CareFirst

CareFirst BlueCross BlueShield

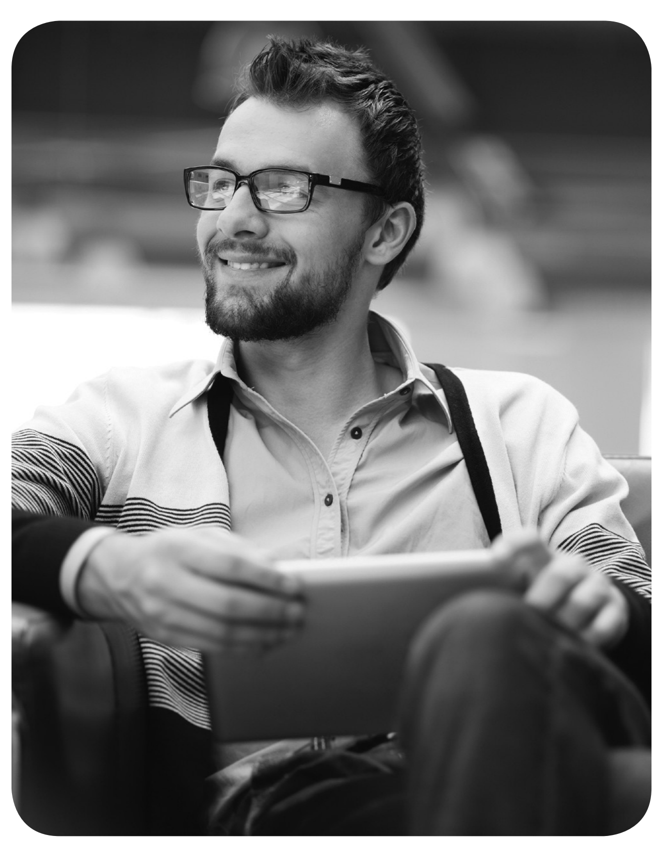
Preferred Provider Organization

A Referral-Free Go Anywhere Health Plan

Designed for today's health conscious and busy families, the Preferred Provider Organization (PPO) plan offers one less thing to worry about during your busy day. Your PPO plan gives you the freedom to visit any provider you wish—any time you wish. This means you can receive care from the provider of your choice without ever needing to select a primary care provider (PCP) or obtaining a PCP referral for specialist care.

Benefits of PPO

- Access to our network of more than 26,000 doctors, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- No primary care provider required, and no referrals to see a specialist.
- Take your health care benefits with you—across the country and around the world.
- Receive coverage for preventive health care visits at no cost.
- Avoid balance billing when you receive care from a preferred provider.
- Enjoy the freedom to visit providers outside of the PPO network and still be covered but with a higher out-of-pocket cost.



No referrals.
No PCPs.
Coverage everywhere.

How your plan works

In-network vs. out-of-network coverage

The amount of coverage your PPO plan offers depends on whether you see a provider in the PPO network (preferred provider). You will always receive a higher level of benefits when you visit a preferred provider. However, the choice is entirely yours. That's the advantage of a PPO plan.

In-network benefits provide a higher level of coverage. This means you have lower out-of-pocket costs when you choose a preferred provider. If you are out of the CareFirst BlueCross BlueShield (CareFirst) service area, you have the freedom to select any provider that participates with a Blue Cross and Blue Shield PPO plan across the country and receive benefits at the in-network level.

Out-of-network benefits provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose. If you receive services from a provider outside of the PPO network (non-preferred provider), you may have to:

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

Hospital authorization/ Utilization management

Preferred providers will obtain any necessary admission authorizations for in-area covered services. You will be responsible for obtaining authorization for services provided by non-preferred providers and out-of-area admissions. Call toll-free at (866)—PREAUTH.

Your benefits

Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your PPO coverage will become available to you.

You will have a different deductible amount for in-network vs. out-of-network benefits. However, any amount applied to your in-network deductible will also count toward your out-of-network deductible and vice versa.

If more than one person is covered under your PPO plan, once the total deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements vary based on your coverage level (e.g. individual, family) as well as the specific PPO plan selected. Members should refer to their Evidence of Coverage for detailed deductible information.

Step 2: Your PPO plan will start to pay for services

After you satisfy your deductible, your PPO plan will start to pay for covered services. The level of those benefits will depend on whether you see preferred or non-preferred providers.

In general, non-preferred providers do not have an agreement with CareFirst to accept the allowed benefit as payment in full for their services. Therefore, if you receive services from a non-preferred provider, you may be balance billed based on the provider's actual charge. In addition, you may be required to pay the non-preferred provider's total charges at the time of service and submit a claim to CareFirst for reimbursement.

Depending on your particular plan, you may have to pay a copay or coinsurance when you receive care.

Step 3: Your out-of-pocket maximum

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

You will have a different out-of-pocket maximum for in-network vs. out-of-network benefits. However, deductible amounts applied to your in-network out-of-pocket maximum will also count toward your out-of-network out-of-pocket maximum and vice versa.

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

Out-of-area coverage

You have the freedom to take your health care benefits with you—across the country and around the world. BlueCard® PPO, a program from the Blue Cross and Blue Shield Association, allows you to receive the same health care benefits when receiving care from a BlueCard® preferred provider while living or traveling outside of the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia). The BlueCard® program includes more than 6,100 hospitals and 600,000 other health care providers nationally.

Important terms

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

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

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

These benefits are issued under policy form numbers:

CFMI/TOC (R. 4/05), CFMI/DEF (7/14), CFMI/ELIG (R. 7/06), CFMI/MCSO (7/14), CFMI/TERM (7/14), CFMI/CONT (R. 7/06), CFMI/CONV (R. 7/08) , CFMI/COB; SUBRO (7/14), CFMI/CERT OF CRED COV (7/14), CFMI/HTPW, PPO (7/14), CFMI/BLUECARD (R. 10/07), CFMI/DOCS (7/14), CFMI/UM (7/14), CFMI/EXCLUSIONS (R. 4/05), CFMI/ELIG SCHED (R. 10/07), CFMI/PPO SOB (R. 7/06), CFMI/OP PSYCH & NEUROPSYCH (7/14), CFMI/CLAIMS PROCEDS (7/14), CFMI/GROUP CONTRACT (7/14) And any amendments.

