

Individual BluePreferred-Saver Application

OFFICE USE ONLY:

(Virginia 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

TYPE OF ENROLLMENT (CHECK ONE)

Underwritten Underwritten (First choice) or HIPAA (Second choice)
 HIPAA

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		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		

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. © Registered trademark of the Blue Cross and Blue Shield Association. © Registered trademark of CareFirst of Maryland, Inc.

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						<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"/>	<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 Blue Shield coverage?	<input type="checkbox"/>	<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 BluePreferred coverage replace your existing policy?	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
If yes, please list name(s): _____			

5. HIPAA ELIGIBILITY INFORMATION

		YES	NO
1. Are any applicant(s) eligible (whether enrolled or not) for coverage under any group health benefits plan or employer sponsored health benefit plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please state the name(s) of the applicant(s) _____			
2. Are any applicant(s) eligible or entitled (whether enrolled or not) for Medicare, Part A or Part B?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If entitled, please state the name(s) of the applicant(s) _____			
and the applicant's Medicare Claim Number _____			

5. HIPAA ELIGIBILITY INFORMATION (Continued)

3. Are any applicant(s) eligible (whether enrolled or not) for Medicaid, or any similar state plan under Title XIX of the Social Security Act? **YES** **NO**

If yes, please state the name of the applicant(s) _____

4. Are any applicant(s) currently covered under any other health benefit plan?

If yes, please state the name of the applicant(s) _____

Provide coverage information in Section 4 (Other Insurance Information), above.

5. Was the applicant's prior health benefits plan terminated because of nonpayment of premium or subscription charges by the applicant?

If yes, please state the name of the applicant(s) _____

6. Was the applicant's prior health benefits plan terminated for reasons of fraudulent act or intentional misrepresentation by the applicant?

If yes, please state the name of the applicant(s) _____

Federal law requires that a group health plan sponsored by an employer who regularly employs 20 or more employees offer employees and their families the opportunity for a temporary extension of health coverage called Continuation Coverage (or COBRA coverage). This Continuation Coverage is offered for a specific number of months depending on the applicant's situation. The employer or Plan Administrator will be able to tell an applicant(s) how many months of Continuation Coverage is available.

7. If the applicant(s) were offered this Continuation Coverage, did the applicant(s) refuse this coverage or elect to terminate this coverage before the end of the allowed Continuation Coverage period?

If yes, please state the name of the applicant(s) _____

INSTRUCTIONS:

Applicants REQUIRED to Complete the Health Status Section of the Application:

- Any applicant who has not been covered under any health benefits plan for the past 63 days.
- Any applicant who answered any of the above questions in Section 5 (HIPAA Eligibility Information) with "YES".
- Any applicant who wants to be considered for the Underwritten coverage only or for both the Underwritten coverage (first choice) and the HIPAA coverage (second choice).

Applicants who are NOT Required to Complete the Health Status Section of the Application:

- Any applicant who submits a Certificate of Coverage(s) that states: 1) that the applicant has a total of 18-months or more of continuous creditable coverage; 2) whose most recent creditable coverage was under individual health insurance coverage, a group health plan, governmental plan, or church plan, or any health benefit plan offered in connection with these plans; and 3) the applicant answered all of the above questions in Section 5 (HIPAA Eligibility Information) with "NO".
- Any applicant who submits a Certificate of Coverage(s) that states: 1) that the applicant has a total of 12-months or more of continuous creditable coverage; 2) whose most recent creditable coverage was under an individual health insurance policy which was nonrenewed by the health insurance issuer because the health insurance issuer is no longer offering any type of health insurance coverage in the individual market; and 3) the applicant answered all of the above questions in Section 5 (HIPAA Eligibility Information) with "NO".

NOTE: An applicant's prior insurer(s) or health plan(s) are required by federal law to provide a Certificate of Coverage that indicates how many months the applicant has been continuously covered under "creditable coverage", as defined under Federal and State law. Please attach all Certificates of Coverage to this application. Retain a copy for your records.

6. HEALTH EVALUATION

PLEASE COMPLETE SECTIONS A, B, AND C. CHECK EACH ITEM “YES” OR “NO”.

Have you or any family member named in the accompanying application had a physical examination within the past five years? **YES** **NO**

SECTION 6A — 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"/> |
| 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.

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

6. HEALTH EVALUATION (Continued)

SECTION 6B — If you have checked “YES” to any part of SECTION 6A, 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

SECTION 6C — 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

7. 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.

