CareFirst

2016 Medicare Health Benefit Options

MONTGOMERY COUNTY
PUBLIC SCHOOLS

Montgomery County Public Schools

Welcome

Welcome to your plan for healthy living

From preventive services to maintain your health, to our extensive network of providers and resources, CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) is there when you need care. We will work together to help you get well, stay well and achieve any wellness goals you have in mind.

We know that health insurance is one of the most important decisions you make for you and your family—and we thank you for choosing CareFirst. This guide will help you understand your plan benefits and all the services available to you as a CareFirst member.

Please keep and refer to this guide while you are enrolled in this plan.

How your plan works

Find out how your health plan works and how you can access the highest level of coverage.

What's covered

See how your benefits are paid, including any deductibles, copayments or coinsurance amounts that may apply to your plan.

Getting the most out of your plan

Take advantage of the added features you have as a CareFirst member:

- Wellness discount program offering discounts on fitness gear, gym memberships, healthy eating options and more.
- Online access to quickly find a doctor or search for benefits and claims.
- *My Care First* wellness website with health calculators, tracking tools and podcast videos on specific health topics.
- *Vitality* magazine with healthy recipes, preventive health care tips, and articles on nutrition, physical fitness, and stress management.

FREE *My Account* mobile app

Get our free app from your favorite app store by searching for "CareFirst."

Health care information is in the palm of your hand with CareFirst's new mobile app that allows you to manage your care, access claims information, view your ID cards and find a doctor or urgent care center any time of the day or night from your smartphones or tablets.

BlueChoice Advantage POS/PPO

Offers you the freedom to choose

BlueChoice Advantage POS/PPO provides you with choices that offer control over your out-of-pocket costs. You have the freedom to visit any provider and your choice will determine your out-of-pocket costs.

No need to select a PCP or obtain a referral.

Benefits of BlueChoice Advantage POS/PPO

- Choose from more than 37,000 CareFirst BlueChoice providers, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- Access to more than 1 million professional providers nationally through the BlueCard® PPO network.
- No PCP selection required.
- No PCP referral required to see a specialist.
- Pay predictable copays when you receive care from an in-network provider.
- Preventive services, including well child visits, annual adult physicals and routine cancer screenings at no cost.

How your plan works

The BlueChoice Advantage Plan POS/PPO offers you the flexibility and freedom to choose from both in and out-of-network providers.

Receiving care inside the CareFirst service area

When care is rendered in Maryland, Washington, D.C. or Northern Virginia, use the CareFirst BlueChoice or CareFirst PPO network to receive the highest level of coverage and pay lower out-of-pocket costs.

Receiving care outside the CareFirst service area

Members seeking care outside the CareFirst service area will lower costs by using a national BlueCard® PPO provider. Members will still have the option to opt-out of this network but will pay a higher out-of-pocket expense.

If you receive services from a provider outside of the BlueCard network, you will have to:

- Pay the provider's actual charge at the time you receive care.
- File a claim for reimbursement.
- Satisfy a deductible and coinsurance.

The choice is entirely yours. That's the advantage of this plan.

Hospital Authorization/Utilization Management

If you are receiving care in Maryland, Washington, D.C. or Northern Virginia, your CareFirst BlueChoice or out-of-network participating provider in the service area will obtain any necessary admission authorizations for in-area covered services.

If you are receiving care outside of Maryland, Washington, D.C. or Northern Virginia, you'll be responsible for obtaining authorization for services. Call toll-free at (866) PREAUTH (773-2884) for authorization.

Your benefits

Step 1: Meet your deductible

Your plan requires you to meet an out-of-network deductible. You will be responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your full benefits will become available to you.

Your plan requires you to meet an out-of-network deductible. Deductible requirements vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Evidence of Coverage for detailed deductible information.

Step 2: Your plan will start to pay for services

After you satisfy your deductible, your plan will start to pay for covered services.

Step 3: Your out-of-pocket maximum or out-of-pocket limit is the maximum amount you'll pay during your benefit period

Should you ever reach your out-of-pocket limit, CareFirst will then pay 100% of the allowed benefit for all covered services for the remainder of the benefit period. Any amount you pay towards your deductible and most copays and/or coinsurance will count towards your out-of-pocket limit.

If more than one person is covered under your plan, once the out-of-pocket limit is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket limit requirements vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Evidence of Coverage for detailed out-of-pocket limit information.

Important terms

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

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

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

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

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

BlueChoice Advantage POS/PPO Summary of Benefits

Services	In-Network You Pay	Out-of-Network You Pay
ANNUAL DEDUCTIBLE[3,8]		
Individual	None	$300
Individual & Child(ren)[5]	None	$600
Individual & Adult	None	$600
Family	None	$600
ANNUAL OUT-OF-POCKET LIMIT[4,7]		
Individual	None	$1,000
Individual & Child(ren)[5]	None	$2,000
Individual & Adult	None	$2,000
Family	None	$2,000
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum Benefit	None	None
PREVENTIVE SERVICES**		
Well-Child Care		
0–24 months	$15 per visit	20% of Allowed Benefit*
24 months–13 years (immunization visit)	$15 per visit	20% of Allowed Benefit*
24 months–13 years (non-immunization visit)	$15 per visit	20% of Allowed Benefit*
14–19 years	$15 per visit	20% of Allowed Benefit*
Adult Physical Examination	$15 per visit	Not covered
Routine GYN Visits**	$15 per visit	Deductible, then 20% of Allowed Benefit*
Mammograms**	No charge[2]	20% of Allowed Benefit*
Cancer Screening6 ** (Pap Test, Prostate and Colorectal)	$15 per visit	Deductible, then 20% of Allowed Benefit*
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	$15 PCP/$20 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Diagnostic Services[6]	$15 PCP/$20 Specialist per visit	Deductible, then 20% of Allowed Benefit*
X-ray and Lab Tests	No charge[2]	Deductible, then 20% of Allowed Benefit*
Allergy Testing[6]	$15 PCP/$20 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Allergy Shots[6]	No charge[2]	Deductible, then 20% of Allowed Benefit*
Outpatient Physical, Speech and Occupational Therapy	$20 per visit (limited to 90 visits/ condition/benefit period)	Deductible, then 20% of Allowed Benefit*
Outpatient Spinal Manipulation	$20 per visit	Deductible, then 20% of Allowed Benefit*