The CareFirst BlueCross BlueShield
family of health care plans

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc.
CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

FOL5075-9P (7/14)

BlueCard®

Wherever You Go, Your Health Care Coverage Goes with You

With your Blue Cross and Blue Shield member ID card, you have access to doctors and hospitals almost anywhere. BlueCard gives you the peace of mind that you'll always have the care you need when you're away from home.

Your membership gives you a world of choices. More than 85% of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care here in the United States or abroad, you'll have access to health care in more than 190 countries.

When you're outside of the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area (Maryland, D.C., and Northern VA), you'll have access to the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals in that area. You shouldn't have to pay any amount above these negotiated rates. Also, you shouldn't have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductibles, copayments, and coinsurance) that you'd pay anyway.

Within the U.S.

1. Always carry your current member ID card for easy reference and access to service.
2. To find names and addresses of nearby doctors and hospitals, visit the National Doctor and Hospital Finder at **www.bcbs.com**, or call BlueCard Access at (800) 810-BLUE.
3. Call Member Services for pre-certification or prior authorization, if necessary. Refer to the phone number on your ID card because it's different from the BlueCard Access number listed in Step 2.
4. When you arrive at the participating doctor's office or hospital, simply present your ID card.
5. After you receive care, you shouldn't have to complete any claim forms or have to pay up front for medical services other than the usual out-of-pocket expenses. CareFirst will send you a complete explanation of benefits.

As always, go directly to the nearest hospital in an emergency.

Visit **www.bcbs.com** to find providers within the U.S. and around the world.

Around the World

Like your passport, you should always carry your ID card when you travel or live outside the U.S. The BlueCard Worldwide program provides medical assistance services and access to doctors, hospitals and other health care professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- At BlueCard Worldwide hospitals, you shouldn't have to pay up front for inpatient care, in most cases. You're responsible for the usual out-of-pocket expenses. And, the hospital should submit your claim.
- At non-BlueCard Worldwide hospitals, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available online at **www.bcbs.com**.
- To find a BlueCard provider outside of the U.S. visit **www.bcbs.com**, select *"Find a Doctor or Hospital."*

Members of Maryland Small Group Reform (MSGR) groups have access to emergency coverage only outside of the U.S.

Medical Assistance When Outside the U.S.

Call (800) 810-BLUE toll-free or (804) 673-1177, 24 hours a day, 7 days a week for information on doctors, hospitals, other health care professionals or to receive medical assistance services. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization if necessary.

From the CareFirst BlueCross BlueShield family of health care plans.

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BRC6290-9P (5/12)

BluePreferred

Summary of Benefits

Services	Preferred Providers In-Network You Pay[1]	Non-Preferred Providers Out-of-Network You Pay[2]
ANNUAL DEDUCTIBLE (Benefit period)[3,4]		
Individual Family	$300 $600	$600 $1,200
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[7] Prescription Drug[7]	$1,000 Individual/$3,000 Family $4,500 Individual/$9,000 Family	$3,000 Individual/$6,000 Family All drug costs are subject to in-network OOPM
LIFETIME MAXIMUM	None	
PREVENTIVE SERVICES		
Well-Child Care 0–24 months 24 months–13 years (immunization visit) 24 months–13 years (non-immunization visit) 14–17 years	 No charge* No charge* No charge* No charge*	 20% of Allowed Benefit 20% of Allowed Benefit 20% of Allowed Benefit 20% of Allowed Benefit
Adult Physical Examination	No charge*	Deductible, then 20% of Allowed Benefit
Routine GYN Visits	No charge*	Deductible, then 20% of Allowed Benefit
Breast Cancer Screening/Mammograms	No charge*	CareFirst pays 100% of Allowed Benefit
Cancer Screening Pap Test and Prostate Colorectal	 No charge* No charge*	 Plan pays 100% of Allowed Benefit Plan pays 100% of Allowed Benefit
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	$20 per visit	Deductible, then 20% of Allowed Benefit
Diagnostic Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
X-rays and Lab Tests	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Allergy Testing	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Allergy Shots	$5 per visit	Deductible, then 20% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy	$20 per visit	Deductible, then 20% of Allowed Benefit
Outpatient Spinal Manipulation	$20 per visit	Deductible, then 20% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$20 per visit	Deductible, then 20% of Allowed Benefit
Urgent Care Center	$100 per visit	Deductible, then 20% of Allowed Benefit
Hospital Emergency Room (limited to emergency service)	$100 per visit (Waived if admitted) no deductible	Paid as in-network
Ambulance (if medically necessary)	No charge* after deductible	Deductible, then 20% of Allowed Benefit
HOSPITALIZATION		
Inpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit

Services	Preferred Providers In-Network You Pay[1]	Non-Preferred Providers Out-of-Network You Pay[2]
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 40 visits per benefit period)	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Hospice (limited to a maximum 180 day eligibility period)	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days per benefit period)	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
MATERNITY		
Prenatal and Postnatal Office Visits	No charge*	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Initial Office Consultation(s) for Infertility Services/Procedures	$20 per visit	Deductible, then 20% of Allowed Benefit
Artificial Insemination[6]	No charge* after deductible	Deductible, then 20% of Allowed Benefit
In Vitro Fertilization Procedures[6] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	No charge* after deductible	Deductible, then 20% of Allowed Benefit
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Office Visits	$20 per visit	Deductible, then 20% of Allowed Benefit
Partial Hospitalization Facility Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Partial Hospitalization Physician Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Medication Management Visit	$20 per visit	Deductible, then 20% of Allowed Benefit
MISCELLANEOUS		
Durable Medical Equipment	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by CareFirst when used for anesthesia)	Not covered (except when approved or authorized by CareFirst when used for anesthesia)
Transplants	Covered as stated in the Evidence of Coverage	Covered as stated in the Evidence of Coverage
Hearing Aids for ages 0–18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	No charge*	No charge*
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Total charge minus $33
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

* No copayments or coinsurance.

