

CareFirst.    
BlueCross BlueShield

## The Benefits of Blue



# BluePreferred

*Why don't **you** have it?*

**Take control  
of your health  
care coverage.**

*Health Care Coverage for Washington, D.C.  
residents who buy their own health insurance.*

# Why Don't *You* Have Health Insurance?

Too busy to make the arrangements?

Think you can't afford it?

It's a fact. For the cost of many of the things you buy each day, you can have the security and peace of mind of health coverage from CareFirst BlueCross BlueShield (CareFirst).

BluePreferred, a health plan from CareFirst BlueCross BlueShield (CareFirst) combines the freedom to select any doctor or specialist, ***even without a referral***, with the flexibility to customize your plan based on the cost options that you select. And to help you control those out-of-pocket costs, we offer you significant savings when you visit a doctor within the CareFirst Preferred Provider Network.

## **BluePreferred offers you:**

- ◆ Maximum flexibility – six benefit levels to choose from – so you can find a plan that's right for you!
- ◆ Freedom to choose any doctor or hospital – no referrals to delay your visit to a specialist – you just make the appointment.
- ◆ A Preventive Care package that saves you money with no charge for well child care up to age 18 and predictable \$25 copays for adult preventive services – both with no deductible to meet – when you visit Preferred Providers!
- ◆ Major Medical coverage with no policy maximum – to protect you against the high cost of a lengthy illness.
- ◆ Little or no paperwork when you visit CareFirst Participating Providers.
- ◆ Easy access to your benefits with Blue Cross Blue Shield *BlueCard*® Program – your direct link to healthcare services nationwide.
- ◆ Security of knowing that you're protected by the state's leading health care insurers protecting individuals who buy their own insurance.

For over 65 years, CareFirst BlueCross BlueShield has provided its members with protection against the high cost of health care. We offer health insurance options to meet the needs and budget of individuals who purchase their own insurance.

Questions? Call us toll free at 1-877-634-1256  
or call your insurance broker.

# Lower Your Expenses

CareFirst BlueCross BlueShield provides you with access to more than 17,000 providers and 42 hospitals in the Washington, D.C. Metropolitan area who participate in our *Preferred Provider Organization*. When you choose to seek your care from one of these providers, CareFirst is able to offer you lower deductibles and coinsurance. Ask your doctor if he or she is a member of our PPO plan, check our website at [www.InsurancePickle.com](http://www.InsurancePickle.com), or call us directly at 1-877-634-1256 for an up-to-date list of providers.

Of course, BluePreferred also offers you the flexibility to select any doctor – either in or out of the CareFirst network. If you decide to go out-of-network for any covered services, you will simply share more of the costs, in the form of higher coinsurance and deductibles.

## What are the benefits of selecting an in-network doctor?

- **Lower Out-of-Pocket Costs** – When you receive services from our Preferred Providers, or in-network doctors, you will be responsible for a lower deductible and lower coinsurance amounts.
- **Preventive Care** – BluePreferred helps keep you and your family healthy with well-child care (up to age 18) and some cancer screenings covered in full. Plus, adult preventive exams and routine GYN visits are available at one predictable copay with no deductible to meet.
- **No Paperwork** – Your doctor will file your claims directly with CareFirst, which means little or no paperwork for you.
- **No Balance Billing** – Your provider agrees to accept the Allowed Benefit as payment in full for covered services after you pay any applicable copayment or coinsurance. The Allowed Benefit is the pre-negotiated fee agreed to by both the doctor and CareFirst. This means no unexpected costs to you.

## **How is an out-of-network doctor different?**

**Freedom** – One of the biggest benefits of BluePreferred is that you actually can select any doctor you choose. Unlike some managed care plans in which you select a single primary care physician to manage your care, BluePreferred gives you the option to seek care on your own from physicians and specialists outside of the network. Of course, this option will require you to share more of the costs, in the form of higher coinsurance and deductibles.

## **Can I go "out-of network" and still save money?**

Yes. Some out-of-network providers are CareFirst Participating Providers, which means that they have a special agreement with CareFirst regarding how much they charge. This agreement may limit the amount you owe, but you will still be responsible for your deductible and coinsurance amounts up to the out-of-network Allowed Benefit.

Plus, just present your CareFirst BlueCross BlueShield card and your CareFirst Participating Provider will file your claim for you.

## **What if I choose to see an Out of Network Non-Participating Provider?**

That's what makes BluePreferred so desirable – It's so flexible! If you choose to visit an out-of-network, Non-Participating Provider, you will be required to pay the out-of-network deductible and coinsurance amounts, and you will also be responsible for filing the necessary paperwork. In addition, you will be responsible for paying the price difference between CareFirst's Allowed Benefit and what the provider actually charges, also called balance billing.

Questions? Call us toll free at 1-877-634-1256  
or call your insurance broker.

# You Choose the Coverage Level Right for You

As a member of the BluePreferred plan, you can choose the personal health care program that's right for you – and your budget. The more you share in the cost of the coverage through higher deductibles and coinsurance payments, the lower your monthly premium.

This is how BluePreferred helps make health care coverage fit your budget – by letting you decide how much of the plan's cost you want to share through deductibles and coinsurance. Refer to the chart below and the rate charts included in this package to help you make your decision.

