



CareFirst BlueChoice, Inc.
BlueChoice HMO
Open Access

Your Member Handbook

BlueChoice HMO *Open Access*

Thank you for choosing BlueChoice HMO *Open Access*. We are committed to providing our members and their families with the highest level of service possible and hope that the information included in this handbook will assist you in understanding your CareFirst BlueChoice Inc. (CareFirst BlueChoice) HMO *Open Access* benefits and options.

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

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

Keep in a safe place for future reference.



You may also view this handbook online at www.carefirst.com in the *Members & Visitors* section.

Important Information

Member Services

Please call the Member Services telephone number listed on your member identification card. Our service hours are:

Monday – Friday, 7:00 am – 7:00 pm EST
Saturday, 8:00 am – 1:00 pm EST

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

Contact Member Services for benefit and contract information.

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

CareFirst BlueChoice, Inc.
P.O. Box 644
Owings Mills, MD 21117-9998

Please refer to the Evidence of Coverage for specific terms, conditions, limitations and exclusions.



Emergency Assistance and Medical Advice

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

FirstHelp® Health Care Advice Line

(24 hours a day) Toll-free: (800) 535-9700

Hospital Authorization/Utilization Management

Your CareFirst BlueChoice provider should obtain any necessary admission authorizations for covered services. Toll-free: (866) PREAUTH (773-2884)

Mental Health/Substance Abuse Care

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

Additional Telephone Numbers

Pharmacy Benefits (Argus Health Systems)*
(800) 241-3371

Vision Benefits (Davis Vision)*
(800) 783-5602

Away From Home Care®
(888) 452-6403

**Your coverage may not include these benefits. Refer to your Evidence of Coverage for details.*

Contents

Welcome to CareFirst BlueChoice HMO <i>Open Access</i>	1
Frequently Asked Questions	2
When You Need Care	5
■ Your Primary Care Physician ■ No Referrals Needed for Specialists ■ Medical Records	
■ Scheduling Appointments ■ Canceling Appointments ■ Laboratory Services	
CareEssentials.....	7
■ Prevention ■ <i>Vitality</i> Newsletter ■ Get Healthy With <i>My Care First</i>	
■ <i>Great Beginnings</i> Program for Expectant Mothers ■ Preventive Services Guidelines	
■ Utilization Management ■ Hospital Care ■ Disease Management Programs ■ Case Management Program	
Options Discount Program	10
■ Discounts on Alternative Therapies and Wellness Services	
Emergency and Urgent Care.....	13
■ Medical Emergencies ■ Urgent Care ■ FirstHelp® Medical Advice Line	
■ BlueCard® Program for Out-of-Area Emergency and Urgent Care ■ Follow-Up Care	
■ The Away From Home Care® Program	
Seeing Mental Health Specialists	16
■ Exclusions	
Additional Benefits	17
■ Dental Benefits ■ Prescription Benefits ■ Vision Benefits	
Administration of Your Plan.....	20
■ Personal and Enrollment Changes ■ Filing a Claim for Reimbursement ■ Provider Reimbursement	
■ Other Insurance ■ Member Satisfaction	
Appeals Process.....	22
Your Coverage.....	23
■ Ending Your Coverage ■ Continuing Your Coverage ■ New Technology Assessment	
Portability (HIPAA).....	24
Confidentiality	25
■ Our Responsibilities ■ Notice of Privacy Practices ■ Your Rights	
Member Rights and Responsibilities	26
■ Rights of Members ■ Responsibilities of Members	
HSA, HRA and Compatible Plans	27
Definition of Terms	32
Index.....	34

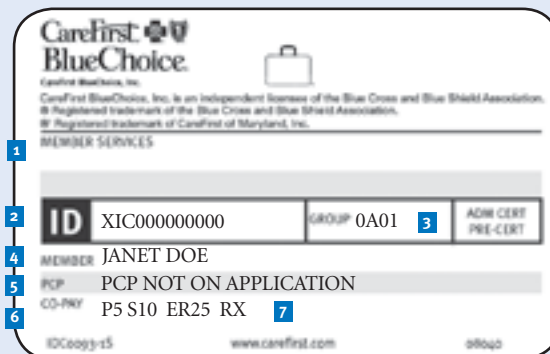
Welcome to BlueChoice HMO Open Access

CareFirst BlueChoice, Inc. is a Health Maintenance Organization (HMO). In an HMO, care is provided and coordinated by a primary care physician (PCP) whom you choose. Your PCP provides preventive care and can help coordinate specialty care using a network of CareFirst BlueChoice specialists. By coordinating your care, your PCP ensures quality of care while reducing medical expenses. Unique to this Plan is that you don't need a PCP referral for in-network care when services are rendered in an office setting. You may still need an authorization from the Plan for some services.

Your Membership Card

By now you should have received your CareFirst BlueChoice membership identification card. Your card identifies you as a CareFirst BlueChoice member and contains important information about you, your primary care physician (PCP), your copayments and some of the benefits for which you are eligible. This is the card that you present to your PCP, a specialist or a hospital to receive care. Always carry your members ID card with you. (If you haven't received your card yet, please use your copy of the CareFirst BlueChoice enrollment form.)

The diagram to the right explains the information on the front of your card. Please take a moment to review your card. If any of the information is incorrect, please contact our Member Services Department immediately.



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

- 1 MEMBER SERVICES TELEPHONE NUMBERS
- 2 MEMBERSHIP IDENTIFICATION NUMBER
- 3 GROUP NUMBER
- 4 MEMBER'S NAME
- 5 PRIMARY CARE PHYSICIAN'S (PCP) NAME
- 6 COPAYMENTS
P= PCP
S= SPECIALIST
ER= EMERGENCY ROOM
RX= PRESCRIPTION
- 7 DENTAL COVERAGE, IF APPLICABLE

The back of the member ID card includes medical emergency assistance and mental health/substance abuse telephone numbers, as well as instructions and an address for filing claims and sending correspondence. If your ID card is lost or stolen, please contact Member Services immediately for a replacement. Remember to destroy any old cards and always present your current ID card when receiving services.



Frequently Asked Questions

What is my ID card for?

Your card is important in getting the most out of your health plan. You will present your member ID card when you receive care. Always carry your member ID card with you.

How can I find out if a certain doctor is a primary care physician with CareFirst BlueChoice?

You can access our CareFirst BlueChoice Provider Directory on our web site at www.carefirst.com. You can also call Member Services at the telephone number on the front of your member ID card to request a CareFirst BlueChoice Provider Directory or have a Member Services Representative access this information for you.

For more information, see the “Selecting Your Primary Care Physician” section on page 5 of this handbook.

How do I obtain specialty care?

Your primary care physician (PCP) can help to coordinate your in-network care; but a PCP referral is not necessary for specialists who participate in the CareFirst BlueChoice network. However, you or your provider may need to obtain an authorization from the Plan for some services, including but not limited to hospital care.

For more information, see the section “No Referrals Needed for Specialists” on page 6 of this handbook.

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

You can check the Provider Directory on our web site at www.carefirst.com, or contact Member Services to verify if a specialist is in the CareFirst BlueChoice network.

Can I change my primary care physician?

Yes, you can change your primary care physician. Contact Member Services and a representative will assist you. CareFirst BlueChoice must be notified and must process the PCP change prior to the time you receive care from the new PCP.

For more information, see the “Changing Your Primary Care Physician” section on page 6 of this handbook.

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

Your benefits are detailed in the Evidence of Coverage. You may also contact Member Services to obtain specific information on contract benefits such as medical care, vision care, dental care, prescription benefits, etc.

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

When you are outside the service area, benefits are available for emergency or urgent care only. With the BlueCard® program, when you see an out-of-area participating Blue Cross and Blue Shield physician or hospital for emergency or urgent care, you will only be responsible for paying out-of-pocket expenses (copayment) and your benefits will be paid at the in-network level. This relieves you of the hassle and worry of paying for the entire visit up-front and then filing a claim form later. The suitcase and prefix to your membership number on your member ID card tells Blue Cross and Blue Shield participating physicians and hospitals throughout the country that your benefits include the BlueCard® program.

In addition, if you will be traveling for 90 days or more, you may be eligible for the Away From Home Care® Program.

For more information, see the sections “Emergency and Urgent Care” on pages 13-15, “The Away From Home Care® Program” on page 15 and “Filing a Claim for Reimbursement” on page 20 of this handbook.

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

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

For more information, see the “Emergency and Urgent Care” section on pages 13-15 of this handbook.

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

If the college is outside of the CareFirst BlueChoice service area, coverage is limited to emergency or urgent care only. For more information, see the section “Emergency and Urgent Care” on pages 13-15 of this handbook. Students who will be out of the area for 90 or more days may be eligible for the Away From Home Care® Program.