1 In-network: When covered services are rendered by a provider in the Preferred Provider network, care is reimbursed at the in-network level. In-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueCross BlueShield (CareFirst), however, in certain circumstances, the Allowed Benefit for a Preferred Provider may be established by law.

2 Out-of-network: When covered services are rendered by a provider not in the Preferred Provider network, care is reimbursed as out-of-network. Out-of-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment of covered services. These payments are established by CareFirst, however, in certain circumstances, the Allowed Benefit for an out-of-network provider may be established by law. When services are rendered by Non-Preferred Providers, charges in excess of the Allowed Benefit are the member's responsibility.

3 For family coverage only: When one family member meets the individual deductible, they can start receiving benefits as indicated above. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.

4 Copayment or portion of deductible may be required at the point of service while in the deductible period. Member will never be required to pay more than CareFirst's Allowed Benefit for a covered service rendered by a Preferred Provider.

5 For family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.

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

7 Plan has separate out-of-pocket maximums for medical and drug expenses which accumulate independently.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under the following form numbers: MD/CF/GC (R. 9/11); MD/BP/EOC (10/07); MD/GHMSI/DOL APPEAL (R. 9/11); MD/BP/DOCS (10/07); MD/CF/BP/SOB (R. 4/08); MD/CF/VISION (R. 10/11); MD/CF/RX (R. 7/12); MD/CF/ATTC (R. 7/09); CFMI/51+/GC (R. 9/11); CFMI/51+/EOC (4/09); CFMI/DOL APPEAL (R. 9/11); CFMI/51+/DOCS (4/09); CFMI/51+/PPO SOB (4/09); CFMI/VISION RIDER (10/11); CFMI/51+/RX (R. 7/12); CFMI/51+/ELIG (R. 1/10) and any amendments.

www.carefirst.com

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CST2386-1P (10/14) ■ MD ■ National Academy of Sciences - Fellowship

Pharmacy Program

$0 Deductible ■ $0/10/20/35 Retail Copays
50% Injectables Coinsurance

National Academy of Sciences – Fellowship

Summary of Benefits

Plan Feature	Amount	Description
Deductible	None	Your benefit does not have a deductible.
Family Deductible	None	Your benefit does not have a family deductible.
Annual Out-of-Pocket Maximum	See medical summary of benefit for annual out-of-pocket amount	Once you reach your out-of-pocket maximum, CareFirst will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance, and other eligible out-of-pocket costs count toward your out-of-pocket maximum. Balance billed amounts do not count toward your annual out-of-pocket maximum.
Preventive Drugs (Affordable Care Act) (up to a 34-day supply)	$0	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List (ACA)* (examples: Folic Acid, Flouride and FDA approved contraceptives for women).
Oral Chemotherapy Drugs Diabetic supplies (up to a 34-day supply)	$0 (not subject to deductible)	Diabetic supplies include needles, lancets, test trips, alcohol swabs, medical covers glucose pumps and meters.
Generic Drugs – (Tier 1) (up to a 34-day supply)	$10	All Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	$20	All Preferred Brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	$35	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Check the online Preferred Drug List to see if there is an alternative drug available. Discuss using alternatives with your physician or pharmacist.
Maintenance Copays (up to a 90-day supply)	Generic: $20 Preferred Brand: $40 Non-preferred Brand: $70	Maintenance drugs of up to a 90-day supply are available for twice the copay only through mail order or retail pharmacy.
Restricted Generic Substitution	Yes	If you choose a Non-preferred Brand drug (Tier 3) instead of its Generic equivalent, you will pay the Non-preferred Brand copay PLUS the difference in cost between the Non-preferred Brand drug and the Generic. If a Generic version is not available, you will only pay the copay. Also, if your prescription is written for a Brand-name drug and DAW (dispense as written) is noted on the prescription, you will only pay the copay.

*Access the drug search tool at **www.carefirst.com/rx** for the most up-to-date Preferred Drug List, Preventive Drug List (ACA) and care management criteria. Care management criteria are applied so that some medications can be used in limited quantities; others require advanced approval or prior authorization by your doctor before they can be filled.

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Policy Form Numbers: MD/CFBC/RX (R. 7/12) • MD/CF/RX (R. 7/12) • CFMI/51+/RX (R. 7/12)

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Preferred Dental

Includes access to a National Provider Network

National Academy of Sciences – Fellowship

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

Advantages of the plan

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

Three options for care

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

Frequently asked questions

How do I find a preferred dentist?

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

How much will I have to pay for dental services?

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

Is there a lot of paperwork?

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

Who can I call with questions about my dental plan?

Call Dental Customer Service toll free at: (866) 891-2802 between 8:30 am and 5:00 pm ET, Monday–Friday.