Services	In-Network You Pay	Out-of-Network You Pay
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$20 per visit	Paid as in-network
Urgent Care Center	$20 per visit	Paid as in-network
Hospital Emergency Room	$100 per visit (waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	No charge[2]	Paid in-network
HOSPITALIZATION		
Inpatient Facility Services	No charge[2]	Deductible, then 20% of Allowed Benefit*
Outpatient Facility Services	No charge[2]	Deductible, then 20% of Allowed Benefit*
Inpatient Physician Services	No charge[2]	Deductible, then 20% of Allowed Benefit*
Outpatient Physician Services	No charge[2]	Deductible, then 20% of Allowed Benefit*
HOSPITAL ALTERNATIVES		
Home Health Care (up to 60 visits per calendar year combined in- and out-of-network)	No charge[2]	Deductible, then 20% of Allowed Benefit*
Hospice	No charge[2]	Deductible, then 20% of Allowed Benefit*
Skilled Nursing Facility (up to 60 visits per calendar year combined in- and out-of-network)	No charge[2]	Deductible, then 20% of Allowed Benefit*
MATERNITY		
Prenatal and Postnatal Office Visits	$20 per visit	Deductible, then 20% of Allowed Benefit*
Delivery and Facility Services	No charge[2]	Deductible, then 20% of Allowed Benefit*
Nursery Care of Newborn	No charge[2]	Deductible, then 20% of Allowed Benefit*
Initial Office Consultation(s) for Infertility Services/Procedures	$20 per visit	Deductible, then 20% of Allowed Benefit*
In Vitro Fertilization Procedures1	No charge[2] (limited to 3 attempts/ live birth up to $100,000 lifetime maximum)	Deductible, then 20% of Allowed Benefit* (limited to 3 attempts/ live birth up to $100,000 lifetime maximum)

Services	In-Network You Pay	Out-of-Network You Pay
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)		
Inpatient Facility Services	No charge[2]	Deductible, then 20% of Allowed Benefit*
Inpatient Physician Services	No charge[2]	Deductible, then 20% of Allowed Benefit*
Outpatient Services (MH & SA)	$15 copay	Deductible, then 20% of Allowed Benefit*
Medication Management Visit	$15 per visit	Deductible, then 20% of Allowed Benefit*
MISCELLANEOUS		
Durable Medical Equipment	No charge[2]	Deductible, then 20% of Allowed Benefit*
Acupuncture	$20 per visit for pain therapy	Deductible, then 20% of Allowed Benefit*
Hearing Aids for ages 0-18 (limited to $1,400 max per hearing aid every 3 years)	No charge[2]	No charge[2]

[1] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment option for infertility. However, assisted reproduction (AI & IVF) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.

[2] No copayments or coinsurance.

[3] If you have two-party coverage, each Member must satisfy his/her own deductible by meeting the individual deductible. If you have family coverage, all Members' individual deductibles will be combined to meet the family deductible; however, no individual Member may contribute more than the individual deductible amount.

[4] If you have two-party coverage, each Member must satisfy his/her own out-of-pocket limit by meeting the individual out-of-pocket limit. If you have family coverage, all Members' individual out-of-pocket limits will be combined to meet the family out-of-pocket limit; however, no individual Member may contribute more than the individual out-of-pocket amount.

[5] Please refer to your Evidence of Coverage to determine your coverage level.

[6] If office copayment has been paid, additional copayment not required for this service.

[7] The actual out-of-pocket limit may vary based on the types of coverage selected by your employer.

[8] Copayment or portion of deductible may be required at the point of sale while in the deductible period. Member will never be required to pay more than CareFirst's Allowed Benefit for service rendered.

**Out-of-network coinsurances are based on a percentage of the out-of-network Allowed Benefit. If services are received from a non-participating provider, the member is responsible for 100% of charges above the Allowed Benefit. However, if services are received from a participating provider, the member is only responsible for amount up to the Allowed Benefit.*

***Applies to services not listed in the previous preventive care charts; In-Network only.*

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.

Indemnity Plan Summary of Benefits

Services	Indemnity You Pay
ANNUAL DEDUCTIBLE[3,8]	
Individual Individual & Child(ren)[5] Individual & Adult Family	$200 $400 $400 $400
ANNUAL OUT-OF-POCKET LIMIT[4,7]	
Individual	$1,500
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum Benefit	None
PREVENTIVE SERVICES**	
Well-Child Care 0–24 months 24 months–13 years (immunization visit) 24 months–13 years (non-immunization visit) 14–19 years	 10% of Allowed Benefit* 10% of Allowed Benefit* 10% of Allowed Benefit* 10% of Allowed Benefit*
Adult Physical Examination	10% of Allowed Benefit*
Routine GYN Visits**	10% of Allowed Benefit*
Mammograms**	10% of Allowed Benefit*
Cancer Screening** (Pap Test, Prostate and Colorectal)	10% of Allowed Benefit*
OFFICE VISITS, LABS & TESTING	
Office Visits for Illness	Deductible, then 10% of Allowed Benefit*
Diagnostic Services[6]	Deductible, then 10% of Allowed Benefit*
X-ray and Lab Tests	Deductible, then 10% of Allowed Benefit*
Allergy Testing[6]	Deductible, then 10% of Allowed Benefit*
Allergy Shots[6]	Deductible, then 10% of Allowed Benefit*
Outpatient Physical, Speech and Occupational Therapy	Deductible, then 10% of Allowed Benefit*
Outpatient Spinal Manipulation	Deductible, then 10% of Allowed Benefit*
EMERGENCY CARE AND URGENT CARE	
Physician's Office	Deductible, then 10% of Allowed Benefit*
Urgent Care Center	Deductible, then 20% of Allowed Benefit*
Hospital Emergency Room	Deductible, then $100 per visit copay (waived if admitted)
Ambulance (if medically necessary)	Paid in-network

Services	Indemnity You Pay
HOSPITALIZATION	
Inpatient Facility Services	Deductible, then 10% of Allowed Benefit*
Outpatient Facility Services	Deductible, then 10% of Allowed Benefit*
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit*
Outpatient Physician Services	Deductible, then 10% of Allowed Benefit*
HOSPITAL ALTERNATIVES	
Home Health Care (up to 60 visits per calendar year combined in- and out-of-network)	Deductible, then 10% of Allowed Benefit*
Hospice	Deductible, then 10% of Allowed Benefit*
Skilled Nursing Facility (up to 60 visits per calendar year combined in- and out-of-network)	Deductible, then 10% of Allowed Benefit*
MATERNITY	
Prenatal and Postnatal Office Visits	Covered in full
Delivery and Facility Services	Deductible, then 10% of Allowed Benefit*
Nursery Care of Newborn	Deductible, then 10% of Allowed Benefit*
Initial Office Consultation(s) for Infertility Services/ Procedures	Deductible, then 10% of Allowed Benefit*
In Vitro Fertilization Procedures[1]	Deductible, then 10% of Allowed Benefit* (limited to 3 attempts/live birth up to $100,000 lifetime maximum)
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)	
Inpatient Facility Services	Deductible, then 10% of Allowed Benefit*
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit*
Outpatient Services (MH & SA)	Deductible, then 10% of Allowed Benefit*
Medication Management Visit	Deductible, then 10% of Allowed Benefit*
MISCELLANEOUS	
Durable Medical Equipment	Deductible, then 20% of Allowed Benefit*
Acupuncture	Deductible, then 20% of Allowed Benefit*
Hearing Aids for ages 0-18 (limited to $1,400 max per hearing aid every 3 years)	No charge[2]