For more information, see the “Away From Home Care®” section on page 15 of this handbook.

Where should I go for covered laboratory services?

Members must go to LabCorp® for any laboratory services in order to obtain in-network coverage for those services. LabCorp® is contracted to provide services for CareFirst BlueChoice members throughout Maryland, Virginia and Washington, DC.

For more information, see the “Laboratory Services” section on page 6 of this handbook.

What is CareEssentials?

CareEssentials is CareFirst BlueChoice’s Care Management program that provides you with the tools and resources that will help you stay healthy or make you well.



Our Prevention tools are designed to help you stay strong and healthy.



Utilization Management helps ensure you receive the right care at the right time in the right place.



Disease Management assists members with chronic illnesses to make smart choices for healthy living.



Case Management provides support to members when it is needed most.

Look for the CareEssentials logos in this member handbook to learn more about how CareEssentials can work for you.

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

To ensure that you are paying the lowest copay for a prescription, you should check the status of the drug on the CareFirst preferred drug list before:

- You talk with your doctor about a refill or a change in your medication.
- You call the pharmacy to order a refill.
- You order a prescription through mail order.

**This information applies only to members whose prescription drug program is based on the CareFirst BlueChoice preferred drug list (also called a formulary).*

For example, if you check the status of your brand-name drug and find out there is a generic equivalent on the CareFirst BlueChoice preferred drug list, we suggest you talk with your doctor to see if a generic alternative is the right choice for you.

For more information on how to cut prescription drug costs, see the “Prescription Drug” section on pages 17-18 of this handbook.

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

At www.carefirst.com you can:

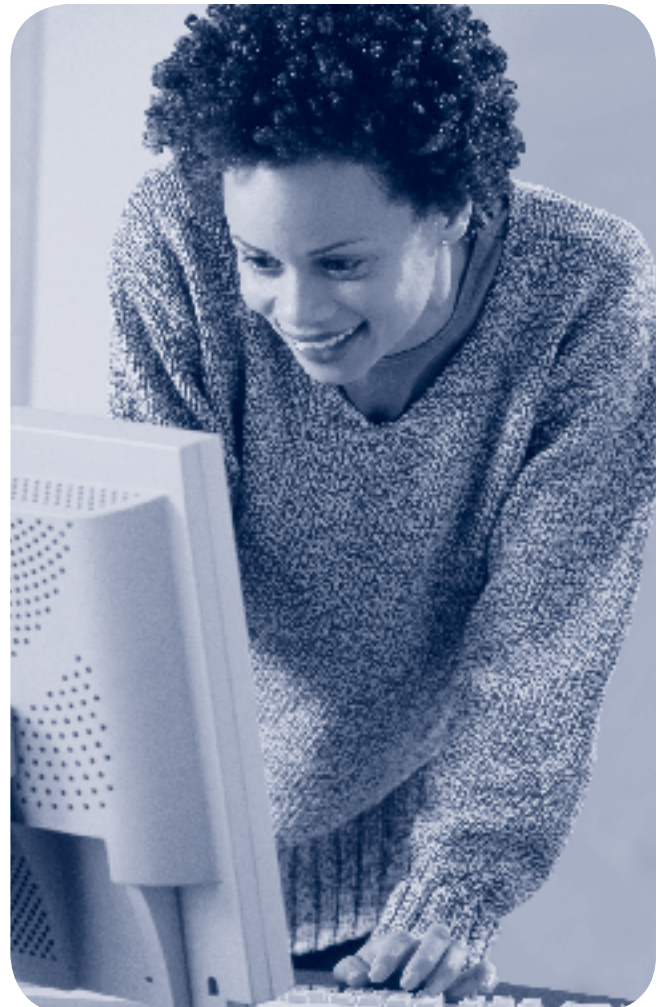
- Find out the latest member news and updates.
- Download claim forms and privacy forms.
- Learn how to get discounts on alternative therapies, vision and hearing services, fitness centers and more through the *Options* discount program.
- Find a doctor who participates in your plan using our searchable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

What kind of information can I find on “My Account”?

When you visit *My Account* on www.carefirst.com, you can find information about your medical plan including who and what is covered, claims status, and how much has been applied to your deductible if you have one. (Note: While claims information is available to all members, some members do not yet have access to all features.) In addition, our secure e-mail feature will enable you to send inquiries to us.

To use *My Account*:

1. Go to the *Members & Visitors* section of www.carefirst.com and click on the *My Account* button on the left.
2. Register using the membership number located on your member ID card.





When You Need Care

Your Primary Care Physician

When you joined CareFirst BlueChoice, you should have chosen a primary care physician (PCP) to be responsible for your primary medical care. If you did not choose a PCP upon enrollment, please contact Member Services. The name of the PCP currently on file for you appears on the front of your CareFirst BlueChoice ID card.

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

If the situation is a medical emergency, call 911 or go directly to the nearest emergency facility. The treatment of medically necessary emergencies are covered. See the “Emergency and Urgent Care” section on page 13 of this handbook for more information.

Establishing a relationship with one doctor is the best way for you to receive consistent, quality health care. We encourage you to contact your PCP for an initial health assessment within 90 days of your enrollment. If you have any questions about scheduling your appointment, please call your PCP’s office.



We encourage you to find a physician whom you feel comfortable with and schedule all of your appointments with him or her.

Your PCP will:

- provide basic medical care – treating illnesses and providing preventive care;
- prescribe any medications you may require;
- maintain your medical history; and
- work with you to determine when you should see a specialist, and assist in the selection of a specialist.

Selecting your primary care physician

You may choose a doctor who specializes in family practice, general practice, pediatrics, or internal medicine as your PCP. Each member must choose a PCP from our CareFirst BlueChoice Provider Directory at the time of enrollment. Your entire family may select the same doctor, or each member may choose a different doctor based on each individual’s age or medical needs.

If you have not selected a PCP for yourself or a covered family member, medical emergencies may be covered, however, other covered services may be denied.

You may select your PCP by reviewing our list of participating PCPs in the CareFirst BlueChoice Provider Directory, by visiting our web site www.carefirst.com, or by contacting Member Services. Our staff is ready to assist you in selecting a physician, and we can provide you with information about a doctor’s background and hospital affiliation. You can obtain specific information about a physician’s practice style and office hours directly from the physician’s office.

Changing your primary care physician

If you wish to change your PCP, contact Member Services and give the representative the name of the PCP to whom you want to switch. If the change is requested prior to the 20th of the current month, it will be effective on the first of the following month. Requests received after the 20th of the current month will be effective on the first of the second month following your request. For example, a request received on January 21 would be effective March 1. You will receive a new identification card with your new PCP's name. Please destroy your old ID card once the change becomes effective. Also, if you require urgent medical care that cannot wait until your new PCP becomes effective, seek care from your previous PCP.

No referrals needed for specialists

Your PCP can coordinate your medical care and provide treatment for a variety of medical conditions. You can also go directly to a specialist from those listed by specialty type in your CareFirst BlueChoice Provider Directory. If a provider with the required specialty is not available within the CareFirst BlueChoice network, your PCP should contact CareFirst BlueChoice to determine if authorization is available for treatment by an out-of-network specialist. You don't need a referral form for a specialist visit. However, an authorization may be required by the Plan for certain services. Please refer to your Evidence of Coverage to determine your authorization requirements.

Medical Records

Each physician's office keeps a copy of your medical records. If you are a new member, we encourage you to transfer your previous medical records to your PCP's office. Transferring your records to your PCP's office will give your PCP easier access to your medical history. Your previous physician may charge you a fee for this transfer of records. Your medical records are kept in confidence and will only be released as authorized by law. Please refer to the "Confidentiality" section on **page 25** of this handbook for our guidelines on the release of medical information.

Scheduling appointments

CareFirst BlueChoice physicians see patients in their own offices. Always call for an appointment before visiting your physician and identify yourself as a CareFirst BlueChoice member. Don't forget to bring your member ID card to your appointment and

present the card to the receptionist. You should always present your CareFirst BlueChoice ID card whenever you seek care at your PCP's or specialist's office or the hospital.

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

If you have an urgent problem, call your PCP as soon as possible, and the office staff will arrange an appropriate time for you to be seen. For a symptomatic (acute) problem, most offices try to schedule you within 24-72 hours or less, depending on the urgency of the problem. The nurse or the appointment staff at your doctor's office will help you determine how quickly you need to be seen.

Canceling appointments

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

Laboratory Services

Members must go to a LabCorp® facility for any laboratory services in order to obtain coverage for those services. LabCorp® is contracted to provide services for CareFirst BlueChoice members throughout Maryland*, Virginia and Washington, DC.