## Deductibles, Coverage Levels and Out-of-Pocket Maximums Per Individual:

Your Deductible		Your Coverage Level		Your Out-of-Pocket Maximum	
In-Network	Out-of-Network	In-Network	out-of-Network	In-Network	out-of-Network
\$100	\$300	90%	70%	\$2,500	\$5,000
\$300	\$600	90%	70%	\$2,500	\$5,000
\$300	\$600	80%	60%	\$2,500	\$5,000
\$500	\$1,000	80%	60%	\$2,500	\$5,000
\$750	\$1,500	80%	60%	\$3,500	\$7,000
\$2,500	\$5,000	80%	60%	\$5,000	\$7,500

*It's very important to note that your out-of-pocket maximum includes your deductible and most coinsurance payments.*

# The Benefits of Blue

## How the Plan Works

- ◆ You pay the deductible when applicable – **Remember, no deductible is required for preventive care provided by an in-network doctor.**
- ◆ BluePreferred then pays a percentage (90%, 80%, 70% or 60%) of the allowed amount. This is the coverage percentage that you initially selected.
  - When you visit any CareFirst participating doctor you only pay the out-of-network coinsurance.
  - If you visit an out-of-network, non-participating provider you will not only be responsible for the coinsurance, but also for paying the difference between CareFirst's Allowed Benefit and what the provider actually charges.
- ◆ Unlike many other plans, your medical deductible is included as part of your out-of-pocket maximum, which is the maximum a person on your policy spends towards coinsurance and deductibles per year.  
*Note: Outpatient mental health coinsurance does not count toward the out-of-pocket maximum.*
- ◆ Members are responsible for their coinsurance until they reach the out-of-pocket calendar year maximum.
- ◆ Once your out-of-pocket maximum is reached, BluePreferred then pays 100% of the allowed amount for most covered services.
- ◆ Prescription drug benefits are subject to separate deductibles, copayments, and maximums.
- ◆ Families never have to meet more than two individual out-of-pocket maximums per calendar year.

Questions? Call us toll free at 1-877-634-1256  
or call your insurance broker.

# In-Network Benefits at a Glance

Benefit	Covered	You Pay
Well-Child Care	<input checked="" type="checkbox"/>	\$0
Mammograms, Pap Tests and PSAs (cancer screenings)	<input checked="" type="checkbox"/>	\$0
Allergy Shots	<input checked="" type="checkbox"/>	\$5, no deductible (in-network)
Adult Preventive Physical Exams	<input checked="" type="checkbox"/>	\$25, no deductible (in-network)
OB/GYN Preventive Care	<input checked="" type="checkbox"/>	\$25, no deductible (in-network)
Physician Office Visits	<input checked="" type="checkbox"/>	\$25, no deductible (in-network)
Emergency Care – Emergency Room	<input checked="" type="checkbox"/>	\$50, plus deductible and coinsurance (in-network)
365 days Hospitalization per year		Your selected coinsurance percentage (after deductible)
Inpatient Physician Services	<input checked="" type="checkbox"/>	Your selected coinsurance percentage (after deductible)
Inpatient/outpatient Surgery	<input checked="" type="checkbox"/>	Your selected coinsurance percentage (after deductible)
Diagnostic Tests and X-rays	<input checked="" type="checkbox"/>	Your selected coinsurance percentage (after deductible)
Annual Routine Eye Exam	<input checked="" type="checkbox"/>	\$10, no deductible (in-network)
Physical Therapy	<input checked="" type="checkbox"/>	Your selected coinsurance percentage (after deductible)
Prescription Drugs*	<input checked="" type="checkbox"/>	\$100 deductible \$10 Generic copay \$25 Preferred Brand copay \$45 Non-Preferred Brand wpay \$1,500 annual benefit maximum

\* Generic drugs must be chosen when available or an additional expense will be incurred. Self-injectable drugs are covered at a 50% coinsurance up to a maximum membership payment of \$75 per covered injectable medication and are subject to the annual benefit maximum.

Note: If you use a provider who do a notparticipate with any Blue Cross and Blue Shield plan, you will be responsible for any applicable deductible, copayment and coinsurance plus charges over the Plan Allowance.

## Prescription Drug Card Program

Your BluePreferred coverage includes a 3-Tier Prescription Drug Card Program, designed to combat rising drug costs that drive up your premiums and overall healthcare costs. The Prescription Drug Program covers both non-maintenance and maintenance prescription drugs dispensed by a retail pharmacy or the Caremark mail service pharmacy. You can use

# The Benefits of Blue

your card at over 59,000 participating pharmacies – including chains and independent pharmacies – nationwide. And, by visiting a participating pharmacist there are no claims to file.

What's more, the convenience doesn't stop there. Our mail order service offers you an easy way to have your prescriptions filled without having to go to the pharmacy while saving you money at the same time. This is especially helpful if you take maintenance medications over an extended period of time. While maintenance drugs can be obtained either through retail pharmacies or through our mail-order program, the mail order program provides additional savings and convenience. When you use the mail order program, you pay only two copays for a 90-day supply of maintenance drugs, not three copays as you would through the retail program. Plus, you don't have to make a special trip to the pharmacy.