[1] *Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment option for infertility. However, assisted reproduction (AI & IVF) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.*

[2] *No copayments or coinsurance.*

[3] *If you have two-party coverage, each Member must satisfy his/her own deductible by meeting the individual deductible. If you have family coverage, all Members' individual deductibles will be combined to meet the family deductible; however, no individual Member may contribute more than the individual deductible amount.*

[4] *If you have two-party coverage, each Member must satisfy his/her own out-of-pocket limit by meeting the individual out-of-pocket limit. If you have family coverage, all Members' individual out-of-pocket limits will be combined to meet the family out-of-pocket limit; however, no individual Member may contribute more than the individual out-of-pocket amount.*

[5] *Please refer to your Evidence of Coverage to determine your coverage level.*

[6] *If office copayment has been paid, additional copayment not required for this service.*

[7] *The actual out-of-pocket limit may vary based on the types of coverage selected by your employer.*

[8] *Copayment or portion of deductible may be required at the point of sale while in the deductible period. Member will never be required to pay more than CareFirst's Allowed Benefit for service rendered.*

**Out-of-network coinsurances are based on a percentage of the out-of-network Allowed Benefit. If services are received from a non-participating provider, the member is responsible for 100% of charges above the Allowed Benefit. However, if services are received from a participating provider, the member is only responsible for amount up to the Allowed Benefit.*

*** Applies to services not listed in the previous preventive care charts; In-Network only.*

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.

BlueChoice HMO *Open Access*

An HMO plan with no referrals required

With a BlueChoice HMO *Open Access* plan, your primary care provider (PCP) provides preventive care and works with you to find specialty care using a large network of CareFirst BlueChoice specialists. However, unique to this plan is its Open Access feature which allows you to visit specialists directly without needing a referral from your PCP.

Benefits of BlueChoice HMO *Open Access*

- Choose from more than 37,000 providers, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- HMO plans encourage you to establish a relationship with your PCP for consistent, quality care.
- No PCP referral required to see a specialist.
- Receive comprehensive coverage for preventive health care visits at no cost.
- Avoid the unwelcome surprise of high medical costs with predictable copays and deductibles (if applicable).
- Save time—you don't have to file a claim when you receive care from a CareFirst BlueChoice provider.
- Avoid balance billing when you receive care from a CareFirst BlueChoice provider.
- Access the Away From Home Care® program to enjoy plan benefits if you're out of the area for at least 90 days.

The BlueChoice HMO plan achieved a "Commendable" rating from the National Committee for Quality Assuarcnce (NCQA).

How your plan works

Establishing a relationship with one provider is the best way for you to receive consistent, quality health care. When you enroll in a BlueChoice HMO *Open Access* plan, you will select a PCP to manage your primary medical care. Make sure you select

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a PCP for not only yourself but each of your family members as well. Your PCP must participate in the CareFirst BlueChoice provider network and must specialize in either family practice, general practice, pediatrics or internal medicine.

To ensure you receive the highest level of benefits (and pay the lowest out-of-pocket cost), you should first call your PCP when you need care.

Your PCP will:

- Provide basic medical care.
- Prescribe any medications you need.
- Maintain your medical history.
- Work with you to determine when you should see a specialist.
- Assist you in the selection of a specialist, if needed.

While traditional HMO plans require you to obtain a written referral from your PCP before seeing a specialist, this plan has an Open Access feature, so you have direct access to CareFirst BlueChoice specialists without needing a written referral from your PCP. Make sure you only receive care from a CareFirst BlueChoice provider or you will not be covered, with the exception of emergency services and follow-up care after emergency surgery.

Your benefits

Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you pay during your benefit period. Should you ever reach your out-of-pocket maximum, CareFirst BlueChoice, Inc. will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Any amount you pay toward your deductible (if applicable) and most copays and/or coinsurance will count toward your out-of-pocket maximum.

If more than one person is covered under your BlueChoice HMO *Open Access* plan, once the total out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family). Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

Laboratory services

To receive the maximum laboratory benefit from your BlueChoice HMO *Open Access* plan, you must use a LabCorp® facility for any laboratory services. Services performed at a facility that is not part of the LabCorp network may not be covered under your plan. Also, any lab work performed in an outpatient hospital setting will require a prior authorization from your PCP.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call 888-LAB-CORP (522-2677) or visit **www.labcorp.com**.

Out-of-area coverage

Out-of-area coverage is limited to emergency or urgent care only. However, members and their covered dependents planning to be out of the CareFirst BlueChoice, Inc. service area for at least 90 consecutive days may be able to take advantage of a special program, Away From Home Care®.

This program allows temporary benefits through another Blue Cross and Blue Shield affiliated HMO. It provides coverage for routine services and is perfect for extended out-of-town business or travel, semesters at school or families living apart. For more information on Away From Home Care, please call Member Services at the phone number listed on your identification card.

BlueChoice HMO *Open Access* Summary of Benefits

Services	In-Network You Pay
PREVENTIVE SERVICES AND OFFICE VISITS	
Routine/Preventive health exams**	$10 PCP/$15 specialist
Physician office visits	$10 PCP/$15 specialist
Well-child care including immunizations and boosters**	$10 copay per visit
Colorectal screening**	$10 PCP/$15 specialist
Gynecological visit	$10 PCP/$15 specialist (no charge Pap smears)
Family planning and infertility benefits (including infertility testing, infertility and contraceptive counseling and intrauterine insemination)	$10 PCP/$15 specialist
Artificial insemination and in-vitro fertilization	50% of Plan Allowance services subject to limitations as described in certificate of coverage
Allergy testing	$15 copay per visit/$25 copay per testing series
Allergy shots	$10 PCP/$15 specialist
Annual eye exam (non-routine)	$25 ophthalmologist
Hearing test (covered for all ages)	$10 PCP/$15 specialist
Hearing aids for children under the age of 18 (For each ear every 36 months if prescribed, fitted and dispensed by a licensed audiologist)	100% of Plan Allowance less $15 office visit copay
Outpatient Physical, Speech and Occupational Therapy (limited to 30 visits per calendar year)	$15 copay per visit
MEDICAL AND SURGICAL SERVICES	
Outpatient physician services (specialist)	$15 copay per visit
Outpatient surgery	$10 PCP/$15 specialist (Facility covered in full)
Morbid obesity surgery	$10 PCP/$15 specialist
Diagnostic tests, X-ray and lab tests at participating facilities	Covered in full
Chemotherapy (outpatient)	$15 copay per visit
Radiation therapy (outpatient)	$15 copay per visit
Renal dialysis	$15 copay per visit

