money, in the event of a medical emergency, and let CareFirst BlueCross BlueShield (CareFirst) cover you. With BluePreferred-Saver, you know what your maximum out-of-pocket expenses will be in any given year. Once you reach the out-of-pocket maximum, which is the maximum an individual on your policy spends toward coinsurance and deductibles per year. CareFirst pays 100% of your covered medical expenses (excluding prescriptions) for that benefit year. And, you can rest assured knowing that your BluePreferred-Saver coverage has a substantial \$3,000,000 lifetime benefit maximum for covered medical services.

A health plan that actually gives you opportunities to save while keeping you covered, at a competitive price.

Individuals under the age of 30 can get coverage for less than \$100 a month! Choose a plan with a higher deductible, and you'll pay even less for your coverage.

As a member, you'll get built-in cost savings from one of the region's leading health insurers, CareFirst BlueCross BlueShield. And, you'll be able to count on the negotiating power of CareFirst, by receiving discounts on medical care, prescriptions and a host of other programs designed to help you maintain your good health.

- **Save more by using in-network doctors.**

You can see any doctor you like. However, you'll notice significant savings when you use doctors within CareFirst's Preferred Provider Network, which includes more than 29,000 providers and 42 hospitals locally.

- **Save time by avoiding cumbersome paperwork.**

You won't need referrals. And you'll have few, if any, claim forms.

- **Save with discounts on health-related programs.**

As a CareFirst member, you are entitled to discounts on alternative therapies and health and wellness programs such as chiropractic, acupuncture, massage, yoga, Pilates, tai chi, qi gong, guided imagery and fitness centers. Also, this program offers discounts on Weight Watchers® Online and Jenny Craig®, mail order contacts, laser-vision correction, hearing aids, and eldercare management. Since this program is in addition to your medical plan rather than a benefit, there are no claim forms, paperwork or referrals.

Leaving more money in your hands

Choose the deductible level right for you

With BluePreferred-Saver, you have three plans to choose from. The choice is yours. The higher your deductible, the lower your premium and member coinsurance. Tailor your coverage to your budget.

All three BluePreferred-Saver plans give you the security and peace of mind of a substantial \$3 million lifetime policy maximum.

Option 1: \$2,500 Deductible

	In-Network	Out-of-Network
Deductible	Individual: \$2,500	Individual: \$5,000
	Family: \$5,000	Family: \$10,000
Member Coinsurance	30%	40%
Out-of-Pocket Maximum	Individual: \$5,000	Individual: \$10,000
	Family: \$10,000	Family: \$20,000

Option 2: \$5,000 Deductible

	In-Network	Out-of-Network
Deductible	Individual: \$5,000	Individual: \$10,000
	Family: \$10,000	Family: \$20,000
Member Coinsurance	0%	20%
Out-of-Pocket Maximum	Individual: \$5,000	Individual: \$12,500
	Family: \$10,000	Family: \$22,500

Option 3: \$10,000 Deductible

	In-Network	Out-of-Network
Deductible	Individual: \$10,000	Individual: \$12,500
	Family: \$20,000	Family: \$25,000
Member Coinsurance	0%	20%
Out-of-Pocket Maximum	Individual: \$10,000	Individual: \$15,000
	Family: \$20,000	Family: \$27,500

How the Plan Works:

- ◆ You pay up to the deductible, when applicable. Families never pay more than two times the individual deductible in a benefit year. Remember, for just a \$30 copay per visit, your first two in-network office visits (excluding preventive care) are covered.
- ◆ Once the deductible has been met, BluePreferred-Saver pays a percentage (100% or 70% for in-network providers) of the allowed amount. This is called the coverage level. The percentage that you pay (0% or 30% for in-network providers) is referred to as coinsurance.
- ◆ Unlike many other plans, your deductible and most coinsurance payments are included as part of your out-of-pocket maximum, which is the maximum an individual on your policy spends toward coinsurance and deductibles per year.
- ◆ Once your out-of-pocket maximum is reached, no further coinsurance or deductibles will be required in that calendar year.*
- ◆ Eligible expenses of all covered members can be combined to satisfy the family out-of-pocket limit. An individual family member cannot contribute more than the individual out-of-pocket limit toward meeting the family out-of-pocket limit.