## Vision Care Services

BluePreferred offers you eye care benefits as part of your medical plan, through our network administrator, Davis Vision, Inc. For annual routine eye examinations, just call and make an appointment with one of the participating providers and pay the \$10 copay at the time of service. Additionally, through Davis Vision, you receive discounts of approximately 30% on eyeglass lenses and frames or contact lenses. *For medical eye care, please follow your normal medical procedures.*

## Optional Maternity and Prenatal Coverage

You may also choose to add maternity and prenatal care coverage to your policy (for yourself or your covered spouse). For an additional \$126 a month, you will receive coverage of up to \$3,000 per pregnancy for covered pre- and post-natal care as well as covered services associated with the delivery. If you add maternity coverage at any time following your initial enrollment in BluePreferred, there will be a 10-month waiting period for maternity benefits.

## BlueCard® Program Features

*Taking your benefits with you when you travel.*

With BluePreferred, getting access to care while out of town is as easy as presenting your CareFirst BlueCross BlueShield identification card. Providers, hospitals and urgent-care facilities who participate with the local Blue Cross Blue Shield PPO plan – wherever you are in the U.S.- will recognize and honor your card. Need help finding a provider? Just call the *BlueCard®* phone number listed on your CareFirst ID card for personal assistance.

# When You Need Care

CareFirst's Care Management Program helps you to receive necessary care in the most appropriate setting. The Care Management Program is administered by registered nurses and board-certified practitioners who will work with you and your providers. The purpose of the program is to promote your ongoing good health, while reviewing the medical necessity of treatments according to a nationally accepted set of criteria. As such you'll become more involved in the management of your health care needs through the following:

- ◆ **Inpatient Hospital Care:** Anytime you face non-emergency surgery or hospitalization, this must be pre-authorized to determine if the hospital is the most appropriate place for your procedure and recovery. To receive benefits your hospitalization must be authorized by CareFirst. The CareFirst Preferred Provider who admits you to the hospital is responsible for obtaining the authorization for your care. When the admitting physician does not participate in the CareFirst Preferred Provider Network or the admission is to an out-of-area facility, you are responsible for obtaining precertification from CareFirst.
- ◆ **Concurrent Review and Discharge Planning:** After your hospital admission has been authorized, the Care Management nurse will review your admission to determine if additional inpatient hospital days are medically necessary. Your physician will coordinate with a hospital representative and the Care Management nurse to determine the need for additional hospital days.
- ◆ **Other Prior Authorization:** Before receiving services such as home health care, hospice care, skilled nursing services or outpatient hospital procedures, your CareFirst Preferred Provider will coordinate with CareFirst regarding precertification requirements. If your service or procedure is with a provider who does not participate with CareFirst, you must call CareFirst to coordinate precertification.

- ◆ **Case Management:** This voluntary program works with patients who have serious illnesses, chronic conditions, and complex health care needs. It helps patients receive needed care by working with the patient, family, and medical team to develop the best treatment plan. Case managers are specially trained nurses who can help patients make the best use of their coverage, and can arrange and coordinate care in an appropriate setting to meet the needs of the patient and family.

## "Options" Discount Program

The advantages of carrying the CareFirst BluePreferred card go beyond the benefits listed in the enclosed benefits chart. The CareFirst card entitles you to discounts on alternative therapies and health and wellness programs such as chiropractic, acupuncture, massage, yoga, Pilates, tai chi, qi gong, guided imagery, and fitness centers. Additionally, the program offers discounts on Weight Watchers Online, mail order contacts, laser vision correction, hearing aids, and elder care management.

Since this program is in addition to your medical plan, rather than a benefit, there are no claim forms, referrals or paperwork to complete. We see this as a way for our members to tap into health and wellness practitioners at discounted rates. To find out more, visit our website at [www.InsurancePickle.com](http://www.InsurancePickle.com).

## Health Information on the Internet

Visit CareFirst at [www.InsurancePickle.com](http://www.InsurancePickle.com) for your own online, interactive guide to health topics. Called *My Care First*, this site offers information on nutrition, fitness, chronic illnesses, mental health, and much more. You'll also find support if you're trying to lose weight, quit smoking, manage stress, manage blood pressure or are new parents. *My Care First* covers the latest developments in medicine and health. Check it out to learn how you can maintain a healthier lifestyle.

Questions? Call us toll free at 1-877-634-1256  
or call your insurance broker.

# Frequently Asked Questions

**Q:** *Can I choose my own physician?*

**A:** Yes. You have the freedom to select any doctor or hospital. And you can still save on out-of-pocket expenses by using either our Preferred or Participating Provider Networks. To view a listing of BluePreferred or CareFirst Participating Providers who automatically file claims for you and will not balance bill you, please visit us on the web at [www.carefirst.com](http://www.carefirst.com). (For more information on balance billing, please read the FAQ on this page titled "What is balance billing and how does it affect my out-of-pocket costs?")

**Q:** *What types of health costs should I expect?*

**A:** BluePreferred requires you to first pay your pre-chosen deductible before the insurance will pay. This deductible will vary depending on whether you visit an in-network or out-of-network doctor. Once the deductible is met you pay a coinsurance for most visits and procedures, which is a percentage of the total cost of the visit – this also varies depending on whether you visit an in-network or out-of-network doctor. (Please note: *Many BluePreferred preventive care benefits are covered even before you meet your deductible when you visit an in-network doctor.*)

**Q:** *What is balance billing and how does it affect my out-of-pocket costs?*

**A:** As a member of BluePreferred you have the option to visit doctors who do not participate with CareFirst. In addition to your coinsurance, you are also responsible for whatever amount the doctor charges over and above CareFirst's negotiated amount (also called the Allowed Benefit) for the procedure.