Services	In-Network You Pay
HOSPITALIZATION (365 days per year)	
Room & Board (semi-private room)	Covered in full
Physician services	Covered in full
Prescription drugs (inpatient)	Covered in full
Ancillary services	Covered in full
MATERNITY	
Prenatal and postnatal care	$15 copay per visit
Delivery and hospitalization	Covered in full
Nursery care of newborn	Covered in full
MENTAL HEALTH/ALCOHOL AND SUBSTANCE ABUSE	
Outpatient visits	$10 copay
Hospitalization (includes halfway house)	Covered in full
Partial hospitalization	100%
Medication management	$10 copay per visit (outpatient visit PCP copay)
EMERGENCY SERVICES	
In plan urgent care center	$15 copay
In plan physicians office	$10 PCP/$15 specialist
Emergency room	$100 (waived if admitted)
SKILLED NURSING FACILITY	
Room, board and physician and medical services	Covered in full
HOSPICE CARE	
Inpatient facility or at-home care	Covered in full
Home Health Care	Covered in full
MISCELLANEOUS SERVICES	
Ambulance	Covered in full
Medical devices (including durable medical equipment)	25% of Plan Allowance
Spinal Manipulation (up to 20 visits per calendar year)	$15 copay
Diabetic Educating/Training	$15 copay
Diabetic Supplies (Unlimited)	100% of Plan Allowance

Note: This summary is for comparison purposes only and does not create rights not given through the benefit plan.
** All services are reimbursed at the Plan Allowance.*
*** Applies to services not specifically listed in the previous preventive care charts; In-Network only.*

What Medicare Does and Doesn't Cover

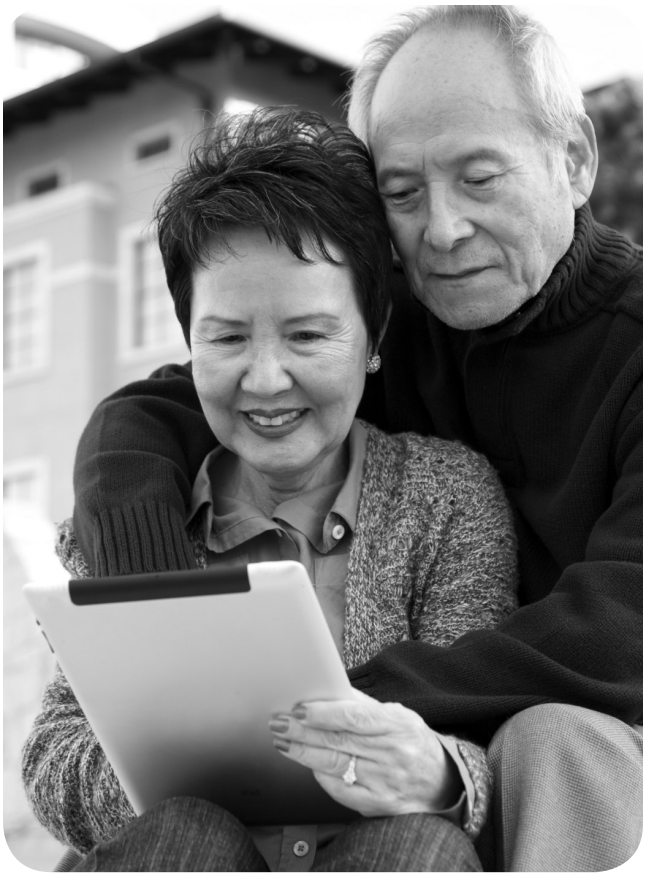
What does Medicare cover?

Medicare has two parts, A and B. Medicare Part A (hospital insurance) partially pays for medically necessary:

- Inpatient hospital facility charges.
- Care in a skilled nursing facility after a hospital stay.
- Home health care provided by a Medicare—participating home health agency.
- Hospice care for the terminally ill.

Medicare Part B (medical services insurance) partially pays for medically necessary:

- Physician's services.
- Outpatient hospital services.
- Home health visits.
- Physical and speech therapy.
- Services and supplies covered by Medicare, such as x-rays and durable medical equipment.



What isn't covered by Medicare?

Medicare does not pay the full cost of all covered services. Medicare requires that you pay a share of the costs in the form of deductibles and coinsurance/copays.

What You'll Need to File Claims

You never have to submit a claim to Medicare. By law all providers must file these claims for you. And that applies to non-participating providers as well as participating providers.

If I receive care in Maryland, will I have to file any claims to CareFirst?

You will not have to file any claims with CareFirst for covered services if you receive the services in Maryland, Washington, D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. While you may be asked to fill out claim forms for the provider, you will not have to submit the claims yourself.

CareFirst electronically receives claims from Medicare for covered services received in Maryland, Washington, D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. That means that your claims automatically come to us from Medicare when you give your CareFirst membership number to your provider at the time you receive care.

Make sure that you always give your CareFirst membership number to your provider when you give your Medicare membership number. Without your CareFirst number, Medicare won't know to forward your claim information to us. You will then have to file your own claim.

Will I have to file any claims to CareFirst if I receive care outside of the states listed above?

Yes, your providers will file your Medicare claims for you. That's the law. But you will have to file claims with CareFirst to get benefits from your plan.

Here's what you should do. After Medicare has paid its share, you will receive an "Explanation of Medicare Benefits" (EOMB). Make copies of this form and of your bills for each claim. Do not send the original EOMB and medical bills. Keep the originals in your files. Claims rarely get lost, but if that should happen, you can resubmit your claim if you have kept the originals.

Send a copy of the EOMB, your bills and a completed claim form to the following address:

- CareFirst Blue Cross Blue Shield
  Mail Administrator
  P.O. Box 14114
  Lexington, KY 40512

What if I need a claim form or help submitting a claim?

Just call your CareFirst customer service representative. The numbers to call are (410) 581-3539 or (888) 417-8385. You can also call these numbers if you want to find out if your claim has been received.

Is there a deadline for filing claims?

The Medicare timely filing period is 12 months from the date of service.

What happens if my claim arrives after the deadline?

Your claim will not be covered, and you will not receive payment. So be sure to file your claim right away.

Words You Need to Know

Approved amount

The amount that Medicare allows participating providers to be paid for Medicare-covered services. Payments are made according to the Medicare fee schedule. Participating providers agree to accept the approved amount as payment in full for covered services. Non-participating providers can charge you more than this amount for your care (see limiting charge). The "approved amount" also may be called the "allowed amount" or "assignment".

Coinsurance

Some services require that you pay a percentage of the costs for your medical care.