Labwork performed in an outpatient hospital setting will require a prior authorization.

Before going to the LabCorp® site, members must have a LabCorp® requisition form or physician's order on a prescription pad or letterhead.

LabCorp® has approximately 70 locations in the Maryland, Washington, DC and northern Virginia areas. If you need more information or need assistance with lab requisitions, please call LabCorp® at (800) 322-3629. To locate the nearest LabCorp® patient service center, call (888) LAB-CORP (522-2677), or visit the LabCorp® web site at www.labcorp.com.

**Some exceptions apply in Western Maryland.*



CareEssentials



Prevention

Visit *My Care First*, the health and wellness section of www.carefirst.com for information that can help you manage your health.

At *My Care First* you will find:

- Information on over 300 health-related topics
- Personalized health calculators that determine your body mass index or target heart rate

Vitality Newsletter

You may receive *Vitality*, our quarterly member newsletter. *Vitality* can give you the tools you need to help you achieve a happier and healthier lifestyle. Each issue is filled with useful and timely information on a variety of health-related topics. You'll learn about food and nutrition, physical fitness, recreation and preventive health care. You will also get to know about our company and how to get the most from your benefits.

Get Healthy with *My Care First*

Looking for ways to get healthy and stay healthy? Go surfing— on the web, that is. Visit *My Care First*, the health and wellness section of www.carefirst.com. Our award-winning site contains a wealth of health information and interactive features that can help you take an active role in managing your health.

If you are looking for information about a specific condition, just select a topic from our health library. You can also learn about a variety of health issues from our weekly stories, quizzes and Health Scout news, which is updated several times a week. You also can offer your opinion on a health issue by taking the weekly poll.

If you or a loved one has asthma, diabetes or heart disease, visit our asthma center, diabetes center or

heart health center for the information, quizzes and tools to help manage these conditions.

You can also obtain personalized health information, such as your body mass index, your target heart rate and your ideal weight by using the health calculator. For even more detail about your health, you can register with the site. Registering will enable you to take a personalized health assessment, set health goals, track your progress and have reminders sent via e-mail. You can even get help to manage weight, stress or blood pressure and to quit smoking.

To visit *My Care First*, go to www.carefirst.com and click on “Health and Wellness – *My Care First*” in the Solution Center.

Great Beginnings Program for Expectant Mothers

CareFirst also offers Case Management support to members during pregnancy. The *Great Beginnings* program is designed to supplement the prenatal care and education you receive from your doctor during pregnancy. Our Case Managers strive to help you and your baby stay healthy during pregnancy.

When you enroll in *Great Beginnings*, one of our Case Managers will contact you to review your medical history and to identify any other conditions that may affect your pregnancy. You will receive information related to your condition and your baby's development. Your Case Manager will contact you during each trimester to see how you are feeling and to answer any questions.

If you have not chosen a pediatrician, the Case Manager also may assist you in finding a pediatrician close to your home. If you experience any complications during pregnancy, your Case Manager will work closely with your doctor to coordinate necessary services and provide additional support and information you may need during this time.

Case Managers are available to answer questions, Monday through Friday, 8:30 am to 4:30 pm. To find out more information about the program, call (888) 264-8648.

Preventive Services Guidelines

Each year, CareFirst BlueChoice publishes a list of preventive services guidelines. Preventive services are procedures you should have, if applicable, to detect any health problems. Your primary care physician may recommend additional tests or exams.

Adult preventive services include:

- periodic physicals
- blood pressure checks
- height and weight monitoring
- cholesterol tests
- colon and prostate cancer tests
- gynecological exams
- testicular exams
- diabetes screening
- mammograms
- immunizations

The preventive services for children include:

- periodic physicals
- blood pressure checks
- height and weight monitoring
- hearing and vision screenings
- cholesterol and TB tests
- growth, development and behavior assessments
- immunizations

If you would like a list of the specific guidelines, call Member Services at the number listed on your member ID card. You may also visit our web site at www.carefirst.com and click on *My Care First*.



Utilization Management

Utilization Management ensures that care is provided at the right time and in the proper setting. Registered nurses and board-certified practitioners administer CareFirst BlueChoice's Utilization Management Program.

The program includes prior authorization requirements for certain services; review of authorizations for hospital admissions according to a nationally-accepted set of criteria; and retrospective review of treatment for which CareFirst BlueChoice did not give prior authorization.

Hospital care

If you need to be hospitalized, your primary care physician (PCP) or CareFirst BlueChoice specialist will select a hospital and will make arrangements for your admission. The hospital selected will usually be where your PCP or specialist has admitting privileges.

Discuss all the details of your admission in advance with your PCP or CareFirst BlueChoice specialist. You may want to ask about details such as length of stay, special diets or procedures. Knowing the answers in advance can make your stay easier and more comfortable.

Obtaining authorization

Requirements are handled by your CareFirst BlueChoice providers. Your PCP or the CareFirst BlueChoice specialist in conjunction with the hospital is responsible for obtaining the authorization.

Continued stay review

After your hospital admission has been authorized, a Care Management nurse, working in conjunction with a CareFirst BlueChoice Medical Director, will review your admission to determine if additional inpatient hospital days are medically necessary. This type of review is known as Continued Stay Review. Your physician, a hospital representative and the Care Management nurse will coordinate the approval of additional hospital days. The Care Management nurse can also assist with discharge planning as needed. If it is determined that extra days are not medically necessary, your doctor will be notified in writing.



Disease Management Programs

Disease Management Programs provide eligible members with educational materials and reminders that enable them to manage chronic diseases.

In more serious cases, Case Managers make telephone contact with members and their doctors. CareFirst BlueChoice has programs for asthma, COPD, diabetes and heart disease.

Members who enroll in the disease management programs receive educational materials that will help them better understand and manage their condition. Members are also given telephone access to a nurse who can answer their questions about medications, tests their doctor ordered or other concerns related to their condition. All of these programs are voluntary and are provided at no additional cost to eligible members.



Case Management Program

When faced with health care decisions, you and your family may have many questions and difficult choices to make. The Case Management Department of CareFirst BlueChoice wants to make sure you get all the help you need for any health problems or concerns you may have.

The Case Management Program is part of your medical benefits. As a member of CareFirst BlueChoice, you will not be charged any fee for this service. It's one of the ways we can help you to remain active and in the best health possible.

Case Managers are registered nurses who play an active role in working with your primary care physician to help develop a plan of care that will ensure that you receive the best possible care in an efficient and timely manner. Your relationship with your Case Manager enables you to receive prompt answers to any of your questions or concerns.

Please keep in mind that since this program is voluntary you can withdraw at any time without a penalty.

When appropriate, Case Management can help you with conditions such as (but not limited to):

- Spinal Cord Injury
- Amputation
- AIDS
- Asthma
- Burns
- Cancer
- Diabetes
- Heart Disease
- High Risk Newborns
- High Risk Pregnancies
- Multiple Fractures
- Severe Head Trauma
- Stroke

If you want to enroll or would like more information about the Case Management Program, please call (888) 264-8648, Monday through Friday between 8:30 am and 4:30 pm.



Options Discount Program

Options is a discount program provided to members of CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice. Because this is a discount program and not a covered benefit, there are no claim forms, referrals or paperwork. To receive these discounts, simply show your BlueChoice ID card or visit the special website for members if it's an online program. In order to be responsive to your needs, *Options* continually adds new services. Visit www.carefirst.com/options for the latest *Options* programs.

Discounts Include:

Weight Loss Assistance Programs

Weight Watchers, one of the nation's most recognized weight loss programs is online, and CareFirst BlueChoice members can save \$10 on a 3-month subscription to **Weight Watchers Online**®. Weight Watchers Online® provides a set of personalized weight loss tools, such as Online Journal, Meal Planner, Weight Tracker, and Progress Charts. Search a database of more than 800 Weight Watchers recipes and calculate POINTS® for your own foods and meals.

Join **Jenny Craig** and receive a FREE 30-day program*. Jenny Craig will design a personalized comprehensive program with one-on-one support, that fits your lifestyle. You can also enjoy up to 50% off the 6-month program* or 20% off the 1-year Premium Success Program*.

** Plus the cost of food and shipping when applicable. Discounts apply to membership fee only. Offer good at participating Centres and Jenny Direct® in the United States, Canada and Puerto Rico.*

Fitness Club Memberships

Through 3 different networks, *Options* offers flexibility in choosing a gym that is right for you. With **GlobalFit**'s lowest price guarantee, you'll receive the best available rates at more than 10,000 fitness clubs nationwide, including Bally Total Fitness clubs and Curves, all with month-to-month memberships and no long-term contracts.