For example, if the cost of a procedure is \$100, CareFirst's negotiated amount for that procedure, when provided by a Participating Provider, may only be \$60. Should you choose to use a Non-participating Provider, you would be responsible for the \$40 difference between the doctor's actual charge and CareFirst's Allowed Benefit.

# The Benefits of Blue

**Q:** *Is preventive care covered?*

**A:** Yes. BluePreferred coverage includes a special package of preventive care benefits for only \$25 per doctor visit – and you don't have to meet your deductible first – when you see an in-network doctor. Plus, well child visits up to age 18 and cancer screenings are covered at 100% when you seek care from an in-network doctor.

**Q:** *When does coverage begin?*

**A:** Coverage begins the first day of the month following the date you're approved and is contingent upon receipt of payment.

**Q:** *What about waiting periods?*

**A:** There is a 10-month waiting period for pre-existing conditions.

**Q:** *How long does the medical underwriting approval process take?*

**A:** An underwriter at CareFirst will review your completed application. When you are medically underwritten, past claims may be examined and personal physicians surveyed. Approval can take about 4-6 weeks. If medical records are not required, approvals will usually take 10 days.\*

*\* Products are available without medical underwriting or preexisting condition waiting periods for those who meet the criteria specified by the Health Insurance Portability and Accountability Act (HIPAA). If you are HIPAA eligible, you have the option to be medically underwritten and qualify for a lower rate. (See yellow Insert.1*

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## Other Coverage Available

- **CareFirst BlueChoice\*\*** – Flexible HMO coverage (offered by an affiliated HMO)
- **Supplement-65\*\*** – Traditional coverage to supplement your Medicare policy. For more information about this plan, please call our Product Specialists toll free at **1-877-634-1256**.
- **Temporary Medical Coverage\*\*** – For people between jobs, just graduated or waiting for permanent insurance to be effective (offered through Celtic Life Insurance).
- **Travel Assistance** – Valuable coverage when you are out of the country, including emergency medical evacuation, baggage insurance and a 24-hour multi-lingual hotline for referrals (offered through Worldwide Assistance Services, Inc.).

**\*\* Medical questionnaire must be completed.**

# It's Easy to Apply

To be eligible for BluePreferred coverage, each family member applying for coverage must be a resident of the District of Columbia and complete a medical questionnaire.

## **Just follow these easy steps to apply for BluePreferred.**

1. Choose what type of coverage you need.

Individual

Individual and Child\*

Individual and Adult\*\*

Family\* - [for 2 adults and child(ren), or an individual with more than one child]

\* "Child means your unmarried, *eligible* child up to age 23. Eligibility requirements are defined in the BluePreferred contract.

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

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

2. Choose the plan that fits your needs using the BluePreferred Deductibles, Coverage Levels and Out-of-Pocket Maximums chart on page 5.
3. Locate your monthly premium using the rate charts enclosed.
4. Complete the enclosed application and medical questionnaire. Please make sure that all information is complete and accurate. This will help speed up the application process.
  - ◆ Make sure you check "Yes" in the Maternity benefit selection area if you want maternity coverage.
  - ◆ Also, you must sign and date the application and medical questionnaire.
5. Send no money now. You'll receive an invoice when your coverage is approved.

## The Benefits of Blue

We begin processing your application as soon as it is received. The review process typically takes 4-6 weeks. Once you have submitted your application, you can call the BluePreferred Application Status Hotline toll free at **1-877-634-1256** for a status report on your application.

**Don't spend another day without coverage from  
CareFirst BlueCross BlueShield.**

Send your application today!

If you have any questions, call us toll free at

**1-877-634-1256**

**or call your insurance broker.**

# Following is your DC Health Insurance application from InsurancePickle.com

Steps to complete CareFirst DC Health Insurance application.

- 1) Print out the attached application.
- 2) Complete application including ALL details and signatures.  
Common mistakes that delay the start of application processing are missing social security numbers, heights, weights, doctor's names, etc..
- 3) Return application without payment. If you're approved CareFirst Blue Cross will send you billing information.
- 4) **FAX direct to 1-877-877-5801** or Mail all materials to:  
InsurancePickle.com  
Attn: CareFirst Blue Cross Blue Sheild  
5965 Sandy Ridge  
Elkridge, MD 21075
- 5) Call with any questions.

1-877-634-1256

InsurancePickle.com  
*"We Give You More."<sup>SM</sup>*

\*rates subject to change without notice.

Please note that underwriting can take 4-6 weeks (less for healthy applicants with complete applications). You are NOT covered until accepted by Carefirst. During the underwriting period, DON'T cancel any existing coverage. If you don't have coverage you can apply for a temporary health insurance policy to cover you in the interim from our web site <http://www.insurancepickle.com>. Temporary Health Insurance can start as early as tomorrow. Select a monthly payment, so you can keep it during the underwriting process.