Some services require that you pay a set-dollar amount for your care. For example, under Medicare Part A, you must pay a set amount per day for inpatient hospital care after you've been hospitalized for over 60 days.

Your plan pays the Part A coinsurance for you.

Deductibles

Some services require that you pay a deductible before Medicare begins to pay.

Limiting charge

Some providers do not accept the Medicare approved amount as payment in full for Medicare-covered services. To protect you from high charges for these services, Medicare limits the amount that these non-participating providers can bill you. The limiting charge does not apply to any of the Traditional Medicare Supplemental Plan benefits that Medicare does not cover.

Medicare fee schedule

In general, payments for services are made according to the standard Medicare-approved fee schedule.

Medicare participating provider

Physicians and suppliers who agree to always accept the Medicare approved amount as payment in full for services. (You still pay deductibles and coinsurance.) Medicare participating providers can charge you full price for services that Medicare does not cover.

Medicare non-participating provider

Other physicians and suppliers who do not agree to always accept the Medicare Non-Participating approved amount as payment in full for services. Medicare limits the amount that non-participating providers can charge for Medicare-covered services. If you choose to see a non-participating provider, you must pay any difference between the limiting charge and the Medicare approved amount.

Provider

Any licensed doctor, nurse or professional. A provider may also be a health care facility, such as a hospital, laboratory or clinic.

CareFirst BlueChoice Advantage Medicare Summary of Benefits

Benefits	Costs	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment
FACILITY		
Inpatient Hospital Days 1–60 Days 61–90 Lifetime reserve	Part A initial deductible – $1,216 $304 per day $608 per day	$1,216 $304 per day $608 per day
Skilled Nursing Facility Days 1–20 Days 21–100	None $152 per day	None $152 per day
Home Health	None	None
Hospice Care	Medicare pays most charges. Remaining costs include drug copayment and limited cost for respite care.	Remaining cost
PHYSICIAN SERVICES		
Inpatient	20% of Medicare's approved amount and Part B deductible if accepting assignment	100% up to CareFirst allowed benefit
Emergency	20% of Medicare's approved amount and Part B deductible	Plan pays the Medicare Part B deductible and 20% Medicare coinsurance after $100 copay for emergency visit (waived if admitted)
Surgery	20% of Medicare's approved amount and Part B deductible	Plan pays the Medicare Part B deductible and 20% Medicare coinsurance after $15 copay for PCP and $20 copay for specialist
Laboratory Services	$0	Not applicable
Radiology Services (Inpatient)	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit
Radiology Services (Outpatient or Office)	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit
Office Visit	20% of Medicare's approved amount and Part B deductible	Plan pays the Medicare Part B deductible and 20% Medicare coinsurance after $15 copay for PCP and $20 copay for specialist

Benefits	Costs	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment
OFFICE THERAPY		
Radiation/Chemotherapy	20% of Medicare's approved amount	Plan pays the Medicare Part B deductible and 20% Medicare coinsurance after $15 copay for PCP and $20 copay for specialist
Physical Therapy	20% of Medicare's approved amount and Part B deductible	Plan pays the Medicare Part B deductible and 20% Medicare coinsurance after $15 copay for PCP and $20 copay for specialist
OTHER SERVICES		
Ambulance Services	20% of Medicare's approved amount and Part A/B deductible	100% up to allowed benefit
Durable Medical Equipment	20% of Medicare's approved amount and Part A/B deductible	100% up to allowed benefit
Prosthetic Appliances	20% of Medicare's approved amount deductible	Plan pays the Medicare Part B deductible and 20% Medicare coinsurance after $15 copay for PCP and $20 copay for specialist
Whole Blood (Part A — Paid in full; Part B — 3 pint deductible)	20% of Medicare's approved amount and Part A/B deductible	100% up to allowed benefit
Medical Supplies	20% of Medicare's approved amount and Part A/B deductible	100% up to allowed benefit
Mammograms	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare

- The Medicare deductibles and coinsurance amounts shown are based on 2014 figures. Your benefits will automatically adjust to meet any amounts that change in 2015.
- CareFirst's allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge.
- If Medicare benefits are exhausted, or service is not covered by Medicare, CareFirst Medicare Plan benefits may be provided.
- Blue Cross and Blue Shield benefits for inpatient hospital services are provided for 90 days per inpatient stay with a 60-day renewal interval. That is, an inpatient stay will be one stay if discharge date and readmission date are not separated by at least 60 days.

Preferred Dental

Includes access to a national provider network

CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice)[1] offer Preferred (PPO) Dental coverage, which allows the freedom to see any dentist you choose.

Advantages of the plan

- **Freedom of choice, freedom to save—**With Preferred Dental coverage, you can see any dentist you choose. However, this plan also gives you the option to reduce your out-of-pocket expenses by visiting a dentist who participates in our Preferred Provider network. It's your choice!
- **Comprehensive coverage—**Benefits include regular preventive care, X-rays, dental surgery and more.
- **Nationwide access to participating dentists—**You have access to one of the nation's largest dental networks, with more than 95,000 participating dentists throughout the United States. Preferred Dental gives you coverage for the dental services you need, whenever and wherever you need them.

Three options for care

- **Option 1**—By choosing a dentist in the Preferred Provider Network, you incur the lowest out-of-pocket costs. These dentists accept CareFirst's allowed benefit as payment in full, which means no balance billing for you.
- **Option 2**—You can receive out-of-network coverage from a dentist who participates with CareFirst, but not through the Preferred Provider Network. Similar to Option 1, there is no balance billing. You are responsible for out-of-network deductibles and coinsurance, and also have the convenience of your provider being reimbursed directly.
- **Option 3**—You can receive out-of-network coverage from a dentist who has no relationship with CareFirst. With this option, you may experience higher out-of-pocket costs since you pay your provider directly. You can be balance billed and must pay your deductible and coinsurance as well.

[1] *The CareFirst BlueChoice Dental Plan is offered in conjunction with Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield, which contracts with participating dentists and provides claims processing and administrative services under the Dental Plan.*

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Preferred Dental

Includes access to a national provider network

Frequently asked questions

How do I find a preferred dentist?

You can access an online directory 24 hours a day at **www.carefirst.com/doctor**. Click on the Dental tab, followed by Preferred Dental (PPO).

How much will I have to pay for dental services?

The chart on the following page gives you an overview of many of the covered services along with the percentage of what you will pay for each class of services, both in and out-of-network.

Is there a lot of paperwork?

There is no paperwork when you see a participating dentist, you are free from filing claims. However, if you use a non-participating dentist, you may be required to pay all costs at the time of care, and then submit a claim form in order to be reimbursed for covered services.

Who can I call with questions about my dental plan?

Call Dental Customer Service toll free at: 888-755-2657 between 8:30 am and 5:15 pm ET, Monday–Friday.