NOTE: Discounts in GlobalFit clubs are for new members only. If you are already a club member (or were a member in the last 90 days**) you are not eligible for the discounted rate. The only exception is Bally Total Fitness. After you have completed your current Bally contract, you are eligible for the discounted rate.

** There are a limited number of clubs that require a longer "run-out" period than 90 days. Please contact GlobalFit for more information.

Healthways WholeHealth Networks offers a nationwide network of approximately 2,900 fitness centers and spas. With your CareFirst BlueChoice plan, you can receive discounts on the following:

- 10-50% off fitness center initiation fees and/or membership dues
- Spa memberships or services ranging from 10-30%

NOTE: Membership obligations for fitness centers and discounted spa services are based on individual location policies.

National Fitness Network consists of approximately 100 independent regional health clubs*** and is the only health club network that offers the convenience of unlimited access to its entire network of clubs with a single membership. There is no need to select a primary club or transfer your membership. National Fitness Network offers the following discounts:

- Up to 40% off membership fees
- One-time registration fee of \$49 for the member and \$29 for each additional family member.

NOTE: To receive a discount, you must enroll directly through the National Fitness Network. If you are already a member of a National Fitness Network club, you must complete your current contract before you can get the discounted rate.

***Available in MD, DC, VA, NJ, and FL only.

Hearing Care Services

Better hearing enriches your quality of life. Take advantage of the many discounted services offered by both **Beltone Hearing Care Centers** and **TruHearing**. With **Beltone**, parents, children, spouses and grandparents receive free hearing screenings and a 25% discount off the cost of Beltone hearing aids. All Beltone hearing aids include free batteries for one year, a two-year warranty, free cleaning and minor repairs and adjustments for the life of the hearing aid. **TruHearing** offers free hearing screenings and discounts of up to 60% off quality digital instruments for CareFirst BlueChoice members, their children, parents, and grandparents. TruHearing also offers an extended two-year warranty and a 45-day money back guarantee. All hearing tests are performed using the latest diagnostic equipment.

Laser Vision Correction & Contact Lenses

Through **TruVision**, CareFirst BlueChoice members can receive 10% off of LASIK or PRK procedures. All pricing includes a pre-operative exam, the Laser Vision Correction procedure, post-operative care and a one-year enhancement warranty. Discounts are also available on Custom LASIK, IntraLase Bladeless procedures, and some centers offer lifetime re-treatment plans. Members can also receive discounts of up to 50% off most brands of contact lenses ordered through the Mail and receive free shipping and handling.

QualSight provides affordable access to quality laser vision correction services at 600 locations nationwide. QualSight partners with leading ophthalmologists and credentials each doctor in order to verify their experience and work history. Included in the \$895 price per eye are the pre-operative exam, LASIK or PRK procedure, post-operative exams, and a retreatment warranty. Discounts are also available on Custom LASIK, Conductive Keratoplasty, and IntraLase.

Medical IDs

American Medical ID offers a 22% discount on customized medical identification bracelets and necklaces. Medical IDs allow medics or other medical professionals to give prompt, precise treatment in a medical emergency. They help ensure a patient will receive proper care, eliminate unnecessary testing and reduce the chance of costly medical errors. Those who have chronic medical conditions, drug or food allergies, or are taking multiple medicines, are advised to wear a medical ID.

ElderCare Information & Referral Program

ElderCarelink is a free, internet-based service that specializes in providing referrals for services for elders and their families. Services include home health care, home support, assisted living, adult day care, long-term care, nursing home options and more. Members fill out a needs assessment online survey and then ElderCarelink will e-mail a list of participating network providers that match your needs. Members are also eligible to receive a free 90-day subscription to The Caregiver's Home Companion newsletter.

Alternative Health & Wellness Services

The following services are offered through Healthways WholeHealth Networks, Inc. Through the Options program, members can receive up to a 30% discount on these alternative health and wellness services.

- Acupuncture
- Chiropractic Care
- Guided Imagery
- Magazine Discount Program
- Massage Therapy
- Meditation Instruction
- Mind-Body Instruction
- Nutrition Counseling
- Personal Training/Pilates
- Qi Gong/Tai Chi
- Yoga



In addition to the Options program, the Blue Cross and Blue Shield Association gives you access to even more discounts through Blue365. Blue365 provides tools and guides to help you learn more about wellness services that go beyond your covered services. There are four key areas of Blue365:

- Health and Wellness
- Family Care
- Health-Focused Financial Services
- Travel Information

Want to know more about what Blue365 has to offer? Look for the list of Blue365 vendors and resources on a special Web site designed just for BlueChoice members. It's all available at www.carefirst.com/options. You can also call Member Services for more information on Blue365.

Visit www.carefirst.com/options for more information on these services or see the following contact information below.

Options Program Directory

Alternative Health & Wellness Services

Healthways WholeHealth Networks, Inc. (800) 514-6502
<http://options.wholehealthmd.com>

Eldercare Information & Referrals

ElderCarelink (866) 451-5577
www.eldercarelink.com/carefirst

GlobalFit (800) 294-1500
www.globalfit.com

Fitness Centers

Healthways WholeHealth Network (800) 514-6502
<http://options.wholehealthmd.com>

National Fitness Network (800) 811-5454
www.nationalfitnessnetwork.com

Hearing Care

Beltone (800) 235-8663
www.beltone.com

TruHearing (877) 587-3937
www.truhearing.com

Laser Vision Correction & Contact Lenses

QualSight LASIK (877) 285-2010
www.qualsight.com/-carefirst

TruVision LASIK* (800) 398-7075
www.truvision.com/carefirst/LASIK.htm

**Also offers discounts on mail-order contact lenses*

Medical IDs

American Medical ID (800) 363-5985
www.americanmedical-id.com/extras/carefirst.php

Weight Loss & Management

Weight Watchers Online®
www.weightwatchers.com/cs/cfbcb

Jenny Craig® (800) 96-JENNY
www.jennycraig.com/corporatechannel/carefirst.aspx



Emergency and Urgent Care

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

Medical Emergencies

If the situation is a medical emergency:

- call 911 or
- go directly to the nearest emergency facility.

A "Medical Emergency" is the sudden onset of a serious illness or injury that in the absence of immediate medical attention could reasonably be expected by a prudent layperson (one who possesses an average knowledge of health and medicine) to result in:

- serious jeopardy to the patient's health;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

An authorization is not needed for emergency room services.

Urgent Care

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

If the situation is urgent:

- Contact your PCP. If your PCP is unavailable or if you are unsure about the meaning or seriousness of the symptoms, you can call FirstHelp® at (800) 535-9700 for medical advice
- Go directly to an urgent care center. A list of participating CareFirst BlueChoice Urgent Care Centers can be found in the CareFirst BlueChoice Provider Directory or on our web site at www.carefirst.com.

Urgent Care Centers

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

You may refer to the list of urgent care centers in your CareFirst BlueChoice Provider Directory or call FirstHelp® for a participating urgent care center near you.

Remember, urgent care centers do not take the place of your PCP. Your PCP should be your first contact whenever you need medical care.

FirstHelp®: 24-Hour Emergency Assistance and Medical Advice

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

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

If your urgent condition is related to mental health or substance abuse, see the section "Seeing Mental Health Specialists" on page 15 of this handbook.

**FirstHelp® 24-Hour
Emergency Assistance and
Medical Advice Hotline
(800) 535-9700**

Care When Traveling

- Seek medical attention immediately in the case of emergencies and urgent conditions.
- If you are unsure about the meaning or seriousness of the symptoms, call FirstHelp® at (800) 535-9700 for medical advice.

BlueCard® Program for Out-of-Area Emergency and Urgent Care



As a CareFirst BlueChoice member, your benefits include the BlueCard® program for out-of-area emergency and urgent care situations. The BlueCard® program is a benefit because when you see an out-of-area participating Blue Cross and Blue Shield physician or hospital for emergency or urgent care, you will only be responsible for paying out-of-pocket expenses (co-payment) and your benefits will be paid at the in-network level. This relieves you of the hassle and worry of paying for the entire visit up-front and then filing a claim form later. The participating Blue Cross and Blue Shield physician or hospital will file the claim directly to their local Blue Cross and Blue Shield plan. In turn, the participating provider will be reimbursed directly on your behalf.

To use the BlueCard® program for out-of-area emergency and urgent care, please call (800) 810-BLUE (2583) to locate the nearest Blue Cross and Blue Shield physicians and hospitals. At the time of service, present your member ID card.

If your physician or hospital does not bill its local Blue Cross and Blue Shield plan for out-of-area emergency or urgent care, the physician or hospital should bill CareFirst BlueChoice directly. However, if an up-front payment is requested, obtain itemized receipts and contact Member Services when you return to obtain a claim form for consideration and reimbursement of charges.