7. CONDITIONS OF ENROLLMENT — Continued

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 - Virginia



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 AT EFFECTIVE DATE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$53	—	—	—
6-17	\$47	\$93	\$95	\$126
18-20	\$69	\$134	\$137	\$182
21	\$70	\$136	\$140	\$186
22	\$71	\$138	\$142	\$189
23	\$73	\$143	\$146	\$195
24	\$74	\$145	\$149	\$198
25	\$75	\$147	\$151	\$200
26	\$78	\$152	\$155	\$207
27	\$79	\$154	\$158	\$209
28	\$80	\$156	\$160	\$213
29	\$82	\$160	\$164	\$218
30	\$83	\$162	\$167	\$222
31	\$86	\$167	\$170	\$227
32	\$87	\$168	\$172	\$231
33	\$89	\$172	\$177	\$235
34	\$90	\$175	\$179	\$239
35	\$92	\$179	\$184	\$244
36	\$93	\$181	\$186	\$248
37	\$96	\$186	\$190	\$253
38	\$98	\$190	\$195	\$260
39	\$99	\$193	\$197	\$263
40	\$100	\$197	\$202	\$269
41	\$105	\$205	\$211	\$281
42	\$110	\$216	\$222	\$296
43	\$115	\$225	\$231	\$307
44	\$121	\$236	\$241	\$322
45	\$126	\$246	\$252	\$337
46	\$132	\$257	\$264	\$352
47	\$138	\$268	\$275	\$366
48	\$144	\$282	\$289	\$384
49	\$151	\$294	\$301	\$403
50	\$158	\$307	\$315	\$421
51	\$165	\$320	\$328	\$438
52	\$171	\$335	\$344	\$459
53	\$179	\$351	\$360	\$479
54	\$187	\$365	\$374	\$500
55	\$196	\$382	\$393	\$523
56	\$205	\$400	\$411	\$548
57	\$215	\$420	\$430	\$574
58	\$224	\$437	\$448	\$598
59	\$235	\$459	\$470	\$627
60	\$245	\$478	\$491	\$654
61	\$256	\$500	\$512	\$684
62	\$269	\$524	\$537	\$717
63	\$281	\$547	\$561	\$749
64	\$293	\$571	\$586	\$782
65	\$306	\$597	\$613	\$817
66 and Over	\$321	\$625	\$641	\$855

*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:

V/DP/IEA-5/96 • PPP/A/BPDB 4/96 • VA/CF/LC70 (R. 1/05) • VA/CF/LCRX (1/05) and any amendments.

BluePreferred - Saver

Underwritten - Virginia



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 AT EFFECTIVE DATE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$52	—	—	—
6-17	\$46	\$90	\$92	\$123
18-20	\$67	\$130	\$133	\$177
21	\$68	\$132	\$136	\$181
22	\$69	\$134	\$138	\$184
23	\$71	\$139	\$142	\$190
24	\$72	\$141	\$145	\$192
25	\$73	\$143	\$146	\$194
26	\$76	\$147	\$150	\$201
27	\$77	\$149	\$153	\$203
28	\$78	\$151	\$155	\$207
29	\$79	\$155	\$159	\$212
30	\$80	\$157	\$162	\$215
31	\$83	\$162	\$166	\$220
32	\$84	\$164	\$167	\$224
33	\$86	\$167	\$172	\$229
34	\$87	\$170	\$174	\$233
35	\$89	\$174	\$179	\$237
36	\$90	\$176	\$181	\$241
37	\$93	\$181	\$185	\$246
38	\$95	\$185	\$190	\$253
39	\$96	\$188	\$191	\$256
40	\$98	\$191	\$196	\$261
41	\$102	\$199	\$205	\$273
42	\$107	\$210	\$215	\$287
43	\$112	\$218	\$224	\$299
44	\$118	\$230	\$234	\$313
45	\$122	\$239	\$245	\$327
46	\$128	\$250	\$256	\$342
47	\$134	\$260	\$267	\$356
48	\$140	\$274	\$280	\$373
49	\$146	\$285	\$293	\$391
50	\$153	\$299	\$306	\$409
51	\$160	\$311	\$319	\$426
52	\$166	\$325	\$334	\$446
53	\$174	\$341	\$349	\$465
54	\$182	\$355	\$364	\$486
55	\$190	\$371	\$382	\$508
56	\$199	\$388	\$399	\$532
57	\$209	\$408	\$418	\$558
58	\$217	\$425	\$435	\$581
59	\$229	\$446	\$456	\$609
60	\$238	\$464	\$476	\$635
61	\$249	\$486	\$497	\$664
62	\$261	\$509	\$521	\$696
63	\$273	\$531	\$545	\$727
64	\$284	\$555	\$569	\$759
65	\$297	\$580	\$595	\$794
66 and Over	\$312	\$607	\$623	\$830

*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:

V/DP/IEA-5/96 • PPP/A/BPDB 4/96 • VA/CF/LC100 (R.1/05) • VA/CF/LCRX (1/05) and any amendments.