**Please note that the prescription program deductible, copayments and maximums are separate from the medical deductible, copayments and maximums.*

Leaving more money in your hands

In-Network Benefits at a Glance

Medical Benefits	You Pay (In-Network)
Preventive Services	
Routine Adult Physical	\$30 per visit (no deductible)
Well-Child Care Including Exams and Immunizations	\$30 per visit (no deductible)
Routine OB/GYN Visits	\$30 per visit (no deductible)
PAP test, Mammograms, Prostate Screening & Colorectal Screening	No charge
Office Visits, Labs and Testing	
Office Visits (excluding preventive care) 1-2 visits 3+ visits	\$30 per visit (no deductible) Deductible & Coinsurance
X-ray and Lab Tests	Deductible & Coinsurance
Allergy Treatments	Deductible & Coinsurance
Emergency Care	
Emergency Room	Deductible & Coinsurance
Urgent Care Center	Deductible & Coinsurance
Ambulance (when medically necessary)	Deductible & Coinsurance
Hospitalization	
Inpatient Facility Services	Deductible & Coinsurance
Inpatient Physician Services	Deductible & Coinsurance
Outpatient Facility Services	Deductible & Coinsurance
Outpatient Physician Services	Deductible & Coinsurance
Vision Services	
Routine Annual Exam (administered by Davis Vision)	\$10
Prescription Drug Benefits	
Deductible	\$150
Generic Copay	\$15
Preferred Brand Copay	Discount
Non-Preferred Brand Copay	Discount
Annual Maximum (per person)	\$1,500 (generic drugs)

Care received out-of-network is subject to higher deductibles and coinsurance.

There is a 10-month pre-existing conditions exclusion period.

Optional Extended Maternity Services may be added for you or your covered spouse or domestic partner. For an additional \$126 a month, you'll receive benefits for covered pre- and postnatal care as well as covered services associated with the delivery. **If you add maternity coverage, at any time, and you are pregnant on the effective date of your coverage, there will be a 10-month pre-existing conditions exclusion period for extended maternity and related services. If you become pregnant after your effective date, then CareFirst will begin covering extended maternity and related services immediately.**

When You Need Care



UTILIZATION MANAGEMENT

When you need to be hospitalized or need therapy, your doctor will work with the Utilization Management team to ensure you receive the right care in the right place at the right time.

Hospital Precertification and Review

Any time you face non-emergency surgery or hospitalization, the Hospitalization Precertification and Review program works with your provider to determine if the hospital is the most appropriate place for your procedure and recovery. If you are hospitalized, a Utilization Management nurse will review your information and assist with discharge planning or approve additional inpatient hospital days if necessary.

Maximizing Your Drug Benefit

To help you and your family face the challenge of the rising cost of prescription drugs, CareFirst develops drug utilization programs to encourage drugs that are effective and cost-efficient in order to maximize the value of your prescription drug benefit. In addition, we frequently update the preferred drug list (Formulary) which can be found online. Here you can also find tools to help you get the most from your prescription dollar such as learning how to save money with generic alternatives, finding participating pharmacies and much more.



CASE MANAGEMENT

When faced with a serious diagnosis or condition, you and your family have many tough choices and decisions to make. The Case Management program can help you navigate the complex health care system and provide support during your time of need. Some of the conditions most frequently case managed include:

- ◆ serious trauma
- ◆ cancer
- ◆ rehabilitation
- ◆ special needs

Leaving more money in your hands

Our case managers will:

- ◆ Work closely with you and your doctors to identify a treatment plan
- ◆ Coordinate necessary services
- ◆ Contact you regularly to see how you are doing
- ◆ Answer any of your questions
- ◆ Suggest community resources that may be available



DISEASE MANAGEMENT¹

Our disease management programs can help you avoid or delay the complications related to chronic conditions.