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

Summary of Benefits

		IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY
DEDUCTIBLE APPLIES TO ALL BASIC AND MAJOR SERVICES		$25 Ind./$75 Family	$50 Ind./$150 Family
ANNUAL MAXIMUM APPLIES TO ALL SERVICES		Plan pays $1,500 Combined Maximum	
PREVENTIVE & DIAGNOSTIC SERVICES			
▪ Oral Exams (two per benefit period) ▪ Prophylaxis (two cleanings per benefit period) ▪ Bitewing X-rays ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months)	▪ Fluoride treatments (two per benefit period per member, until the end of the year the member reaches the age 19) ▪ Sealants on permanent molars (once per tooth per 36 months per member, until the end of the year the member reaches the age 19) ▪ Space maintainers (once per 60 months) ▪ Palliative emergency treatment	No charge	20% of Allowed Benefit[1]
BASIC SERVICES			
▪ Direct placement fillings using approved materials (one filling per surface per 12 months)	▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment) ▪ Simple extractions	20% of Allowed Benefit after deductible[1]	40% of Allowed Benefit after deductible[1]
MAJOR SERVICES—SURGICAL			
▪ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy)	▪ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section) ▪ General anesthesia rendered for a covered dental service	50% of Allowed Benefit after deductible[1]	65% of Allowed Benefit after deductible[1]
MAJOR SERVICES—RESTORATIVE			
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges, crowns, inlays and onlays (once per 60 months) ▪ Denture adjustments and relining (limits apply for regular and immediate dentures)	▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance) ▪ Dental implants, subject to medical necessity review (once per 60 months)	50% of Allowed Benefit after deductible[1]	65% of Allowed Benefit after deductible[1]

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

Summary of Exclusions: Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Benefits issued under policy form numbers: Group Hospitalization and Medical Services, Inc.: DC/CF/GC (R. 10/11) · DC/CF/COC DEN (9/04) · DC/CF/DO-DOCS (R. 10/11) · DC/CF/DO-SOB (R. 1/04) · DC/CF/ELIG (9/04) · and any amendments.

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CST2492-1P (10/14) ▪ DC ASO

New Coverage Checklist

- ☐ Make sure your current provider is in-networks using the BlueCross Blue Shield website at www.provider.bcbs.com.

- ☐ To find a dental provider please visit the provider directory at www.carefirst.com/doctor and select the "dental" tab.

- ☐ Review the new Prescription Drug formulary to make sure all current Prescriptions you use fall within your new coverage. If not, speak with your doctor about your options. To search prior to the 1/1/2015 effective date, enter your drug's name in the search field at https://member.carefirst.com/individuals/drug-pharmacy-information/non-aca-druglist-three-tier.page. After 1/1/2015, you can use MyAccount to search for drugs and find pricing at multiple pharmacies.

- ☐ If you are currently utilizing mail order prescriptions drugs, you will need to have your doctor write a new prescription to continue doing so. Also, locate the Mail Service order form at http://www.caremark.com/portal/asset/MOF_Carefirst.pdf. We recommend getting your prescription filled prior to 11/1/14 to allow time to set up the new mail order script.

- ☐ Look for your new ID card in the mail and on the CareFirst mobile app after 11/1/14.

- ☐ On 11/1/14, sign-up for MyAccount at CareFirst.com and download our mobile app in order to receive your electronic ID card, benefits information, and your explanations of benefits. The mobile app will help you find providers using your current location.

- ☐ If you are being treated for an ongoing issue at an out-of-network provider, you may be able to continue to use that provider and receiving in-network benefits for up to 90 days using our Transition of Care Service. Please let your benefits office know if you have any ongoing issues and for more information on how to qualify for this service.

  Examples of conditions that qualify for Transition of Care are:

  - Pregnancy (beyond 24 weeks gestation)
  - Bone Fractures
  - Recent Heart Attack
  - Other Acute Trauma or Surgery
  - Newly diagnosed Cancer

Request for Transition of Care Instructions

One of your concerns as you seek enrollment in a CareFirst BlueCross BlueShield (CareFirst) and/or CareFirst BlueChoice, Inc. (CareFirst BlueChoice) plan may be continuity of treatment. CareFirst and CareFirst BlueChoice members and their covered dependent(s) who receive care from an out-of-network physician for an unstable or serious medical condition may be eligible for the Transition of Care program.

What is Transition of Care?

In order to ensure continuity of treatment, CareFirst and CareFirst BlueChoice offer a special program called Transition of Care. If your request is approved, the Transition of Care program allows you or your covered dependent(s) to continue to receive care from an out-of-network physician for up to 90 days following the date of enrollment. Benefits will be paid at the in-network level (i.e., minimal copayments and no calendar year deductible.)

Who should use this form?

If you or your covered dependent(s) have an unstable or serious medical condition that requires a limited course of treatment or follow-up care, and are currently being treated by a specialist who is not a CareFirst and/or CareFirst BlueChoice participating provider, you should complete this form. Information is required from both you and your physician.

Please be sure to submit a separate form for each non-participating physician currently treating you or your covered dependent(s) for an unstable or serious medical condition. Your newly selected participating CareFirst and/or CareFirst BlueChoice physician must coordinate any other unrelated treatment for you or your covered dependent(s).

Note: If the physician treating your condition participates in the CareFirst and/or CareFirst BlueChoice network, it is not necessary to complete this form. Instead, contact your new primary care physician to discuss the current treatment.

Examples of medical conditions that may qualify for the Transition of Care program include:

- pregnancy (beyond 24 weeks gestation)
- bone fractures
- recent heart attack
- other acute trauma or surgery
- joint replacement
- newly diagnosed cancer

Examples of chronic medical condition that typically are not eligible for the Transition of Care program include:

- arthritis
- asthma
- allergies
- diabetes
- hypertension
- COPD/emphysema

Please complete the *Employee/Retiree Information* and *Patient Information* sections on the other side of this form. Also, have the physician complete the *Physician Information* section. Return the form to the following address **before the effective date of your coverage**. No forms will be accepted after that date.

Qualified medical professionals in the CareFirst and CareFirst BlueChoice Care Management Department will review the request and notify your provider of a determination by phone within (2) business days following the receipt of all required information. If the services are not approved, you and your provider will also be notified in writing.

Mail the completed form and any attachments to:
CareFirst BlueCross BlueShield
Pre-Service Review Department
1501 South Clinton Street
8th Floor
Mail Stop: CT-08-02
Baltimore, MD 21224

Or fax the completed form and any attachments to:
410-720-3060
Attention: Pre-Service Review

If you have any questions concerning benefits or provider status, contact Member Services. The phone number is listed on the back of your identification card.