Preferred Dental Summary of Benefits

		In-Network Carefirst Pays	Out-of-Network Carefirst Pays
MAXIMUM ANNUAL BENEFIT		$2,000 (combined in-and out-of-network)	
ANNUAL DEDUCTIBLE ■ Class I ■ Class II & Class III ■ Class IV		None $50 $50	None $100 $100
PREVENTIVE & DIAGNOSTIC SERVICES (CLASS I)			
■ Oral Exams (three per benefit period) ■ Prophylaxis (two cleanings per benefit period) ■ Bitewing X-rays ■ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months)	■ Fluoride treatments (two per benefit period per member, until the end of the year the member reaches the age 19) ■ Sealants on permanent molars (once per tooth per 36 months per member, until the end of the year the member reaches the age 16) ■ Space maintainers (once per 60 months) ■ Palliative emergency treatment	100% of Allowed Benefit[1]	80% of Allowed Benefit[1]
BASIC SERVICES (CLASS II)			
■ Direct placement fillings using approved materials (one filling per surface per 12 months)	■ Periodontal scaling and root planing (once per 24 months, one full mouth treatment) ■ Simple extractions	100% of Allowed Benefit after deductible[1]	80% of Allowed Benefit after deductible[1]
MAJOR SERVICES – SURGICAL (CLASS III)			
■ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) ■ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy)	■ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section) ■ General anesthesia rendered for a covered dental service ■ Removal of impacted teeth	100% of Allowed Benefit after deductible[1]	80% of Allowed Benefit after deductible[1]

		In-Network Carefirst Pays	Out-of-Network Carefirst Pays
MAJOR SERVICES – RESTORATIVE (CLASS IV)			
■ Full and/or partial dentures (once per 60 months) ■ Fixed bridges, crowns, inlays and onlays (once per 60 months) ■ Denture adjustments and relining (limits apply for regular and immediate dentures)	■ Recementation of crowns, inlays and/or bridges (once per 12 months) ■ Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance)	50% of Allowed Benefit after deductible[1]	40% of Allowed Benefit after deductible[1] ($400 maximum benefit per service)

[1] *NOTE: CareFirst and CareFirst BlueChoice payments are based on the CareFirst and CareFirst BlueChoice Allowed Benefit. Participating and Preferred Dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.*

BlueVision *Plus*

A plan for healthy eyes, healthy lives

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

How the plan works

How do I find a provider?

To find a provider, go to **www.carefirst.com** and utilize the *Find a Provider* feature or call Davis Vision at **800-783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

How do I receive care from a network provider?

Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueCross BlueShield or CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

What if I go out-of-network?

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

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

With BlueVision *Plus*, the benefit covers one pair of eyeglasses or a supply of contact lenses per benefit period.

Mail order replacement contact lenses

Free membership and access to a mail order replacement contact lens service provides a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1-855-589-7911 or visit **www.davisvisioncontacts.com**.

Need more information?
Please visit **www.carefirst.com**
or call **800-783-5602.**

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BlueVision *Plus* Summary of Benefits

(18-month benefit period)

In-Network	You Pay
EYE EXAMINATIONS	
Routine Eye Examination with dilation (per benefit period)	Plan pays up to $25 allowance Optometrist; $33 Ophthalmologist; you pay balance.
FRAMES	
Davis Vision Frame Collection	No copay
Non-Collection Frame	Plan pays up to $20 allowance, you pay balance
SPECTACLE LENSES	
Basic Single Vision (inluding lenticular lenses)	Plan pays up to $20 allowance, you pay balance
Basic Bifocal	Plan pays up to $35 allowance, you pay balance
Basic Trifocal	Plan pays up to $45 allowance, you pay balance
In-Network	**You Pay**
CONTACT LENSES *(initial supply)*	
Medically Necessary Contacts	Plan pays up to $230 allowance with prior approval, you pay balance
Davis Vision Contact Lens Collection	Plan pays up to $40 allowance, you pay balance
In-Network	**You Pay**
LENS OPTIONS[1] *(add to spectacle lens prices above)*	
Standard Progressive Lenses	$65
Premium Progressive Lenses (Varilux®, etc.)	$105
Polarized Lenses	$75
High Index Lenses	$60
Polycarbonate Lenses for children, monocular and high prescription	No copay
Polycarbonate Lenses for all other patients	$35
Scratch-Resistant Coating	included
Standard Anti-Reflective (AR) Coating	$40
Premium AR Coating	$55
Ultra AR Coating	$69
Ultraviolet (UV) Coating	$15
Tinting	$15
Plastic Photosensitive Lenses	$70

In-Network	You Pay
CONTACT LENSES[1] *(mail order)*	
DV Contacts Mail Order Contact Lens Replacement Online	Up to 40% off retail price
LASER VISION CORRECTION[1]	Up to 25% off allowed amount or 5% off any advertised special[2]

Out-of-Network	You Pay
Routine Eye Examination with dilation (per benefit period)	Plan pays $25 Optometrist; $33 Ophthalmologist; you pay balance
Frames	Plan pays $20, you pay balance
Single Lenses	Plan pays $20, you pay balance
Bifocal Lenses	Plan pays $35, you pay balance
Trifocal Lenses	Plan pays $45, you pay balance
Lenticular (post-cataract) Eyeglass Lenses	Plan pays $120, you pay balance
Medically Necessary Contacts	Plan pays $230, you pay balance
Elective Contact Lenses	Plan pays $40, you pay balance

[1] *These services or supplies are not considered covered benefits under the Plan. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland may no longer provide these discounts.*

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

Exclusions

The following services are excluded from coverage:

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

FirstHelp™

24-hour health care advice line

Anytime, day or night, you can speak with a FirstHelp nurse. Registered nurses are available to answer your health care questions and help guide you to the most appropriate care.

How FirstHelp™ works

Simply call 800-535-9700 and a registered nurse will:

- Ask about your symptoms.
- Help you decide on the best source of care.