For more information, see the "Filing a Claim for Reimbursement" section on page 20 of this handbook.

Follow-Up Care

If your condition requires follow-up care after your initial visit to an urgent care center or hospital emergency room, you should contact your PCP. In-network benefits may not be available for follow-up care performed in an urgent care center or hospital emergency room for additional services related to the initial condition.

The physician at the emergency room or urgent care center cannot refer you to a specialist for follow-up care. You should contact your PCP for a referral to a specialist. You can always contact Member Services to determine if you are following the correct procedures to receive the highest level of benefits.

The Away From Home Care® Program

The Away From Home Care® program allows BlueChoice HMO *Open Access* members and their dependents to receive care when they are away from home for at least 90 days. The care can be provided by an affiliated Blue Cross and Blue Shield HMO outside of the CareFirst BlueChoice service area (Maryland, Washington DC, and northern Virginia). Whether it is extended out-of-town business or travel, semesters at school or families living apart, with the Away From Home Care® program, members can enjoy a full range of benefits. This includes, but is not limited to routine and preventive care. Your copay and benefits will be those of the affiliated HMO in the area where you are visiting. You will be treated as though you are actually a member of the affiliated plan.

Where can I obtain more information and enroll in the Away From Home Care® program?

If you would like to obtain more information or enroll in the Away From Home Care® program, please call the CareFirst BlueChoice Member Services number on the front of your CareFirst BlueChoice member ID card and ask to be transferred to the Away From Home Care® Coordinator.

The Coordinator will:

1. Check your CareFirst BlueChoice eligibility.
2. Obtain the appropriate information (e.g., destination, duration of stay).
3. Determine if there is a participating affiliated HMO available in the area where you or your dependents are visiting. **If there are no participating affiliated HMOs in the area, the program will not be available to you.**
4. Explain how the program works if there is an affiliated HMO available in the destination area.
5. Send the application to you for your signature, and once the signed application is returned, submit it to the affiliated HMO.





Seeing Mental Health Specialists

Your health care coverage includes mental health and substance abuse benefits. Mental health and substance abuse benefits may be subject to day and/or visit limitations. Also, certain conditions may be excluded, such as chronic, long-term or ongoing conditions. Please consult your Evidence of Coverage for specific information about your particular coverage, or call Member Services at the number on your member ID card for more information.

How to obtain in-network mental health care

If you think you are in need of mental health or substance abuse care, you must first call the Mental Health/Substance Abuse Service and Authorization phone number on the back of your identification card. A trained representative will ask you basic questions and explain your benefits. A Case Manager will discuss your situation with you and evaluate the most appropriate plan of treatment. If the patient is a child or an adolescent, the parent or guardian may provide the necessary information.

Based on your discussion with the Case Manager, you may be referred to a mental health provider to treat your condition. Once you have been referred, your network provider will work directly with the Case Manager to obtain authorization for any additional treatment.

Mental health and substance abuse services must be coordinated through our mental health and substance abuse administrator rather than through your PCP. However, if you wish, you may first discuss your concerns with your doctor. Your PCP may contact our mental health and substance abuse administrator on your behalf. If you receive ongoing care from a mental health practitioner, we suggest that you have this practitioner send regular reports regarding your treatment directly to your PCP.

This is especially important if you are receiving medications, since your PCP will then be able to monitor potential interactions related to any other medications that may be prescribed for you. By working with your PCP and other practitioners, you can assist in the continuity and effective coordination of your health care.

To be eligible for in-network benefits, both mental health and substance abuse services must be coordinated through our administrator. Please refer to your Evidence of Coverage to identify your specific mental health and substance abuse benefits.

For mental health and substance abuse care, including emergencies, call the Mental Health/Substance Abuse Service and Authorization telephone number on the back of your identification card. Service is available 24 hours a day, 7 days a week.

Exclusions

- Your CareFirst BlueChoice coverage does not allow benefits for services rendered by providers that are not part of the CareFirst BlueChoice network except for out-of-area medical emergency treatment.
- Depending on your contract, benefits might not be available for the services rendered by all providers listed in the CareFirst BlueChoice Provider Directory.
- Please refer to your Evidence of Coverage for specific information regarding exclusions from your coverage.



Additional Benefits

Dental Benefits

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

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

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

Your dental coverage may also include orthodontia.

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

The following is a list of dental plans for which you may be eligible if you purchase coverage through your employer. Members with individual coverage are only eligible for Dental HMO coverage.

Traditional Dental

CareFirst BlueCross BlueShield's (CareFirst) Traditional Dental allows you the freedom to seek dental care from any dentist and the opportunity to reduce out-of-pocket costs. When you visit a participating dentist, you have no claims to file and are only responsible for applicable deductibles and coinsurance. If you seek care from a non-participating dentist, you will be required to file claims yourself and you may incur higher out-of-pocket costs. More than 3,800 dentists participate with CareFirst – you may already be seeing a CareFirst participating dentist.

Preferred (PPO) Dental

CareFirst's Preferred (PPO) Dental offers both savings and choice. CareFirst has developed a network of 3,400 preferred dentists who have agreed to provide care at a discount. Once you meet your annual deductible, you can save money by paying a lower coinsurance amount when using a dentist in the Preferred network, and have no claim forms to file. If you receive care outside the Preferred network, you may have to file your own claim forms and pay more out-of-pocket for your care.

Dental HMO

The Dental Network, Inc. (TDN) is the administrator for CareFirst's Dental HMO (DHMO) plans. As a DHMO member, you choose a Primary Care Dentist (PCD) from a carefully selected network. All dental services are provided for the cost of a copay – there are no deductibles to meet, no claim forms to file and no annual maximums. If you have not selected a PCD or have questions about your DHMO dental coverage, please contact TDN at (410) 847-9060 or (888) 833-8464.

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and TDN are independent licensees of the Blue Cross and Blue Shield Association.

Prescription Benefits

Your coverage may include benefits for outpatient prescription drugs. Please review your Evidence of Coverage to determine whether or not you have benefits for outpatient prescription medications under your CareFirst BlueChoice plan. CareFirst BlueChoice members with individual coverage may be eligible for the following prescription drug plans: Generic Only Drug Plan or Generic and Brand Name Drug Plan.

CareFirst BlueChoice uses a preferred drug list (also called a formulary), which is a list of generic (tier 1) and certain preferred brand-name (tier 2) drugs. Drugs that are not on the formulary are called non-preferred (tier 3) drugs and are covered as part of your plan, although your payment will be more for these drugs. If you are prescribed a non-preferred brand-name drug, discuss alternatives that are on the preferred drug list with your doctor.

How often does the preferred drug list change?

As often as needed, but usually no more than a few times each year. Drugs on the preferred drug list are selected by a committee of practicing physicians and pharmacists from the community and CareFirst BlueChoice and are chosen because of their quality, effectiveness, safety and cost. The preferred drug list also changes as new drugs enter the market and as generic equivalents become available. For the most current preferred drug list, please visit www.carefirst.com.

Prior authorization

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

Questions

Argus Health Systems (Argus), our pharmacy claims processor, administers the CareFirst BlueChoice prescription drug program.

If you have any questions about your prescription drug coverage, call Argus Member Services at (800) 241-3371 or visit the Prescription Drug section in the *Members & Visitors* area of www.carefirst.com.

How to manage medication costs

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

1. Know your out-of-pocket costs. Use the online database or price comparison tool at www.carefirst.com to learn more about the costs of your medications.
2. Talk with your doctor. Print a copy of our current preferred drug list to bring to your next doctor's visit. Discuss the medicines you are taking and if they are on the preferred drug list. If your medicine is not on this list – a tier 3 or non-preferred brand name drug – ask if there are more affordable alternatives that may be right for you.
3. Use a participating pharmacy. There are more than 59,000 participating pharmacies nationwide that accept your prescription drug card. Choose one that's convenient, but remember to shop around. Some pharmacies charge more than others, and if you have a plan with coinsurance, those prices may affect how much you pay.
4. Don't forget your member ID card. To help ensure you receive proper service, the pharmacist will need your member ID card and a prescription from your doctor.
5. Be on the lookout for alternatives. New medicines become available often, so the price of your prescription may rise or fall as a result. Changes in the preferred drug list often happen because a new medicine is introduced to the marketplace or a generic becomes available.

Some of these tips apply only to members whose prescription drug benefit is based on the CareFirst BlueCross BlueShield and CareFirst BlueChoice preferred drug list.

Vision Benefits

Your coverage may include benefits for vision care under BlueVision or BlueVision *Plus*. Please review your Evidence of Coverage to determine if your coverage includes benefits for vision care. CareFirst BlueChoice members with individual coverage are only eligible for BlueVision coverage.