Request for Transition of Care Form

Insurance Information			
Member's Name		Date of Birth	
Street Address		Member ID	
City		Group Name	Effective Date of Coverage
State	Zip Code	Group Number	Check one HMO POS PPO
Home Telephone ( )			

Patient Information	
Patient's Name	Patient's Date of Birth

Physician Information			
Name of Physician Currently Treating Condition		Diagnosis Code(s) (ICD-9)	Date Treatment Started
Specialty		Diagnosis Code(s) (CPT/HCPCS)	Date of Next Treatment/Visit
Street Address		For Pregnancy, Please Indicate the Patient's Anticipated Due Date	
City		**Please attach the following:** List of services that may already be scheduled in the next few weeks (CPT code and date, provider) A brief statement of the patient's current condition and treatment plan Copies of any pertinent documentation (e.g., lab results, X-rays)	
State	Zip Code		
Telephone ( )			
Physician's Signature			Date

This information will be used for determining the appropriate level of benefit reimbursement for services provided on or after the effective date of my CareFirst coverage, if I continue treatment with the above named provider for the above diagnosis/ medical condition.

I understand that Transition of Care is granted at the discretion of CareFirst and is subject to contractual limitations and exclusions set forth in the group contract. I understand and agree that Transition of Care does not extend the contractual benefits in any way, except to provide in-network level benefits for a non-network provider for a temporary time period.

Patient's Signature ______________________ Date: ______

Employee/Retiree's Signature* ______________________ Date ______

*If the patient is younger than 18, the employee/retiree must sign this form.

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Patient-Centered Medical Home

Focusing on You and Your Health

Whether you're trying to get healthy or stay healthy, you need the best care available. That's why the CareFirst BlueCross BlueShield[1] family of health plans has created a program to improve health care quality and help slow rising health care costs over time.

Our Patient-Centered Medical Home (PCMH) program focuses on the relationship between you and your primary care provider (PCP)—whether a physician or nurse practitioner (NP). It's designed to provide your PCP[2] with a more complete view of your health needs, as well as the care you're receiving from other providers. As the leader of your health care team, your PCP will be able to use this information to better manage and coordinate your care, a key to better health.

Treating your overall health

Whether you see your PCP for preventive care, or you need more care, your PCP is expected to:

- Coordinate your care with all your health care providers, including specialists, labs, pharmacies, and mental health facilities to help you get access to, and receive, the most appropriate care available in the most affordable settings.
- Identify and address any impact the care you receive for one health issue may have on another.
- Review all of your medications and possible drug interactions with you.
- Review your health records for duplicate tests or services already ordered or performed by another provider.

Why a PCP is important to your health

By visiting your PCP for routine visits as recommended, you can build a relationship, and your PCP will get to know you and your medical history.

A PCP is concerned with your overall health. If you have an urgent health issue, having a PCP who knows your health history often makes it easier and faster to get the care you need. Your PCP can sometimes provide advice over the phone or fit you in for a visit. That helps you avoid long lines and expensive charges at the emergency room.

When you visit your PCP for screenings and preventive services, he or she can detect health concerns in the early stages, when they are easier and less costly to treat.

[1] *All references to CareFirst refer to CareFirst BlueCross BlueShield and CareFirst, BlueChoice, Inc., collectively.*

[2] *The doctors and other medical providers, who provide your care, are independent providers making their own medical determinations and are not employed by either CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc.*

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

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

Extra care for certain health issues

When you participate in PCMH, your PCP will take specific steps to coordinate and manage your care. If you have certain health issues, your PCP will create an online record of your health needs with specific follow-up activities.

Your care coordinator is expected to:

- Assist your PCP by coordinating your care and answering your questions.
- Follow up with you to make sure you're not having problems following your treatment plan. For example, if you have diabetes, the care coordinator can help you take steps to better understand and control your diabetes.
- Assist you in obtaining services and equipment necessary to manage your health condition.

It's your choice

PCMH is a voluntary program. When you participate:

- You pay no additional premium.
- There is no change in your benefits.
- There is no change to your health plan requirements.
- You can opt-out at any time without penalty and without changing your PCP and/or NP.

Please note that if you have a high deductible health plan, certain charges may apply until you meet your deductible.

How do I get started?

Simply sign the Election to Participate form and return it to your PCP.

You can get the form from your PCP, or you can download it from the Forms section at **www.carefirst.com/memberpcmh**. By signing the election form, you agree to give your PCP access to your health information on file with CareFirst. This includes data from claims and notes from any CareFirst programs in which you have participated.

The CareFirst BlueCross BlueShield
family of health care plans

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CST1310-1P (7/14)

Find a Doctor, Hospital or Urgent Care

www.carefirst.com/doctor

It's easy to find the most up-to-date information on health care providers and facilities who participate with CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively CareFirst).

Whether you need a doctor or a facility, **www.carefirst.com** can help you find what you're looking for based on your specific needs.

We make it easy for you to find the doctors you need at **www.carefirst.com**. The site is updated weekly, so you always have the most up-to-date information available.

The most up-to-date information:

Go to **www.carefirst.com/doctor**.

From here you can:

- Find a doctor or provider in your plan.
- Search for a doctor by name.
- Select a Primary Care Physician.

Click *"Find Providers"* tab on **www.carefirst.com** to:

- Learn more about our Directory.
- Change your PCP.
- Research a Doctor or a Hospital.
- Learn about Specialists.

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CUT5766-2P (8/13)

Emergency or Urgent Care

Know when to choose the ER vs. an urgent care center

About 17% of all emergency room visits in the U.S. could be treated at retail medical clinics or urgent care centers, potentially saving $4.4 billion a year in health care costs.[1] That's why it's important to know your options ahead of time so you can make sure you're getting the right care at the right time.