BluePreferred - Saver

Underwritten - Virginia



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 AT EFFECTIVE DATE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$40	-	-	-
6-17	\$35	\$69	\$70	\$94
18-20	\$51	\$100	\$102	\$135
21	\$52	\$101	\$104	\$138
22	\$53	\$102	\$105	\$140
23	\$54	\$106	\$108	\$145
24	\$55	\$108	\$111	\$147
25	\$55	\$109	\$112	\$148
26	\$58	\$113	\$115	\$153
27	\$59	\$114	\$117	\$155
28	\$59	\$115	\$118	\$158
29	\$61	\$118	\$121	\$161
30	\$61	\$120	\$124	\$164
31	\$64	\$124	\$126	\$168
32	\$64	\$125	\$128	\$171
33	\$66	\$128	\$131	\$174
34	\$66	\$130	\$133	\$177
35	\$68	\$133	\$137	\$181
36	\$68	\$134	\$138	\$184
37	\$71	\$138	\$141	\$187
38	\$72	\$141	\$145	\$192
39	\$73	\$143	\$146	\$195
40	\$74	\$146	\$150	\$199
41	\$78	\$152	\$156	\$208
42	\$82	\$160	\$164	\$219
43	\$85	\$166	\$171	\$227
44	\$90	\$175	\$178	\$238
45	\$93	\$182	\$186	\$249
46	\$98	\$190	\$195	\$260
47	\$102	\$198	\$203	\$271
48	\$106	\$208	\$213	\$284
49	\$111	\$217	\$223	\$298
50	\$116	\$227	\$233	\$311
51	\$122	\$236	\$242	\$324
52	\$126	\$247	\$254	\$339
53	\$132	\$259	\$265	\$353
54	\$138	\$270	\$276	\$369
55	\$145	\$282	\$290	\$386
56	\$151	\$295	\$303	\$404
57	\$158	\$310	\$318	\$423
58	\$165	\$323	\$331	\$441
59	\$174	\$338	\$346	\$463
60	\$181	\$352	\$362	\$482
61	\$189	\$369	\$378	\$504
62	\$198	\$386	\$396	\$529
63	\$207	\$403	\$414	\$552
64	\$216	\$421	\$432	\$576
65	\$226	\$440	\$452	\$602
66 and Over	\$237	\$461	\$472	\$630

*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:

V/DP/IEA-5/96 • PPP/A/BPDB 4/96 • VA/CF/LC/100 (R. 1/05) • VA/CF/LCRX (1/05) and any amendments.



BluePreferred-Saver

Leaving more money in your hands

You're active.
You're healthy.
You *still* need health insurance.

*Health Care Coverage for residents of Northern Virginia
who buy their own health insurance.*

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, 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 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.

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

All three BluePreferred-Saver plans give you the security and peace of mind of a substantial \$3,000,000 lifetime policy maximum.

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.*

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In-Network Benefits at a Glance

Medical Benefits	You Pay (In-Network)
Lifetime Maximum	\$3 million
Preventive Services	
Routine Adult Physical	\$30 per visit (no deductible)
Well-Child Care Including Exams and Immunizations	No charge
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	\$30 per visit (no deductible)
3+ visits	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)

Out-of-network service(s) will require the completion of a claim form to obtain reimbursement for the covered benefit(s).

Care received out-of-network is subject to higher deductibles and coinsurance. There is a 10-month waiting period for coverage on pre-existing conditions.

Optional Extended Maternity Services: You may also choose to add maternity and prenatal coverage to your policy (for you or your covered spouse). 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 following your initial enrollment in BluePreferred-Saver, there will be a 10-month waiting period for maternity benefits.

It's easy to apply

To be eligible for BluePreferred-Saver coverage, each family member applying must be a resident of Northern Virginia and complete a medical questionnaire. This area includes the cities of Alexandria and Fairfax, the town of Vienna, Arlington County and the areas of Fairfax and Prince William counties in Virginia lying east of Route 123.