# Individual BluePreferred Application

**OFFICE USE ONLY:**

(District of Columbia Residents)



Group Hospitalization and Medical Services, Inc.  
840 First Street, NE, Washington, DC 20065

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

<b>INSTRUCTIONS</b>
<p>1. Please fill out all applicable spaces on this application. Print or type all information.</p> <p>2. Sign and return this application in the postage-paid return envelope.</p> <p><i>Give careful attention to all questions in this application. <u>Accurate, complete</u> information is necessary before your application can be processed. If incomplete, the application will be returned and delay your coverage.</i></p>

**FAX APPLICATION TO: 1-877-877-5801**  
**OR MAIL 5965 Sandy Ridge, Elkridge, MD 21075**

## 1. APPLICANT INFORMATION

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

## 2. COVERAGE SELECTION (Check one)

- Individual** - Provides coverage for one person
- Individual & Child** - Provides coverage for an individual and one eligible dependent
- Individual & Adult** - Provides coverage for 2 eligible adults
- Family** - Provides coverage for 2 eligible adults and eligible dependent(s) or an individual with more than one eligible dependent

**COVERAGE LEVEL DESIRED:**

(CHECK ONE)	DEDUCTIBLE		COVERAGE LEVEL		OUT-OF-POCKET LIMIT	
	(In-Network)	(Out-of-Network)	(In-Network)	(Out-of-Network)	(In-Network)	(Out-of-Network)
<input type="checkbox"/>	\$ 100	\$ 300	90%	70%	\$2,500	\$5,000
<input type="checkbox"/>	\$ 300	\$ 600	90%	70%	\$2,500	\$5,000
<input type="checkbox"/>	\$ 300	\$ 600	80%	60%	\$2,500	\$5,000
<input type="checkbox"/>	\$ 500	\$1,000	80%	60%	\$2,500	\$5,000
<input type="checkbox"/>	\$ 750	\$1,500	80%	60%	\$3,500	\$7,000
<input type="checkbox"/>	\$2,500	\$5,000	80%	60%	\$5,000	\$7,500

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

<b>FOR BROKER USE ONLY:</b>	<b>Name:</b>	<b>SSN/Tax ID #:</b>	<b>CareFirst-Assigned ID#:</b>
<b>Contracted Broker:</b>	<b>Kelly &amp; Assoc Ins Grp #132</b>	<b>521066374</b>	
<b>Sub-Agent/Sub-Agency:</b>	<b>J. Motsco</b>		
<b>Writing Agent:</b>	<b>J. Motsco</b>		

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association. © Registered trademark of the Blue Cross and Blue Shield Association. © Registered trademark of CareFirst of Maryland, Inc.

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

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH Month Day Year			SEX	HEIGHT	WEIGHT
Spouse/Partner				- -				<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 1				- -				<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 2				- -				<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 3				- -				<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 4				- -				<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 5				- -				<input type="checkbox"/> M <input type="checkbox"/> F		

### 4. MEDICARE INFORMATION

Check this box if any persons listed on this application are eligible for or are receiving benefits under Medicare.  
If you checked the box, please give:

Name: \_\_\_\_\_ Medicare Claim No.: \_\_\_\_\_

Eligible for:  Part A (Hospital Insurance) Eff. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Part B (Medical Insurance) Eff. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for entitlement:  Age 65 or older  End stage renal disease  Disabled

Beginning date of renal treatment, if applicable: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Medicare Claim No.: \_\_\_\_\_

Eligible for:  Part A (Hospital Insurance) Eff. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Part B (Medical Insurance) Eff. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for entitlement:  Age 65 or older  End stage renal disease  Disabled

Beginning date of renal treatment, if applicable: \_\_\_\_/\_\_\_\_/\_\_\_\_

### 5. OTHER INSURANCE INFORMATION

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

5a.  Check this box if any person listed on this application is now or has been enrolled within the last 31 days in health care or catastrophic coverage through a Blue Cross and/or Blue Shield Plan, a Health Maintenance Organization, or another insurance carrier or Medicaid. Is this coverage in effect?  Yes  No

5b. If Yes, will this coverage be continued?  Yes  No If No, please provide cancellation date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for cancellation? \_\_\_\_\_

If you answered "Yes" to question 5a, please complete the following.

1. Policy Holder's Name: \_\_\_\_\_ Sex:  M  F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Name and Location of Insurance Company: \_\_\_\_\_

3. Policy Number: \_\_\_\_\_ Policy covers:  Individual  Individ. & Child  Individ. & Adult  Family

4. Effective Date of Policy: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. Service(s) Covered:

A. Hospital Services  Yes  No E. Dental  Yes  No

B. Physician Services  Yes  No F. Eye/Vision Care Services  Yes  No

C. Major Medical (out-of-pocket expenses)  Yes  No G. HMO  Yes  No

D. Separate Drug Program  Yes  No H. Maternity Services  Yes  No

I. Mental Illness  Yes  No

6. Is coverage through an employer or other group?  Yes  No  
If Yes, name of employer or other group: \_\_\_\_\_

7. Is coverage through an individual insurance policy?  Yes  No

## 6. HEALTH EVALUATION

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

Have you or any family member named in this application had a physical examination within the past 5 years?