When should you go to the ER?

Medical emergencies require a visit to the emergency room.

A medical emergency is a sudden serious illness or injury that, without immediate medical attention, could result in:

- Serious jeopardy to the patient's health.
- Serious impairment to bodily functions.
- Serious dysfunction of a body part or organ.
- Serious health risks for a pregnant woman's fetus.

If the situation is a medical emergency—call 911 or go directly to the nearest emergency care facility.

- Prior authorization is not needed for emergency room services.

Some examples of possible medical emergency situations include:

- Chest pain.
- Trouble breathing.
- Head trauma.
- Bleeding that doesn't stop when pressure is applied.
- Broken bones.
- Loss of consciousness or blacking out.
- Drugs or poisoning.
- Severe burns.
- Rape or assault.

If you're not experiencing an emergency, contact your family doctor for advice. Most doctors offer phone access 24 hours a day, 7 days a week. Even if you're only able to reach a provider on-call, they may be able to see you in the office or direct you to an urgent care facility.

What is Urgent Care?

An urgent condition is not life threatening, but does require prompt medical attention. If you aren't able to schedule a visit with your PCP or child's pediatrician during office hours, then go to an urgent care center. You can often get treatment more quickly than in an emergency room and urgent care facilities ususally have evening and weekend hours.

Some examples of urgent care situations:

- Sprains.
- Broken fingers.
- Painful sore throat.
- Ear or eye infections.
- Flu.

For a list of participating Urgent Care Centers, visit the Provider Directory at **www.carefirst.com/doctor**.

Also, as a CareFirst member, if you can't reach your PCP, or are unsure about the seriousness of your symptoms, you can also call FirstHelp® at (800) 535-9700 for medical advice.

Remember, urgent care centers don't take the place of your PCP. Your PCP should be your first contact whenever you need medical care that isn't an emergency situation.

Questions?

If you have questions about your benefits or health plan requirements, there are several ways to find the information you need:

- Visit **www.carefirst.com** and log on to My Account to get personalized benefit information.
- Email Member Services securely, through My Account at **www.carefirst.com**.
- Call the Member Services phone number on your member ID card.
- Refer to your Evidence of Coverage or the contract you received when you enrolled.
- Speak with your benefits office, if you have coverage through your employer.

[1] Rand Corporation, September 7, 2010. "Some Hospital Emergency Department Visits Could be Handled by Alternative Care Settings." http://www.rand.org/news/press/2010/09/07.html.

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SUM1581-1P (3/12)

ER versus Urgent Care or Doctor's Office Settings

It's important to know ahead of time what to do when you need emergency or urgent care.
The chart below can help you decide where and when to go for care.

Symptom	Doctors' office setting	Urgent care center
Animal bites		√
Stitches		√
Back pain	√	√
Mild asthma	√	√
Minor headache	√	√
Sprain, strain	√	√
Nausea, vomiting, diarrhea	√	√
Bumps, cuts, scrapes	√	√
Burning with urination	√	√
Cough, sore throat	√	√
Ear or sinus pain	√	√
Eye swelling, irritation, redness or pain	√	√
Minor allergic reactions	√	√
Rash, minor bumps	√	√
Vaccination	√	√

Symptom	Emergency Room
Sudden or unexplained loss of consciousness	√
Signs of a heart attack, such as sudden/severe chest pain or pressure	√
Sign of stroke, such as numbness of the face, arm or leg on one side of the body; difficulty talking; sudden loss of vision	√
Sudden shortness of breath	√
High fever with stiff neck, mental confusion and/or difficulty breathing	√
Coughing up or vomiting blood	√
Cut or wound that won't stop bleeding	√
Possible broken bones	√
Poisoning	√
Stab wounds	√
Sudden, severe abdominal pain	√
Suicidal feelings	√
Partial or total amputation of a limb	√

For a complete listing of Urgent Care Centers, visit **www.carefirst.com/doctor** and select your health plan. Then select *Urgent Care* under the *Facilities* section. Medical emergencies require a visit to the emergency room. If your situation is a medical emergency, call 911 or go directly to the nearest emergency care facility.

This information is not intended as medical advice.

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MBR4745 (8/13)

Preventive Drug List

(Affordable Care Act)

$0 Copays

Under the Affordable Care Act, also known as health care reform, certain categories of drugs and other products were identified as preventive and are available to members at no cost. The following list of drugs and other products are not subject to any copay or deductible when a prescription is written by a provider for members meeting the eligibility criteria below. **This list is subject to change**, so please check **www.carefirst.com/rx** regularly for the most up-to-date list.

Aspirin Drugs	Eligibility Criteria
Aspirin (less than 325 mg)	Men and women who are 45 and over and who are at risk for cardiovascular disease
Aspirin Buffered	
Aspirin EC	
Children's aspirin	
Low Dose Aspirin	

Colon Preparations	Eligibility Criteria
Half Lytely/Bisacodyl	Adults age 50 to 74
MoviPrep	
Prepopik	
Suprep	

FDA Approved Contraceptives	Eligibility Criteria
Female Condom (OTC*)	Females ages 10-65 years
Diaphragm (P) with Spermicide (OTC*)	
Sponge (OTC*) with Spermicide (OTC*)	
Cervical Cap (P) with Spermicide (OTC*)	
Spermicide (OTC*)	
Oral Contraceptive (generics) (P)	
Oral Contraceptive (brand name (P) only when generic equivalent drug is medically inappropriate, as determined by the individual's health care provider). Pre-authorization and medical review of brand oral contraceptives is required.	
Contraceptive Patch (P)	
Contraceptive Ring (P)	
Shot/Injection (generic only, except includes brand-name Depo-SubQ Provera 104 injection) (P)	
Morning After Pill (generic only) (OTC*)	
IUD (inserted by doctor)	
Contraceptive Implant System (inserted by doctor)	
Sterilization Implant	
Sterilization Surgery	