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 23. Eligibility requirements are defined in the BluePreferred contract.

**Adult" means the spouse of the Subscriber who satisfies the eligibility requirements defined in the BluePreferred contract.

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.

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Exclusions

10.1 Medical Necessity and Appropriateness. Benefits will not be provided for services, tests, procedures or supplies which we determine are not necessary for the prevention, diagnosis or treatment of the Member's illness, injury or condition. Although a service or supply is listed as covered, benefits will be provided only if it is medically necessary and appropriate in the Member's particular case. A service or supply is medically necessary and appropriate only if, in our judgment it is:

- a. Necessary and appropriate for the symptom, diagnosis, prevention or treatment of the Member's illness, injury or condition;
- b. consistent with the symptom, diagnosis, prevention or treatment of the Member's illness, injury or condition;
- c. the most appropriate supply, treatment or level of service that can be provided safely to the Member and, if the Member is an inpatient, cannot be provided safely on an outpatient basis; and
- d. not primarily for the convenience of the Member or provider.

Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by an Eligible Provider. We may consult with professional medical consultants, peer review committees, or other appropriate sources for recommendations on whether the services, supplies, or accommodations a Member receives are Medically Necessary.

10.2 Accepted Medical Practice. Benefits will not be provided for any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, in our judgment, is experimental, investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment. A service or supply is deemed to be experimental or investigational if:

- a. A preponderance of scientific data, such as controlled studies in peer-reviewed journals or literature has not demonstrated that its use results in an improved net health outcome for a specific diagnosis;
- b. it is not in accordance with generally accepted standards of medical practice; or
- c. it does not have federal or other required governmental agency approval at the time it is received.
- d. This exclusion will not be used, however, to deny Patient Cost when the services for Clinical Trials meet all the requirements under the section entitled "Clinical Trial".

10.3 Free Care. Payment will not be made for services which, if the Member were not covered under the Group Contract, would have been provided without charge, including any charge or any portion of a charge which, by law, the provider is not permitted to bill or collect from the patient directly.

10.4 Routine Care of Feet. Benefits will not be provided for any services related to hygiene and preventative maintenance such as trimming of corns, calluses, flat feet, fallen arches, chronic foot strain or partial removal of a nail without the removal of its matrix, in the absence of an underlying health condition.

10.5 Dental Care. Except as provided in the evidence of coverage, benefits will not be provided for any other type of dental care including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment

of periodontal abscess, removal of impacted teeth, orthodontia, false teeth, or any other dental services or supplies, unless provided in a separate Rider or Endorsement to this Agreement.

10.6 Oral Surgery. Benefits are limited to non-dental diagnostic procedures for congenital defects, such as hare lip, cleft palate, or ectodermal dysplasia and for medically necessary medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to procedures to correct accidental injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth; the reduction of, dislocation of, or excision of temporomandibular joints; procedures involving accessory sinuses, salivary glands or ducts; excision of tumors and cysts of the jaw, cheeks, roof and floor of the mouth when pathological examination is required; excision of exostosis of the jaw and hard palate when not related to the fitting of dentures; extraoral incision and drainage of abscesses with cellulitis. All other procedures involving the teeth or areas surrounding the teeth will not be covered, except for diagnostic and surgical treatment involving a bone or joint of the head, neck, face or jaw, if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.

10.7 Cosmetic Services. Benefits will not be provided for plastic surgery, cosmetic surgery or other services primarily intended to correct, change or improve the Member's appearance. Except as provided in paragraph (b) below, such services are excluded, regardless of the underlying cause of the condition or any expectation that an alteration of the patient's appearance may be psychologically or developmentally beneficial to the patient. Benefits for reconstructive surgery are limited to surgical procedures that, in our judgment, are:

- a. Medically necessary to correct conditions which have resulted in a functional physiological defect; or
- b. Required to correct a congenital anomaly (must be a physical defect that was apparent at birth) that has produced a major physical effect on the Member's condition and provided the surgery or procedure can be reasonably expected to correct the condition; or
- c. Required to correct conditions which have resulted from accidental injury or non-cosmetic surgery if:
The accident or surgery has produced a major physical effect on the Member's appearance; and In our judgment, the surgery can be reasonably expected to correct the condition.
- d. Required for Reconstructive Breast Surgery which is performed as a result of a Mastectomy to re-establish symmetry between two breasts. Reconstructive Breast Surgery includes the augmentation, mammoplasty, reduction, manoplasty, and mastopexy. The coverage shall include all stages of Reconstructive Breast Surgery performed on a non-diseased breast to establish symmetry with the diseased breast when Reconstructive Breast Surgery on the diseased breast is performed.