When to call FirstHelp™

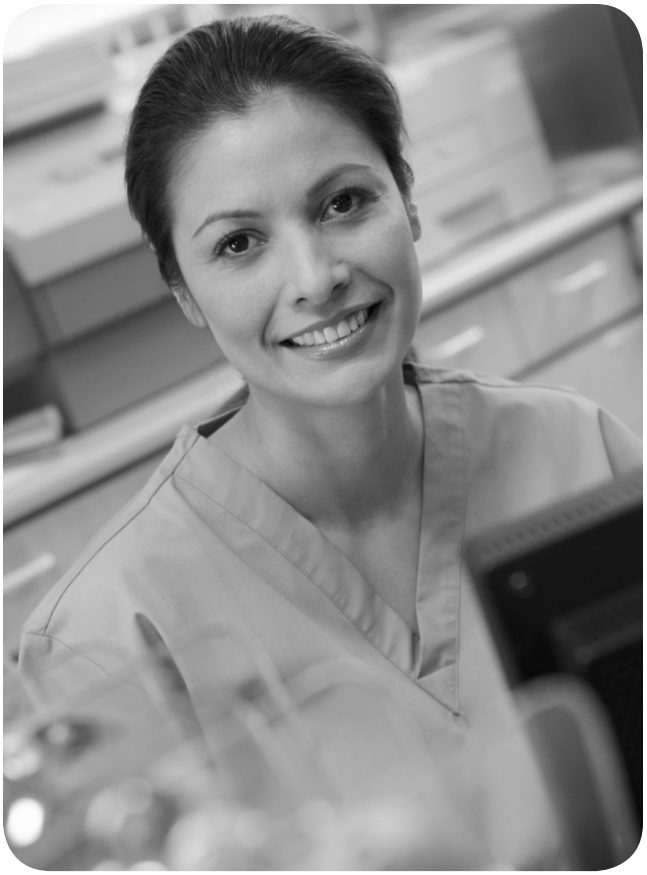
First, you should call your doctor when you have a health concern. If you can't reach your doctor and have questions about your health, an illness or an urgent medical condition, a registered FirstHelp™ nurse is available to answer your questions and assist you in determining your options.

If you have an emergency and can't safely wait to speak with your doctor, call 911 or go to the nearest emergency room.

FirstHelp nurses won't be able to answer questions about the following:

- Your benefits and what is covered by your health care plan.
- Information on your claims.
- Pre-authorizations.

If you have questions about your benefits or claims, please call the Member Services number listed on the back of your ID card. If you need authorization for a service, please call the appropriate number listed on the back of your ID card.



FirstHelp™ 24 Hours
800-535-9700

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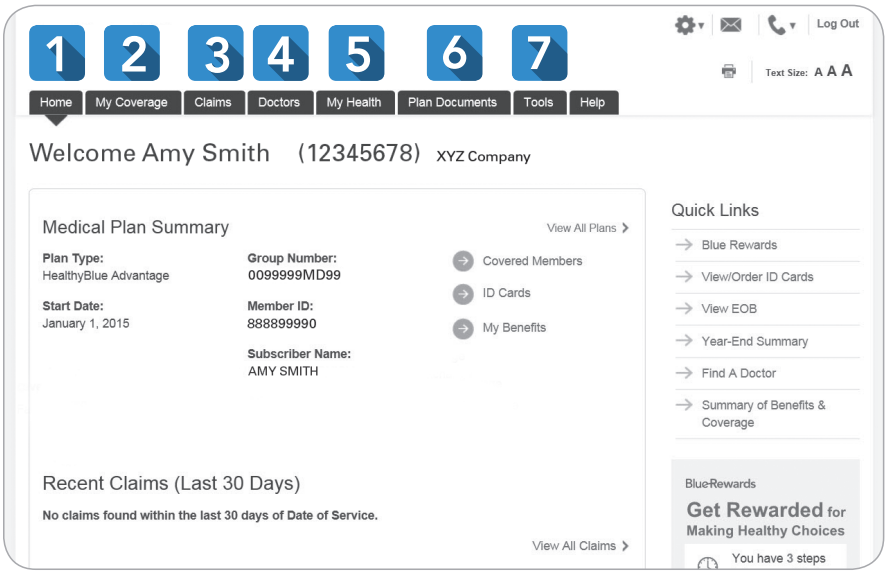
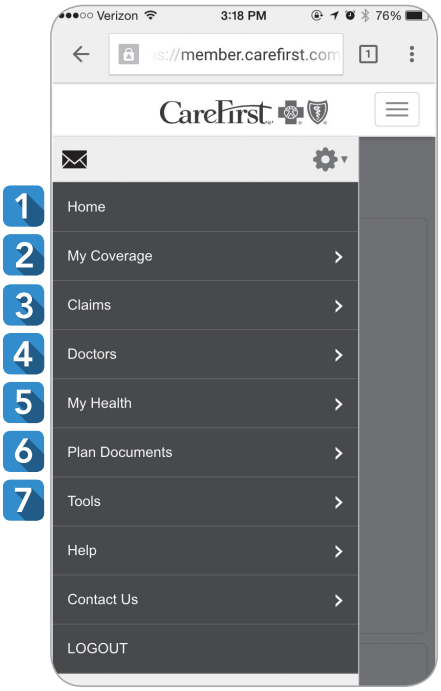
My Account

Online access to your health care information

View your personalized health insurance information online with *My Account.* Simply log on to **www.carefirst.com** from your computer, tablet or smartphone for real-time information about your plan.



As viewed on a computer.



As viewed on a smartphone.

My Account at a glance

1. Home

- Quickly view your coverage, deductible, copays, claims and out-of-pocket costs
- Use *Settings* ⚙ to manage your password and communications preferences
- Access the Message Center ✉

2. My Coverage

- Access your plan information, including who is covered
- Update your other health insurance info
- View/order ID cards
- Oversee your BlueFund account

Signing up is easy

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

- Visit **www.carefirst.com**
- Select *Register Now*
- Create your User ID and Password

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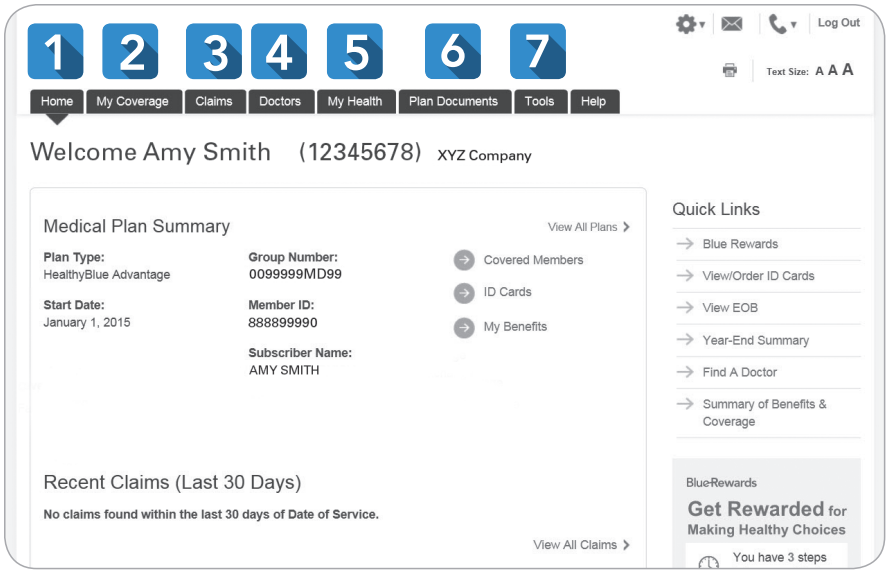
My Account