Folic Acid Drugs	Eligibility Criteria
Folic Acid (0.4 mg – 0.8 mg)	Women planning to become, or capable of becoming pregnant

Preventive Drug List (Affordable Care Act)

$0 Copays

Iron Supplementation Drugs	Eligibility Criteria
Carbonyl Iron Oral Suspension	Asymptomatic children who are 2 years old or younger and who are at increased risk for iron deficiency anemia
Ferrous Sulfate Drops	
Ferrous Sulfate Oral Suspension	

Oral Fluoride Drugs	Eligibility Criteria
Sodium Fluoride	Children 6 years old or younger whose primary water source is deficient in fluoride

Smoking Cessation Products	Eligibility Criteria
Bupropion, generic zyban only	Tobacco users who want to quit smoking
Chantix	
Nicotine Gum	
Nicotine Lozenges	
Nicotine Patch	

Vitamin D Drugs (600 IU – 800 IU)	Eligibility Criteria
Ergocalciferol	Adults age 65 years and older
Cholecalciferol	

Your coverage may not include these benefits. Refer to your Evidence of Coverage for details.
(P) Prescription Required
(OTC) Over the Counter
** Requires a prescription from a physician and must be purchased at a pharmacy to obtain the zero-cost share.*

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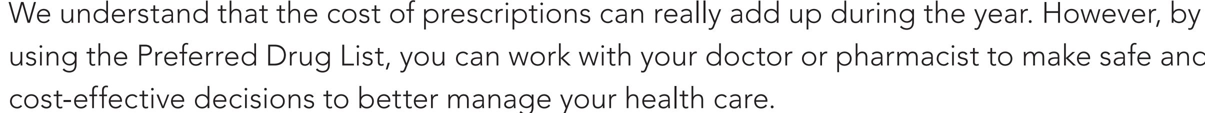
SUM1864-1P (3/14)

Preferred Drug List–3 Tiers

Manage Your Prescriptions and Save



We understand that the cost of prescriptions can really add up during the year. However, by using the Preferred Drug List, you can work with your doctor or pharmacist to make safe and cost-effective decisions to better manage your health care.

At CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) we want you to know what the Preferred Drug List is, and how to use it, so you can make informed choices about your prescription drugs.

What is a Preferred Drug List?

This is a list of covered Preferred Brand and Generic prescription drugs. With your plan, drugs will fall into 1 of 3 Tiers. Tiers 1 and 2 are part of CareFirst's Preferred Drug List and have been selected for their price and effectiveness. Even though Tier 3 drugs aren't part of the Preferred Drug List, they're still covered by your benefits, but at the highest copay.

Talk to your doctor to make sure you're using drugs on CareFirst's Preferred Drug List. Remember, you'll save the most money when you use Tier 1 or Tier 2 drugs. To view CareFirst's Preferred Drug List, please visit **www.carefirst.com/rx**.

How do drugs get on the Preferred Drug List?

You can rest easy knowing your medications have been reviewed for quality, effectiveness, safety and cost by a committee of doctors and pharmacists who serve the CareFirst region. The Preferred Drug List changes frequently in response to Food and Drug Administration (FDA) requirements and is also adjusted when a Generic drug is introduced for a Brand drug. When that happens, the Generic drug will be added to Tier 1 and the Brand drug will automatically move from Tier 2 to Tier 3.

Tier 1* You Pay: Lowest Copay ($)	Generic Drugs	All Generic drugs on the Preferred Drug List will be in Tier 1.
Tier 2* You Pay: Higher Copay ($$)	Preferred Brand Drugs	If a Generic version of a Tier 2 drug is released then: ▪ The Generic drug is added to Tier 1. ▪ The Brand drug moves to Tier 3 and becomes a Non-preferred Brand drug.
Tier 3** You Pay: Highest Copay ($$$)	Non-preferred Brand Drugs	Some plans require members who choose a Tier 3 drug over the Generic version to: ▪ Pay the highest copay, and ▪ Pay the cost difference between the Preferred Brand drug and its Generic.

** Part of CareFirst's Preferred Drug List.*

*** Self-Injectable drugs are covered under Tier 2 or Tier 3 in three-tier designs.*

Rx Authorize

Some medications are only intended to be used in limited quantities, while others require advanced approval. With Rx Authorize, you have access to a program that can help monitor your drug therapy, while promoting the use of clinically approved and cost effective prescription medications.

- **Step Therapy/Prior Authorization**—Step Therapy is used to ensure that you meet the necessary medical criteria to obtain a particular drug. To find out if any of your prescriptions require advance approval (prior authorization) before they can be filled, visit our pharmacy website at **www.carefirst.com/rx**. Please note this list is subject to your benefit plan and may change periodically.

  If you require a prescription for one of these drugs, you or your pharmacist should explain to your doctor that prior authorization is needed before benefits will be available to you and that they must call to begin the process. Without proper authorization, you'll pay the full price of the prescription, rather than only your copay or coinsurance amount.

- **Quantity Limits**—Certain prescription drugs can only be prescribed in limited quantities. These limits are set to ensure that alternative drugs are regularly reconsidered by your doctor. For the most up-to-date list of drugs with quantity limits, visit our pharmacy website at **www.carefirst.com/rx**. This list is subject to change and will be periodically updated.

Maintenance drugs

A maintenance drug is a prescription drug anticipated to be required for 6 months or more to treat a chronic condition. Maintenance drugs can be ordered up to a 90-day supply through retail or Mail Service Pharmacy. The most up-to-date list of maintenance medications can be found on our pharmacy website at **www.carefirst.com/rx**.

Need more information?

Pharmacy tools and resources are available at **www.carefirst.com/rx** so you can take control of your prescription drug costs. You can get the latest information about the 3 Tier pharmacy program, changes to the Preferred Drug List, and more!