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

BlueVision

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

BlueVision Plus

BlueVision Plus provides an extended benefit that includes an eye examination (including dilation) and coverage for eyeglasses or contact lenses once per benefit period. Eyeglass frames and lenses are covered in full when you choose from Davis Vision's Exclusive Tower Collection of approximately 270 frames, or you can receive an allowance toward any other frame. You can also receive coverage for contact lenses in lieu of eyeglasses when you choose Davis Vision contact lenses. The choice is yours! Additionally, Davis Vision offers discounts on laser vision correction surgery, additional lens treatments and coatings. Refer to your Evidence of Coverage to find out what benefits you have under your plan.

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

How to Access In-Network Vision Care

- Call (800) 783-5602 for a list of providers nearest you, or access the network through www.carefirst.com. Just click on *Find a Doctor* in the Solution Center.
- Call the Davis Vision provider of your choice and schedule an appointment.
- Identify yourself as a CareFirst BlueChoice member and a Davis Vision plan participant.
- Provide the office with the member's identification number and the year of birth of any covered dependents needing services.
- The provider's office will verify your eligibility for services and no claim forms are required.

How to Access Out-of-Network Vision Care

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

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

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

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





Administration of Your Plan

Personal and Enrollment Changes

If you change your name, address or phone number, please contact Member Services and we will update our records or advise you of any forms you need to submit. Remember, we need your correct address to keep you informed about critical program information including policies, procedures and benefit changes.

If you have group coverage and you wish to enroll or disenroll a dependent (including newborns) or change your marital status, you must notify your employer within the time frame specified in your Evidence of Coverage.

Filing a Claim for Reimbursement

An advantage of your CareFirst BlueChoice coverage is that you do not have to file claims. CareFirst BlueChoice providers are required to submit claims. All you have to do is pay any necessary copayment at the time of the visit. If you do need to submit a claim for services rendered by a provider who does not participate in the CareFirst BlueChoice network (such as emergency care received outside the service area), you may contact Member Services for a CareFirst BlueChoice Health Benefits Claim Form or print one from our web site at www.carefirst.com. Be sure to attach a complete itemized bill prepared by the provider of service that includes the charges for each service along with the medical condition for which the treatment was performed. Submit the completed claim form and attachments to:

CareFirst BlueChoice, Inc.
P.O. Box 804
Owings Mills, MD 21117-9998

All claims must be filed within the time limit specified in your Evidence of Coverage.

Provider Reimbursement

CareFirst BlueChoice providers are paid on a fee-for-service basis. This means that CareFirst BlueChoice providers receive benefit payments according to a fee schedule for covered services they perform. You may contact Member Services to obtain additional information about provider payment arrangements.

Other Insurance

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

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

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

Member Satisfaction

CareFirst BlueChoice wants to hear your concerns and/or complaints so 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 to do:

- If your comment or concern is regarding the quality of service received from a CareFirst BlueChoice representative or administrative problems (e.g., enrollment, claims, bills, etc.), you should contact Member Services. If you send your comments to us in writing, please include your identification number and provide us with as much detail as possible. 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. If you send your comments to us in writing, please include your identification number and provide us with as much detail as possible regarding any events. Please include your daytime telephone number so that we may contact you directly if we need additional information. Our Quality Improvement department will investigate your concerns, share those issues with the provider involved and request a response. We will then provide you with a summary of our findings. CareFirst BlueChoice member complaints are retained in our provider files and are reviewed when providers are considered for continuing participation with CareFirst BlueChoice.

These procedures are also outlined in your Evidence of Coverage.

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

Virginia:

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

Center for Quality Health Care Services and Consumer Protection

Virginia Department of Health
3600 W. Broad Street, Suite 216
Richmond, VA 23230
(800) 955-1819 or (804) 367-2104
Fax: (804) 367-2149
mchip@vdh.virginia.gov

District of Columbia:

Medical Necessity Issues:

Department of Health
Office of the General Counsel
Grievance and Appeals Coordinator
825 North Capitol Street, NE
Washington, DC 20002
(202) 442-5977
Fax: (202) 442-4797

Issues other than Medical Necessity:

Department of Insurance, Securities, and Banking
810 First Street, NE, Suite 701
Washington, DC 20002
(202) 727-8000

Maryland:

Maryland Insurance Administration
Inquiry and Investigation, Life and Health
525 St. Paul Place
Baltimore, MD 21202-2272
(410) 468-2000 or (800) 492-6116
Fax: (410) 468-2270
www.mdinsurance.state.md.us

Health Education and Advocacy Unit

Consumer Protection Division
Office of the Attorney General
200 St. Paul Place
Baltimore, MD 21202
(410) 528-1840 or (887) 261-8807
Fax: (410) 576-6571
www.oag.state.md.us

Office of Health Care Quality

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



Appeals Process

CareFirst BlueChoice's appeal procedure is designed to enable you to have your concerns regarding a denial of benefits or authorization for services heard and resolved. By following the steps outlined below, you can ensure that your appeal is quickly and responsively addressed. Please note that state mandates may alter the steps below. Refer to your Evidence of Coverage for more specific information regarding your appeal process.

An expedited appeal process has been established in the event that a delay in a decision would be detrimental to your health or the health of a covered family member. In an expedited appeal, a decision by CareFirst BlueChoice shall be made within 24 hours from the time we receive the appeal. Review will be done by a physician in the same or similar specialty as the treatment under review and not part of the original denial decision, as appropriate. Expedited appeals involve care that has not yet occurred or is currently occurring (pre-service or concurrent care).

Step 1: Discussion of the problem

Your concerns can often be handled and resolved through informal discussions and information gathering. If your question relates to our handling of a claim or other administrative action, call and discuss the matter with a CareFirst BlueChoice Member Services representative. In many instances, the matter can be quickly resolved.

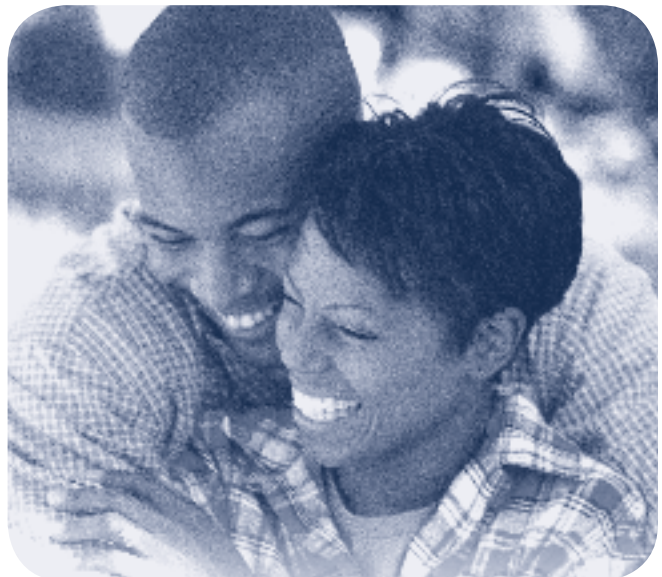
Step 2: Appeal/grievance process

If your concern is not resolved through a discussion with a CareFirst BlueChoice representative, you or someone on your behalf may make a formal request for appeal. CareFirst BlueChoice must receive the request within 180 days of the date of receipt of notification of denial of benefits or services. If the request for appeal is related to a medical or clinical issue, a physician in the same or similar specialty as the treatment under review, not part of the original denial decision, will review the request. This request should be in writing and addressed to the Member

Services Department. A Member Services representative will be available to assist you in submitting your appeal in the event you are unable to put the request in writing. All appeal decisions will be rendered in writing to the member.

If the decision remains as a denial of the original request, a detailed explanation that references the rule, policy or guideline used to make the decision will be included. Also provided will be an explanation of the appropriate next steps a member may take if he or she is not satisfied with the appeal process.

Members have a right to an independent external review of any final appeal or grievance determination. If you wish, you may contact the insurance regulatory department in your area to file a complaint or an appeal regarding a denial or reduction of benefits. The procedure for filing an appeal is also located on our web site at www.carefirst.com. In the *Members & Visitors* section, click on "Frequently Asked Questions" in the Solution Center. If you would like a paper copy of the appeal process, you may also contact the Member Services telephone number located on your member ID card.





Your Coverage

Ending Your Coverage

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

- you are no longer employed by the company that carries your CareFirst BlueChoice coverage;
- your employer cancels coverage with CareFirst BlueChoice;
- divorce from a policyholder; or
- a dependent child marries, is no longer a full-time student or has a birthday placing him or her beyond the age of coverage.