Online access to your health care information



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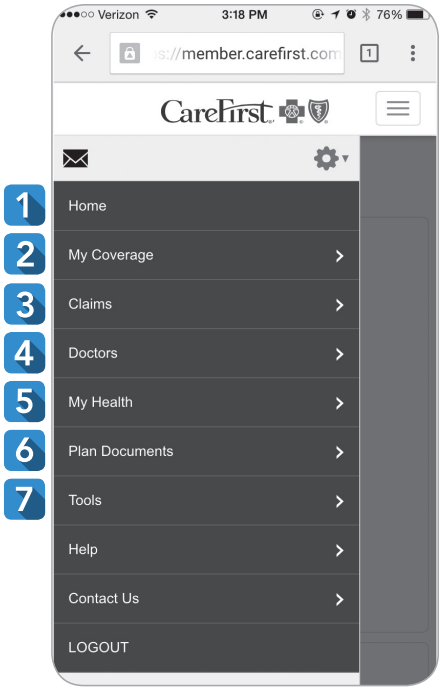


As viewed on a smartphone.

3. Claims

- Check your paid claims, deductible and out-of-pocket totals
- Research your Explanation of Benefits (EOBs) history
- Review your year-end claims summary

4. Doctors

- Select or change your primary care provider (PCP)
- Search for a specialist

5. My Health

- Learn about your wellness program options*
- Locate an online wellness coach*
- Track your Blue Rewards progress

6. Plan Documents

- Look up your forms and other plan documentation*
- Review your member handbook*

7. Tools

- Treatment Cost Estimator
- Hospital comparison tool*

**These features are available only when using a computer at this time.*

Coordination of Benefits

If you're covered by more than one health plan

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

What is Coordination of Benefits (COB)?

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

- You and your spouse have coverage under your employer's plan.
- Your spouse also has coverage with another health insurance plan through his or her employer.
- When you're covered by more than one plan, we coordinate benefit payments with the other health care plan to make sure you receive the maximum benefits entitled to you under both plans.

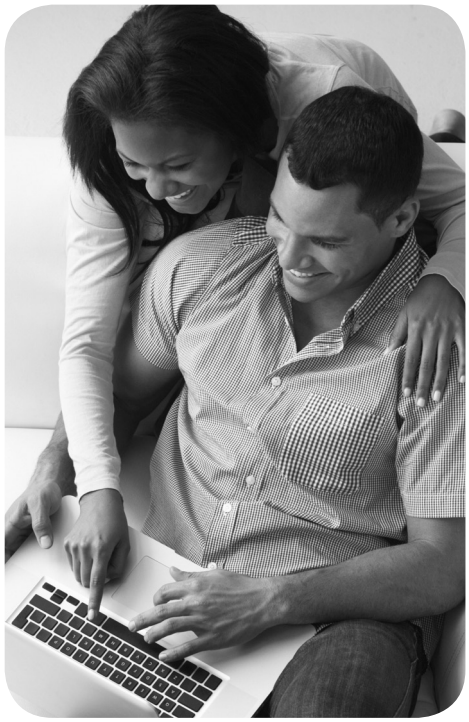
How does COB work?

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

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

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

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



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

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What if I have other coverage?

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

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

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

How do I submit claims?

When CareFirst is the primary plan

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

When CareFirst is the secondary plan

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

When CareFirst is the primary and secondary plan

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

Which health plan is primary?

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

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

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

health+wellness
take charge.

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

Online health education

Find a wide variety of health education articles, nutritious recipes and cooking videos, interactive health-related tools and more at **www.carefirst.com/livinghealthy.**

FirstHelp™

Registered nurses are available 24 hours a day to answer your health care questions. Call 800-535-9700 with your health questions or for help choosing the best source of care.

Vitality magazine

Vitality provides 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.**

Wellness discount program

Blue365 delivers great discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and more. Visit **www.carefirst.com/wellnessdiscounts.**

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

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Health news

Get the latest information to help you and your family maintain a healthy lifestyle. To sign up for our monthly electronic member newsletter, visit **www.carefirst.com/healthnews.**

Pedometer app

Count your steps, distance traveled and calories burned for each workout with the free CareFirst Ready, Step, Go! app. The app is available for iPhone™, iPod Touch™, or Android™ smartphones—visit your app store and search for "Ready, Step, Go!"

Coordinating your care

Whether you're trying to get healthy or stay healthy, you need the best care. CareFirst has programs to help you take an active role in your health, address any health care issues and enjoy a healthier future.

Patient-Centered Medical Home (PCMH)

PCMH was designed to provide your primary care provider with a more complete view of your health needs, as well as the care you receive from other providers. When you participate in this program, you are the focus of an entire health care team whose goal is to better manage and coordinate your care and improve your health.

If you have a chronic condition, or are at risk for one, your PCP may:

- Create a care plan based on your health needs with specific follow-up activities to help you manage your health
- Provide access to a care coordinator, who is a registered nurse, so you have the support you need, answers to your questions and information about your care

Find a participating PCMH provider in our provider directory at **www.carefirst.com/findadoc**.

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 are registered nurses who will:

- Work closely with you and your doctors to develop a personalized treatment plan.
- Coordinate necessary services.
- Answer any of your questions.

Our Case Management program is voluntary and confidential. For more information, or to enroll, call 888-264-8648.

Rights & Responsibilities

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

Notice of privacy practices

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

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

Member satisfaction

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

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

To write to us directly with a quality of care or service concern, you can:

- ☐ Send an email to: **quality.care.complaints@carefirst.com**
- ☐ Fax a written complaint to: (301) 470-5866
- ☐ Write to: **CareFirst BlueCross BlueShield Quality of Care Department, P.O. Box 17636 Baltimore, MD 21297**

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

These procedures are also outlined in your Evidence of Coverage.

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

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

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

Hearing impaired

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

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

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

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

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

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

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

Language assistance

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

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

Confidentiality of subscriber/ member information

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

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

Our responsibilities

We are required by law to maintain the privacy of your PHI, and to have appropriate procedures in place to do so. In accordance with the federal and state Privacy laws, we have the right to use and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We may disclose your protected health information to the plan sponsor/employer to perform plan administration function. The Notice is sent to all policy holders upon enrollment.

Your rights

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

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

Inquiries and complaints

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

Members' rights and responsibilities statement

Members have the right to:

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

Members have a responsibility to:

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

Eligible individuals' rights statement wellness and health promotion services

Eligible individuals have a right to:

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

Habilitative services

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

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

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

Mastectomy-related services

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

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

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

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

Care for mothers, newborns

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

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

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

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

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

CareFirst BlueCross BlueShield
CareFirst BlueChoice, Inc.
10455 Mill Run Circle
Owings Mills, MD 21117-5559

www.carefirst.com

Health benefits administered by:

CareFirst

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