10.8 Prescription Drugs. Except as provided in a separate rider or endorsement to this Agreement, benefits will not be provided for prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an

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average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, except as may be provided in a separate rider or endorsement to this Agreement, even though they may be dispensed or administered in a physician or provider office or facility.

10.9 Organ Transplants. Organ transplant procedures, including complications resulting from any such procedure, services or supplies related to any such procedure such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, except as provided in your Agreement.

10.10 Other Exclusions. Benefits will not be provided for the following:

- a. Services or supplies received before the effective date of your coverage under this Agreement.
- b. Treatment of sexual dysfunctions or inadequacies except surgical implants for impotence (medical therapy and psychiatric treatment are not covered).
- c. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- d. Weight reduction or obesity treatment, except the surgical treatment of Morbid Obesity.
- e. Speech therapy, occupational therapy or physical therapy that is maintenance therapy for a chronic disease or condition or nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
- f. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education. Cardiac rehabilitation programs are covered as described in your Agreement.
- g. Services or supplies for the medical or surgical treatment of errors of refraction, such as myopia or hyperopia, including but not limited to radial keratotomy or any like or similar procedures or any complications arising therefrom.
- h. Services which are provided for or received at no charge to the Member in any federal hospital or facility, or through any federal, state or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless the care is rendered for a condition that is a result of the Member's military service.)
- i. Services that are beyond the scope of the license of the provider performing the service.
- j. Except for covered ambulance services, travel, whether or not recommended by an Eligible Provider.
- k. Services or supplies for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.
- l. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar persons or groups.
- m. Contraceptive devices.

- n. Assistive reproductive procedures, including artificial insemination, invitro fertilization, embryo or ovum transplants and gamate intra fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
- o. Services solely on court order or as a condition of parole or probation unless approved by the Plan.
- p. Any illness or injury caused by war, declared or undeclared, including armed aggression.
- q. Any service, supply or procedure which is not specifically listed in your Agreement as a covered benefit.
- r. Except as otherwise provided in the evidence of coverage, benefits will not be provided for Habilitative Services. Benefits for physical therapy, occupational therapy and speech therapy do not include benefits for Habilitative Services.

PRESCRIPTION DRUG EXCLUSIONS

Benefits will not be provided for:

1. Any devices, appliances, supplies, and equipment other than those specified in Section B, of the Prescription Drug Rider;
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities;
3. Prescription Drugs intended solely for cosmetic use;
4. Prescription Drugs administered by a physician or dispensed in a physician's office;
5. Drugs, drug therapies or devices that are considered Experimental Or Investigative by CareFirst or the FDA;
6. Drugs or medications lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a prescription ("Over-the-Counter" medications);
7. Therapeutic classes where there is a therapeutic equivalent Over-the-Counter product available.
8. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
 - a. prenatal vitamins;
 - b. fluoride and fluoride containing vitamins; and,
 - c. single entity vitamins, such as Rocaltrol and DHT.
9. All infertility drugs or agents;
10. Any portion of a Prescription Drug that exceeds:
 - a. a thirty-four (34) day supply for non-Maintenance Drugs; or,
 - b. a ninety (90) day supply for Maintenance Drugs;
11. prescription Drugs that are dispensed by a nursing home, extended care facility or other such facility for use during a skilled nursing facility inpatient stay.
12. Appetite suppressants;
13. Biologicals and allergy extracts; and,
14. Blood and blood products. Refer to the medical benefits under the Certificate.

Additional Coverage Options

- ◆ **BluePreferred** and BluePreferred HSA**** – A Preferred Provider Organization (PPO) Plan that reduces your out-of-pocket costs with a variety of deductible options including health savings account-compatible plans.
- ◆ **Supplement-65** – Traditional coverage to supplement your Medicare policy. For more information about this plan, please call our Product Specialists toll free at **1-877-634-1256**.

Other Coverage Options:

- ◆ **BlueChoice HSA**** – A health savings account-compatible HMO plan offered by CareFirst BlueChoice, Inc.

*** Medical questionnaire must be completed.*

Policy Form Numbers

VA/CF/LC70 (R. 1/05) • VA/CF/LC100 (R. 1/05) • VA/CF/LCRX (1/05) • VA/DP/IEA-5/96 •
PPP-A BPDB 4/96 • ELIG C BPDB 4/96 and any amendments.



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