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

Continuing Your Coverage

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

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

or individual benefits under certain conditions. A conversion policy is a contract that provides individual or family medical coverage. Dental, vision and prescription plans cannot be added to the conversion policy.

Eligible members must enroll for conversion coverage within 31 days after their eligibility for group coverage ends. Members who end or lose their group coverage may be entitled to a conversion policy in the following situations:

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

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

New Technology Assessment

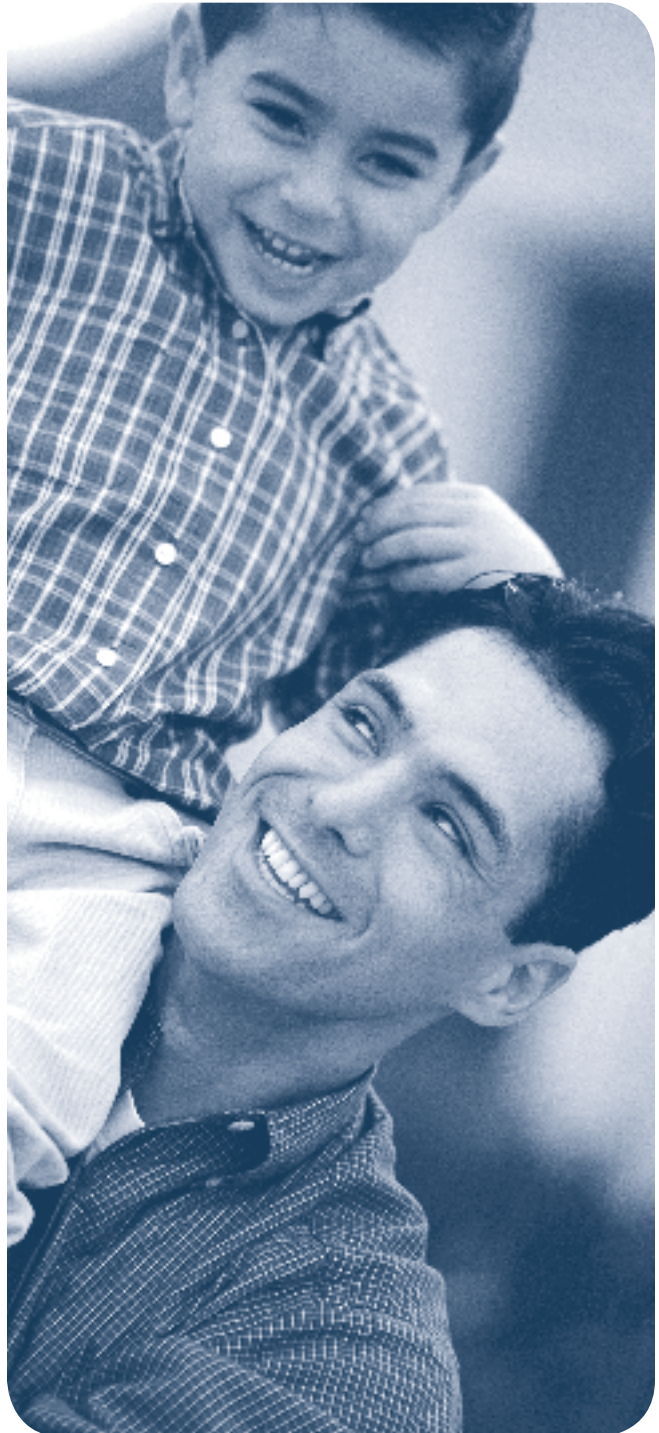
To ensure that our members have access to safe and effective care, CareFirst BlueChoice has a formal process to review and make decisions regarding new developments in medical technology. We evaluate new medical technologies and the use of existing technologies through a formal review process. We refer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



Portability (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) ensures that individuals who have health insurance do not experience a gap in coverage due to termination or departure from their current job. A member terminating coverage with an insurance carrier will receive a Certificate of Creditable Coverage indicating the length of time they have had health insurance coverage. This Certificate of Creditable Coverage is used to reduce any waiting time for pre-existing conditions that may be part of subsequent health insurance coverage, as long as there has not been a break in coverage for more than 63 days.

When a member terminates with CareFirst BlueChoice, they receive a Certificate of Health Plan Coverage that indicates how long the member was covered. The member should then present the certificate to the new insurance carrier. This will reduce or eliminate waiting periods for pre-existing conditions under the member's new policy.





Confidentiality

All health plans and providers must provide information to members and patients regarding how their information is protected. You will receive a notice of privacy practices from CareFirst BlueChoice or your Health Plan, and from your providers as well, when you visit their office.

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

Our Responsibilities

We are required by law to maintain the privacy of your PHI, and to have appropriate procedures in place to do so. In accordance with the federal and state Privacy laws, we have the right to use and disclose your PHI for payment activities and health care operations as explained in the Notice of Privacy Practices. This Notice is sent to all policyholders upon enrollment.

Notice of Privacy Practices

CareFirst BlueChoice is 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 BlueChoice's responsibility for protecting the member's health information.

To obtain a copy of our Notice of Privacy Practices, please visit our web site at www.carefirst.com or call Member Services at the 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.

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 reasons other than treatment, payment, or health care operations; and
- give us written authorization to use your protected health information or disclose it to anyone not listed in this notice.



Member Rights and Responsibilities

Rights of Members

The Plan promotes members' rights by providing mechanisms to ensure:

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

Members have a right to:

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

Responsibilities of Members

Members have a responsibility to:

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





HSA, HRA and Compatible Plans

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

Health Savings Account (HSA)

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

How your HSA works

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

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

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

The money in the HSA always belongs to you

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

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

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

Fund rollover from year to year

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

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

How your deductible works

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

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

Preventive Care

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

Questions and Answers

How do I contribute to my HSA?

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

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

The IRS stipulates that your plan year HSA funding can be no more than your plan year deductible and cannot exceed \$3,000*, if you have individual coverage, and \$5,950*, if you have family coverage. For additional information, you can visit the IRS web site at: www.IRS.gov or call (800) 829-3676.

How are my medical and prescription drug claims paid?

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

These expenses can be paid out of your HSA by using your HSA debit card or fund checks. By seeking services from primary care physicians (PCPs),

**This amount applies to year 2009 only.*

your responsibility will be limited to the discounted amount or plan allowance that our PCPs agree to accept as payment in full.

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

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

What happens when HSA funds have been exhausted?

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

The amount of money you and/or your employer have contributed to your HSA will determine how much of a “bridge” you have before your CareFirst BlueChoice HMO HSA coverage becomes available.

Who administers the Health Savings Account?

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

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

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

Who is eligible to participate in an HSA?

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

To enroll in a health savings account you cannot be:

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

How can I track my health benefits?

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

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

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

Your HSA funds are available to pay for qualified health care expenses covered under your BlueChoice HMO coverage.

What is the definition of a “Qualified Medical Expense”?

Qualified expenses are those permitted by Section 213(d) of the Internal Revenue Tax Code and that are otherwise permissible under the IRS regulations. When you use the account to pay for qualified expenses, you pay with tax-free dollars. Qualified expenses include but are not limited to:

- Prescription Drugs
- Non-Prescription Drugs
- Doctor’s visits, lab, X-ray and other diagnostic and treatment services
- Routine health care, including prenatal care, smoking cessation, obesity weight loss programs
- Qualified long-term care services and qualified long-term care insurance
- COBRA premiums
- Health insurance for those on unemployment compensation
- Medicare Part A and B premiums, Medicare HMO or Medicare Advantage premiums (but not premiums for Medicare Supplemental policies).

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

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

Health Reimbursement Arrangement (HRA)

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

How your HRA works

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

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

Fund rollover from year to year

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

Available to members of employer-based group plans

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

How Your Deductible Works

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

If you have a combined deductible, you also have a combined out-of-pocket maximum. This means your eligible health care and prescription drug out-of-

pocket expenses will be applied towards meeting your out-of-pocket maximum. Should you reach your out-of-pocket maximum, CareFirst BlueChoice will pay 100% of the applicable plan allowance for most covered services for the remainder of the benefit year.

Preventive Care

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

Questions and Answers

How do I contribute to my HRA?

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

What happens when HRA funds have been exhausted?

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

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

What happens if I leave my employer?

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

How are my medical and prescription drug claims paid?

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

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

Reimbursement

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

Prescription drug deductible

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

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

What is the definition of "Qualified Medical Expense"?

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

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

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

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

BlueFund Administration
13511 Label Lane, Suite 201
Hagerstown, MD 21740
Fax: (301) 564-5191

You will have 90 days from the end of your benefit year to submit claims or have claims automatically processed for reimbursement through your HRA for services received during the ending benefit year. Be sure to contact your health care provider and request that he/she submit their claims to CareFirst BlueChoice before the 90 days expire for services that need to be processed through your BlueChoice HMO HRA coverage. Any claims for the ending benefit year posted to your HRA after this 90-day period will not be reimbursed to you.