Yes  No

**SECTION A — To the best of your knowledge or belief, has any person named in this application had within the last 5 years, or does such person now have, any of the following:**

	YES	NO
(a) Cancer, tumor or other growth (malignant or benign) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(b) Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus Seropositivity (Positive HIV test) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(c) Kidney stones, kidney or bladder condition, urinary frequency or burning . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(d) Goiter, thyroid condition, diabetes . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(e) Seizure disorder, central nervous system disorder, multiple sclerosis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(f) Substance abuse (drug or alcohol dependency, abuse or addiction) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(g) Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(h) Cataract or other eye condition . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(i) Tuberculosis, lung condition, asthma, bronchitis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(j) Arthritis, rheumatism, external deformity, amputations(s), back or spinal trouble, limb condition . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(k) Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, . . . . . cerebrovascular accident (stroke) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(l) (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(m) (Female) Is currently pregnant; expected date of delivery: ____/____/____ . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(n) (Male) Prostate condition, reproductive system disorders, infertility . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(o) Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(p) Sexually transmitted diseases . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(q) Anemia, blood disorders . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(r) Excluding physical examinations, consulted a physician, health care provider, or other individual or facility for medical or surgical treatment, advice, screening for any condition, or prescription medication for a medical condition NOT listed above in items A-Q? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
(s) Had any departure from good health not previously mentioned in this questionnaire for which treatment or advice may or may not have been sought? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

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

## 6. HEALTH EVALUATION (Continued)

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

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

## 7. CONDITIONS OF ENROLLMENT — (Please Read This Section Carefully)

### IT IS UNDERSTOOD AND AGREED THAT:

(a) The contract will become effective on the first day of the month following final approval of the application by Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield (hereafter “CareFirst”) or as determined by CareFirst.

(b) The Subscriber shall repay to CareFirst the amount of any payment(s) made in error to the Subscriber or on behalf of the Subscriber or any covered family member as the result of a claim.

(c) A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request. If this application is accepted by CareFirst, a copy of this application will be attached to the contract issued to the Subscriber.

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

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

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

**It is a fraudulent insurance act for a person to knowingly or willfully make a false or fraudulent statement or representation in, or with reference to, an application of insurance.**

**WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.**

Signature of Applicant: **X** \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature of Applicant: **X** \_\_\_\_\_ Date: \_\_\_\_\_

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

Parent or Legal Guardian's Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

# BluePreferred Underwritten District of Columbia



In-Network: ■ **\$100 Deductible**, 90%/10% Coinsurance ■ **\$2,500 Out-of-Pocket**  
 Out-of-Network: ■ **\$300 Deductible**, 70%/30% Coinsurance ■ **\$5,000 Out-of-Pocket**  
 Prescription: \$10 Generic Copay, \$25 Preferred Brand Copay, \$45 Non-Preferred Brand Copay  
 \$100 Deductible, \$1,500 Annual Maximum

Monthly Premium Rates Effective: October 1, 2005

AGE AT EFFECTIVE DATE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$117	-	-	-
6-17	\$105	\$199	\$208	\$282
18-20	\$152	\$289	\$303	\$409
21	\$154	\$294	\$309	\$416
22	\$156	\$298	\$314	\$422
23	\$162	\$309	\$323	\$437
24	\$164	\$314	\$329	\$444
25	\$167	\$316	\$333	\$449
26	\$171	\$326	\$344	\$464
27	\$174	\$331	\$349	\$469
28	\$177	\$336	\$353	\$477
29	\$182	\$346	\$364	\$489
30	\$184	\$351	\$368	\$497
31	\$189	\$360	\$378	\$512
32	\$191	\$364	\$384	\$517
33	\$197	\$373	\$393	\$532
34	\$199	\$378	\$399	\$536
35	\$204	\$388	\$408	\$552
36	\$206	\$393	\$413	\$556
37	\$211	\$403	\$423	\$571
38	\$217	\$411	\$433	\$584
39	\$219	\$415	\$438	\$591
40	\$224	\$426	\$448	\$604
41	\$234	\$446	\$468	\$631
42	\$246	\$468	\$493	\$666
43	\$257	\$488	\$513	\$691
44	\$269	\$511	\$538	\$726
45	\$281	\$535	\$563	\$758
46	\$294	\$558	\$588	\$793
47	\$307	\$583	\$613	\$826
48	\$321	\$610	\$643	\$868
49	\$336	\$641	\$673	\$908
50	\$351	\$667	\$703	\$948
51	\$366	\$695	\$733	\$988
52	\$384	\$730	\$768	\$1,035
53	\$401	\$762	\$803	\$1,083
54	\$419	\$795	\$837	\$1,130
55	\$439	\$835	\$878	\$1,185
56	\$459	\$872	\$917	\$1,237
57	\$481	\$915	\$962	\$1,298
58	\$501	\$952	\$1,002	\$1,353
59	\$526	\$999	\$1,052	\$1,420
60	\$549	\$1,042	\$1,097	\$1,479
61	\$573	\$1,089	\$1,146	\$1,547
62	\$601	\$1,142	\$1,201	\$1,622
63	\$628	\$1,194	\$1,256	\$1,696
64	\$656	\$1,247	\$1,311	\$1,769
65	\$685	\$1,304	\$1,372	\$1,852
66 and over	\$718	\$1,364	\$1,436	\$1,939

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

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

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association.  
 © Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

# BluePreferred Underwritten District of Columbia

In-Network: ■ **\$300 Deductible**, 90%/10% Coinsurance ■ **\$2,500 Out-of-Pocket**  
 Out-of-Network: ■ **\$600 Deductible**, 70%/30% Coinsurance ■ **\$5,000 Out-of-Pocket**  
 Prescription: \$10 Generic Copay, \$25 Preferred Brand Copay, \$45 Non-Preferred Brand Copay  
 \$100 Deductible, \$1,500 Annual Maximum