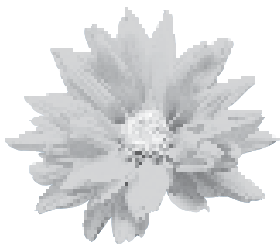
We have programs for:

- ◆ Diabetes
- ◆ Asthma
- ◆ Chronic obstructive pulmonary disease (COPD)
- ◆ Congestive heart failure
- ◆ Coronary heart disease

When you enroll, you will:

- ◆ Receive information on how to manage your condition
- ◆ Be able to call a toll-free number 24 hours a day, seven days a week, to speak with a registered nurse
- ◆ Have access to a Web site that has information about your condition
- ◆ Be able to email questions to a registered nurse

¹ *Disease management programs may not be available for some accounts.*



Options Discount Program

Options discount program provides you with discounts on laser vision correction, hearing care services, fitness club memberships and mail order contact lenses, as well as alternative therapies such as acupuncture, massage therapy and chiropractic care. CareFirst BluePreferred members can also receive discounts on tai chi, qi gong, pilates, yoga, nutrition counseling, guided imagery, meditation instruction, mind-body instruction and personal training.

Options is not a covered benefit under your health plan, but rather a way for you to access health and wellness practitioners at discounted rates.

It's Easy to Apply

To be eligible for BluePreferred-Saver coverage, each family member applying must be a resident of Maryland and complete a medical questionnaire.

Just follow these easy steps to apply.

1. Choose what type of coverage you need. You can select:

- ◆ Individual
- ◆ Individual and Child(ren)*
- ◆ Individual and Adult**
- ◆ Family [Two eligible adults and eligible dependent(s)]

*"Child" means your unmarried, *eligible* child up to age 25 (effective January 1, 2008). Eligibility requirements are defined in the BluePreferred contract.

**"Adult" means the spouse of the subscriber or the domestic partner of the subscriber who resides with the subscriber and satisfies the eligibility requirements defined in the BluePreferred contract. The subscriber and domestic partner may not share a blood or familial relationship, and must have shared a common legal residence continuously for at least six (6) months prior to applying for coverage.

If you have questions about eligibility, please call our Product Specialists at **1-877-634-1256**.

2. **Choose the plan that best fits your needs.** The enclosed rate charts for each plan, coverage type, and age will help you identify your monthly premium.
3. **Locate the application form in this packet.** Be sure to answer all questions honestly and completely, and don't forget to sign your application. Make sure you check "yes" in the Maternity benefit selection area, if you wish to elect optional extended maternity benefits.
4. **Mail your application in the enclosed envelope.** Send no money at this time. We'll begin processing your application right away! The review process takes about 4-6 weeks. Once you have submitted your application, you can call the Application Status Hotline at 1-877-634-1256 with questions. Your coverage will become effective the first of the month following the month in which we approve your application. Once effective, you'll receive your ID cards and everything else you need.

Leaving more money in your hands

Additional Coverage Options

- ◆ **Personal Comp** & Personal Comp HSA**** – Indemnity coverage that gives you the freedom to choose any doctor or hospital and a wide range of deductible levels including health savings account-compatible plans.
- ◆ **MediGap-65** – Traditional coverage to supplement your Medicare policy, offered by CareFirst of Maryland, Inc. For more information about this plan, please call our Product Specialists toll free at **1-877-634-1256**.
- ◆ **BluePreferred** and BluePreferred HSA**** – A Preferred Provider Organization that reduces your out-of-pocket costs with a variety of deductible options including health savings account-compatible plans.

Other Coverage Options:

- ◆ **CareFirst BlueChoice**, BlueChoice-Saver** & BlueChoice-HSA**** – A flexible HMO plan, offered by CareFirst BlueChoice, Inc., an affiliate, including low-premium and health savings account-compatible plans.

***Medical questionnaire must be completed.*

Policy Form Numbers:

IEA OE/DP MD as amended; DOCS-PPO/M; MD/CF/Low Cost 70% Option SOB (1/05); MD/CF_Low Cost 100% Option SOB (1/05); MD/CF/IND DRUG (1/05); MD/BP/DB/ES (10/07)

Not all services and procedures are covered by your benefits contract.

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



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