You'll be able to see exactly where your money goes, so you can make the best decision. Visit the CareFirst BlueChoice web site at www.carefirst.com for more information.

How can I track my health benefits?

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

CareFirst BlueChoice offers online tools which allow you to:

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

Definition of Terms

Allowed Benefit: The lesser of the actual charge or the amount CareFirst BlueChoice allows for the service on the date the service is rendered.

Appeal: A protest filed by a member or a health care provider under CareFirst BlueChoice's internal appeal process regarding a coverage decision.

Authorization: The contractual requirement that the provider or member notify and obtain approval from the plan before certain services are covered for a member. Authorization is required for services such as, but not limited to, non-emergency hospitalizations, certain hospital services, skilled nursing care, home health care, outpatient surgical services, and durable medical equipment.

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

Complaint: A protest filed with the regulatory department involving an adverse decision, coverage decision, appeal decision, or grievance decision.

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

Copayment: A specified amount that the member pays for a covered benefit (e.g., \$10 per office visit to a Primary Care Physician).

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

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

Evidence of Coverage: A document reflecting an individual's or group's enrollment agreement with CareFirst BlueChoice.

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

Health Care Provider: An individual who is licensed or otherwise authorized in this State to provide health care services in the ordinary course of business or practice of a profession, and is a treating provider of the member; or a hospital.

Health Maintenance Organization (HMO): An organization that provides a wide range of health care service through a primary care physician (PCP) who renders or coordinates all of your care to provide you with quality service while reducing medical costs.

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

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

HIPAA: Health Insurance Portability and Accountability Act. This Act addresses many tenets of health insurance coverage including the handling of Personal Health Information (PHI) and the Member's ability to receive credit towards his or her waiting period.

Member: An individual who meets all applicable eligibility requirements stated in Part 2 of the Evidence of Coverage, is enrolled for coverage, and for whom we receive the premiums and other required payments. A member can be either a subscriber or a dependent.

Network: A group of multi-specialty medical groups and individual practice doctors who are contracted to provide services to members of a health plan.

Practitioner: Professionals who provide health care services. Practitioners are required to be licensed as defined by law.

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

Primary Care Physician: The Plan physician selected by or on behalf of, the member to provide primary care to the member and to coordinate and arrange other required services.

Provider: An individual, institution or organization that provides medical services. Examples of providers include physicians, therapists, hospitals and home health agencies.

Referral: A written authorization by the PCP for the member to see a specialty provider.

Specialist: A licensed health care provider to whom a member can be referred to by a primary care physician.

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



Index

- Alternative therapies (*Options*) **10-13**
- Appeals **22**
- Appointments, canceling **6**
- Appointments, making **6**
- Appointments, scheduling guidelines **6**
- Argus Health Systems **18**
- Away From Home Care® **15**
- BlueCard® Program **14**
- BlueVision **19**
- CareEssentials **3, 7-9**
- Case Management Program **9**
- Claim forms **20**
- College students **15**
- Complaints **21-22**
- Confidentiality **25**
- Contact lenses **19**
- Coordination of benefits **20**
- Corrective lenses **19**
- Coverage, continuing **23**
- Coverage, ending **23**
- Denial of benefits, appeals **23-24**
- Dental care **17**
- Disease Management Programs **9**
- Emergency, definition **13**
- Evidence of Coverage **27**
- FirstHelp® **14**
- Follow-Up Care **15**
- Frequently asked questions **2-4**
- Great Beginnings* Program for Expectant Mothers **7**
- Gynecological care **8**
- Health Reimbursement Arrangement (HRA) **30-31**
- Health Savings Account (HSA) **27-29**
- Hospital care, authorization for **8**
- Hospital care, continued stay review **9**
- Laboratory services **6**
- Medical emergency, definition **12**
- Medical records **6**
- Medical records, confidentiality **6, 25**
- Member satisfaction **21-22**
- Member ID card **1**
- Mental health care **16**
- My Care First* **7**
- My Account* **4**
- Options* Discount Program **10-13**
- Other insurance **20**
- Portability (HIPAA) **24**
- Prescription drugs **17-18**
- Prescriptions, drug formulary **18**
- Preventive services guidelines **8**
- Primary care physician, changing **6**
- Primary care physician, choosing **5**
- Primary care physician, role of **5**
- Prior authorization **18**
- Provider directory **2, 4**
- Referrals **6**
- Reimbursement, how to file a claim for **20**
- Responsibilities, member **26**
- Rights, member **26**
- Specialists **2, 6**
- Substance abuse **16**
- Traveling, care while **14**
- Urgent care centers **13**
- Utilization Management **8**
- Vitality* member newsletter **7**

For More Information, Call Member Services at the Telephone Number on Your Member ID Card.

Policy Form Numbers

DC: DC/BC/GC 2/02 • DC/BC/EOC 2/02 • DC/BC/DOC 2/02 • DC/BC-OOP/SOB (R. 6/04) • DC/CFBC/ATTC (R. 5/05) • DC/CFBC/RX3 (R. 1/04) and any amendments or riders.
Prescription Drug Rider: DC/CC/Ind Drug (11/04)

MD: MD/CFBC/GC (R. 7/03) • MD/CFBC/EOC (R. 7/03) • MD/CFBC/DOCS (R. 7/03) • MD/BC-OOP/SOB (R. 7/03) • MD/CFBC/ELIG (R. 5/05) • MD/CFBC/RX3 (R. 1/04)
and any amendments or riders. Prescription Drug Rider: MD/CC/Ind Drug (R. 10/04)

MSGR: GEA-CC (MSGR) (R. 10/01) • EOC-CC (MSGR) (R. 10/05) • DOCS-HMO REV (MSGR) (R. 7/03) • SOB-HMO-CORE (MSGR) (R. 7/04) • MD/BC/AMEND DOCS OPEN
ACCESS MSGR (4/03) • MD/BC OO/OA MSGR (4/04) and any amendments.

VA: VA/CC/GC 5/01 • VA/CFBC/EOC (R. 1/06) • VA/CC/DOC 5/01 • VA/BC-OOP/SOB (R. 6/04) • VA/CFBC/ATTC (R. 5/05) • VA/CFBC/RX3 (R. 1/04) and any amendments or riders.
Prescription Drug Rider: None

Dental Policy Form Numbers

DC: DC/BC/DENTAL RIDER (R. 1/04) • DC/BC/DHMO RIDER (7/03) • DC/BC/DHMO RIDER INOUT (7/03) • DC/BC/DHMO SCHBEN 10 CP (R. 10/05) • DC/BC/DHMO
SCHBEN 20 CP (R. 10/05) • DC/BC/DHMO RIDER OON SCHED (R. 10/05).

MD: MD/BC/DENTAL RIDER (7/03) • MD/BC/DHMO RIDER (7/03) • MD/BC/DHMO RIDER INOUT (7/03) • MD/BC/DHMO SCHBEN 10 CP (R. 10/05) • MD/BC/DHMO
SCHBEN 20 CP (R. 10/05) • MD/BC/DHMO RIDER OON SCHED (R. 10/05).

VA: VA/BC/DENTAL RIDER (R. 1/04) • VA/CC/DENT ASSGN 7/99 • VA/BC/DHMO RIDER (7/03) • VA/BC/DHMO RIDER INOUT (7/03) • VA/BC/DHMO SCHBEN 10 CP
(R. 10/05) • VA/BC/DHMO SCHBEN 20 CP (R. 10/05) • VA/BC/DHMO RIDER OON SCHED (R. 10/05).

Vision Policy Form Numbers

DC: DC/BC-OOP/VISION (R. 6/04) • DC/BCOO/VISION (R. 1/06) • CFBC/EXCLUSION-V (9/04). Direct Bill (non-group): DC/BC-OOP/VISION (R. 6/04) •
CFBC/EXCLUSION-V (9/04)

MD: MD/BC-OOP/VISION (R. 6/04) • MD/BCOO/VISION (R. 1/06) • MD/CFBC/EXCLUSION-V (9/04). Direct Bill (non-group): MD/BC-OOP/VISION
(R. 6/04) • MD/CFBC/EXCLUSION-V (9/04)

VA: VA/BC-OOP/VISION (R. 6/04) • VA/BCOO/VISION (R. 1/06) • CFBC/EXCLUSION-V (9/04).
Direct Bill (non-group): VA/BC-OOP/VISION (R. 6/04) • CFBC/EXCLUSION-V (9/04)



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www.carefirst.com

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