Monthly Premium Rates Effective: October 1, 2005

AGE AT EFFECTIVE DATE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$100	-	-	-
6-17	\$89	\$169	\$177	\$240
18-20	\$129	\$245	\$258	\$348
21	\$131	\$250	\$262	\$354
22	\$133	\$253	\$267	\$358
23	\$137	\$262	\$275	\$371
24	\$139	\$267	\$279	\$377
25	\$142	\$269	\$283	\$382
26	\$145	\$277	\$292	\$394
27	\$148	\$281	\$296	\$399
28	\$150	\$286	\$300	\$405
29	\$155	\$294	\$309	\$416
30	\$156	\$298	\$313	\$422
31	\$161	\$306	\$322	\$435
32	\$163	\$309	\$326	\$439
33	\$167	\$317	\$334	\$452
34	\$169	\$322	\$339	\$455
35	\$173	\$330	\$347	\$469
36	\$175	\$334	\$351	\$472
37	\$180	\$342	\$359	\$485
38	\$184	\$349	\$368	\$496
39	\$186	\$353	\$372	\$502
40	\$190	\$362	\$381	\$513
41	\$198	\$379	\$398	\$536
42	\$209	\$398	\$418	\$566
43	\$218	\$415	\$435	\$587
44	\$228	\$434	\$457	\$617
45	\$239	\$454	\$478	\$644
46	\$250	\$474	\$499	\$673
47	\$260	\$495	\$521	\$701
48	\$273	\$518	\$546	\$737
49	\$285	\$544	\$571	\$771
50	\$298	\$566	\$597	\$805
51	\$311	\$590	\$622	\$838
52	\$326	\$619	\$652	\$879
53	\$340	\$647	\$681	\$919
54	\$355	\$675	\$711	\$959
55	\$372	\$709	\$745	\$1,006
56	\$390	\$740	\$778	\$1,050
57	\$408	\$776	\$817	\$1,101
58	\$425	\$808	\$851	\$1,148
59	\$446	\$848	\$893	\$1,205
60	\$466	\$884	\$931	\$1,255
61	\$486	\$924	\$973	\$1,313
62	\$510	\$969	\$1,019	\$1,377
63	\$533	\$1,013	\$1,066	\$1,439
64	\$556	\$1,058	\$1,113	\$1,501
65	\$581	\$1,106	\$1,164	\$1,571
66 and over	\$609	\$1,158	\$1,219	\$1,645

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

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

Policy Form Numbers:

DC/DP-IEA-9/95 • PPP-A/DC-4/96 • D-CMM/MM ATTB/DB-4/96 • DC/C-DP 4/96 • DC/CF/IND RX3 (R. 1/04) and any attached amendments.

# BluePreferred Underwritten District of Columbia



In-Network: ■ **\$300 Deductible**, 80%/20% Coinsurance ■ **\$2,500 Out-of-Pocket**  
 Out-of-Network: ■ **\$600 Deductible**, 60%/40% Coinsurance ■ **\$5,000 Out-of-Pocket**  
 Prescription: \$10 Generic Copay, \$25 Preferred Brand Copay, \$45 Non-Preferred Brand Copay  
 \$100 Deductible, \$1,500 Annual Maximum

Monthly Premium Rates Effective: October 1, 2005

AGE AT EFFECTIVE DATE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$92	-	-	-
6-17	\$82	\$155	\$162	\$220
18-20	\$119	\$225	\$236	\$318
21	\$120	\$229	\$240	\$324
22	\$122	\$232	\$244	\$328
23	\$126	\$240	\$252	\$340
24	\$127	\$244	\$256	\$345
25	\$130	\$246	\$259	\$350
26	\$133	\$253	\$267	\$361
27	\$136	\$258	\$272	\$365
28	\$137	\$262	\$275	\$371
29	\$142	\$269	\$283	\$381
30	\$143	\$273	\$286	\$387
31	\$147	\$280	\$294	\$398
32	\$149	\$283	\$299	\$402
33	\$153	\$290	\$306	\$414
34	\$155	\$294	\$310	\$417
35	\$159	\$302	\$317	\$429
36	\$160	\$306	\$322	\$432
37	\$164	\$313	\$329	\$444
38	\$169	\$320	\$337	\$454
39	\$170	\$323	\$340	\$460
40	\$174	\$331	\$349	\$469
41	\$182	\$347	\$364	\$491
42	\$192	\$364	\$383	\$518
43	\$200	\$380	\$399	\$538
44	\$209	\$397	\$418	\$565
45	\$219	\$416	\$437	\$589
46	\$228	\$434	\$457	\$616
47	\$238	\$453	\$477	\$642
48	\$250	\$474	\$500	\$675
49	\$261	\$498	\$523	\$706
50	\$273	\$518	\$546	\$737
51	\$284	\$540	\$569	\$767
52	\$298	\$567	\$596	\$804
53	\$311	\$592	\$624	\$841
54	\$325	\$618	\$651	\$878
55	\$341	\$649	\$682	\$921
56	\$357	\$678	\$712	\$961
57	\$374	\$710	\$747	\$1,008
58	\$389	\$739	\$779	\$1,050
59	\$408	\$776	\$817	\$1,103
60	\$426	\$809	\$852	\$1,149
61	\$445	\$846	\$890	\$1,201
62	\$466	\$887	\$933	\$1,260
63	\$488	\$927	\$975	\$1,317
64	\$509	\$968	\$1,018	\$1,374
65	\$532	\$1,012	\$1,065	\$1,438
66 and over	\$557	\$1,059	\$1,115	\$1,505