Or call CareFirst Pharmacy Services at **800-241-3371** for pharmacy coverage or Preferred Drug List questions.

Questions about drug types, interactions, storage or side effects should be answered by your doctor or pharmacist.

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BRC5939-4P (7/14) ■ 51+

Getting the Most from Your Plan

There's More to Your Health Plan Than You Might Think

Whether you need to find a doctor or hospital, plan your health care expenses, manage your claims and benefits or search for information to help maintain your health, CareFirst offers the services and resources you need...right at your fingertips.

This section outlines the added features you receive as a CareFirst member. Feel free to visit us at **www.carefirst.com** to learn more about the following member benefits:

Find a doctor
Quickly search for the type of doctor you need in your area.

Check claims and benefits
Manage many aspects of your CareFirst plan online, day or night.

Compare plans
Make an informed decision if you have more than one health plan to choose from with our Coverage Advisor tool.

Get discounts
Access wellness discounts on fitness gear, gym memberships, healthy eating options and more.

Read up about your health
Find a wide variety of health education articles, nutritious recipes, interactive health tools and more on the My Care First website. Download the latest issue of our Vitality magazine to learn more about your plan and staying healthy.

Find out how you can get the most from your CareFirst plan...

CUT8380-1P (3/14)

My Account

Online Access to Your Claims

View personalized information on your claims and out-of-pocket costs online with My Account. Simply log on to **www.carefirst.com** for real-time information about your plan.

Features of My Account

- View your deductible status and out-of-pocket costs for your current and previous plan year.
- Review up to one year of medical claims—total charges, benefits paid and costs for a specific date range
- Request an ID card
- Sign up for electronic communications and get your information faster and more securely

Signing Up is Easy

Visit **www.carefirst.com**, click on *"Register Now"* and set up your User ID and Password. You'll just need information from your member ID card.

Additional Tools

Depending on your specific health plan, you may have access to the following services through My Account:

- Find out the exact dollar amount you'll pay at a particular pharmacy
- View a side-by-side comparison of costs at local pharmacies
- Download claim forms
- Find in-network providers

Take My Account where ever you go with our mobile App!

- Access claims information
- Find a doctor or urgent care center
- Add providers to your contacts list with a single tap
- View your ID card
- Manage your health plan...and more!

To download the mobile App, go to the Apple App Store or Google Play (for Android), search for "CareFirst" and install the CareFirst app on your smartphone or tablet.

For more information on our mobile site and app, visit **www.carefirst.com**.

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BRC6499-1P (5/14)

HEALTHY LIVING
is just a deal away.

Join Blue365 and start saving today!

Because health is a big deal[SM]

With Blue365, great deals are yours for every aspect of your life – like 20% off at Reebok.com, discounted products through Jenny Craig, or a gym membership for only $25 a month.

Register now at www.carefirst.com/wellnessdiscounts to take advantage of Blue365. It's an online destination featuring healthy deals and discounts exclusively for our members.

Just have your Blue Cross and Blue Shield member ID card handy. In a couple of minutes, you will be registered and ready to shop. Every week, we will send a special deal straight to your email inbox.

Check out these top brands with discounts just for you:

healthways fitness your way

Reebok

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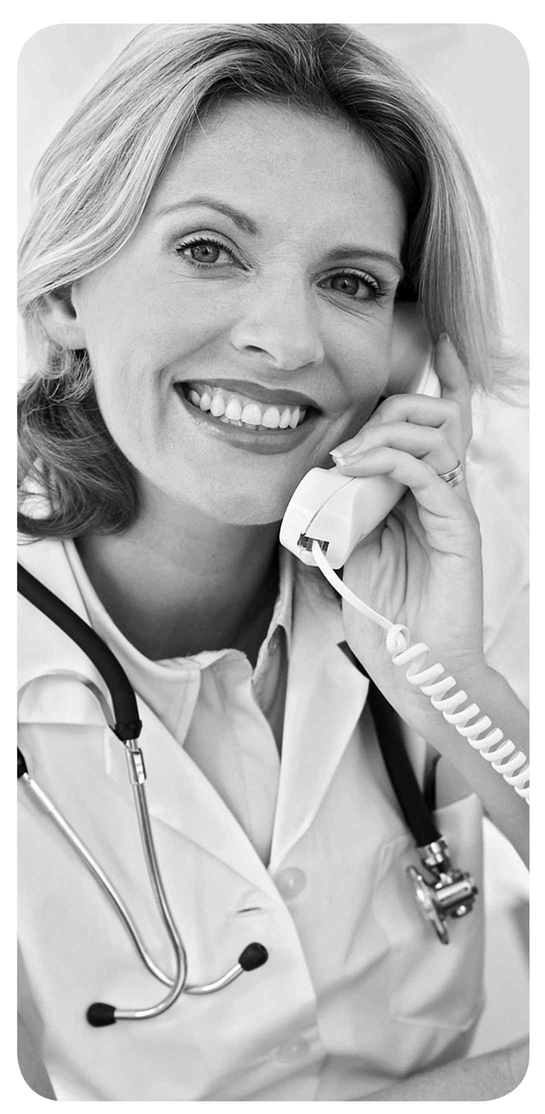
To find out what is covered under your policies, contact your local Blue Company. The products and services described on the Site are neither offered nor guaranteed under your Blue Company's contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding your health insurance products and services may be subject to your Blue Company's grievance process. BCBSA may receive payments from vendors providing products and services on or accessible through the Site. Neither BCBSA nor any Blue Company recommends, endorses, warrants, or guarantees any specific vendor, product or service available under or through the Blue365 Program or Site.

CST2250-1S (3/14)

FirstHelp™ – 24-Hours

Health Care Advice Line (800) 535-9700

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



How FirstHelp Works

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

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

When to Call FirstHelp

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

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

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

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

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

From the CareFirst BlueCross BlueShield family of health care plans.

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