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

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

# BluePreferred Underwritten District of Columbia

In-Network: ■ **\$500 Deductible**, 80%/20% Coinsurance ■ **\$2,500 Out-of-Pocket**  
 Out-of-Network: ■ **\$1,000 Deductible**, 60%/40% Coinsurance ■ **\$5,000 Out-of-Pocket**  
 Prescription: \$10 Generic Copay, \$25 Preferred Brand Copay, \$45 Non-Preferred Brand Copay  
 \$100 Deductible, \$1,500 Annual Maximum

Monthly Premium Rates Effective: October 1, 2005

AGE AT EFFECTIVE DATE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$86	-	-	-
6-17	\$77	\$145	\$152	\$206
18-20	\$111	\$211	\$221	\$298
21	\$113	\$215	\$225	\$304
22	\$114	\$217	\$229	\$308
23	\$118	\$225	\$236	\$318
24	\$119	\$229	\$240	\$324
25	\$122	\$231	\$243	\$328
26	\$125	\$237	\$251	\$338
27	\$127	\$241	\$255	\$342
28	\$129	\$245	\$257	\$348
29	\$133	\$252	\$265	\$357
30	\$134	\$256	\$268	\$362
31	\$138	\$263	\$276	\$373
32	\$139	\$265	\$280	\$377
33	\$143	\$272	\$287	\$388
34	\$145	\$276	\$291	\$390
35	\$149	\$283	\$297	\$402
36	\$150	\$287	\$301	\$405
37	\$154	\$293	\$308	\$416
38	\$158	\$300	\$316	\$425
39	\$159	\$303	\$319	\$430
40	\$163	\$311	\$327	\$440
41	\$170	\$325	\$341	\$460
42	\$179	\$341	\$359	\$485
43	\$187	\$356	\$373	\$504
44	\$195	\$372	\$392	\$529
45	\$205	\$389	\$409	\$552
46	\$214	\$407	\$428	\$577
47	\$223	\$424	\$447	\$601
48	\$234	\$444	\$468	\$632
49	\$245	\$467	\$489	\$661
50	\$255	\$485	\$512	\$690
51	\$266	\$505	\$533	\$718
52	\$279	\$531	\$559	\$753
53	\$291	\$555	\$584	\$788
54	\$305	\$579	\$609	\$822
55	\$319	\$608	\$639	\$862
56	\$334	\$635	\$667	\$900
57	\$350	\$665	\$700	\$944
58	\$365	\$692	\$729	\$984
59	\$382	\$727	\$765	\$1,033
60	\$399	\$757	\$797	\$1,076
61	\$417	\$792	\$833	\$1,125
62	\$437	\$831	\$873	\$1,180
63	\$457	\$868	\$913	\$1,233
64	\$477	\$907	\$953	\$1,286
65	\$498	\$948	\$997	\$1,346
66 and over	\$522	\$992	\$1,044	\$1,409

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

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

Policy Form Numbers:

DC/DP-IEA-9/95 • PPP-A/DC-4/96 • D-CMM/MM ATTB/DB-4/96 • DC/C-DP 4/96 • DC/CF/IND RX3 (R. 1/04) and any attached amendments.

# BluePreferred Underwritten District of Columbia



In-Network: ■ **\$750 Deductible**, 80%/20% Coinsurance, ■ **\$3,500 Out-of-Pocket**  
 Out-of-Network: ■ **\$1,500 Deductible**, 60%/40% Coinsurance, ■ **\$7,000 Out-of-Pocket**  
 Prescription: \$10 Generic Copay, \$25 Preferred Brand Copay, \$45 Non-Preferred Brand Copay  
 \$100 Deductible, \$1,500 Annual Maximum

Monthly Premium Rates Effective: October 1, 2005

AGE AT EFFECTIVE DATE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$79	-	-	-
6-17	\$71	\$134	\$140	\$190
18-20	\$102	\$194	\$204	\$275
21	\$104	\$198	\$207	\$280
22	\$105	\$200	\$211	\$283
23	\$109	\$207	\$217	\$293
24	\$110	\$211	\$221	\$298
25	\$112	\$212	\$224	\$302
26	\$115	\$219	\$231	\$311
27	\$117	\$222	\$234	\$315
28	\$118	\$226	\$237	\$320
29	\$122	\$232	\$244	\$329
30	\$123	\$236	\$247	\$333
31	\$127	\$242	\$254	\$343
32	\$128	\$244	\$258	\$347
33	\$132	\$250	\$264	\$357
34	\$133	\$254	\$267	\$359
35	\$137	\$260	\$274	\$370
36	\$138	\$264	\$277	\$373
37	\$142	\$270	\$284	\$383
38	\$145	\$276	\$291	\$391
39	\$147	\$279	\$293	\$396
40	\$150	\$286	\$301	\$405
41	\$157	\$299	\$314	\$423
42	\$165	\$314	\$330	\$446
43	\$172	\$328	\$344	\$463
44	\$180	\$342	\$361	\$487
45	\$188	\$358	\$377	\$508
46	\$197	\$374	\$394	\$531
47	\$205	\$390	\$411	\$553
48	\$215	\$409	\$431	\$581
49	\$225	\$429	\$450	\$608
50	\$235	\$447	\$471	\$635
51	\$245	\$465	\$491	\$661
52	\$257	\$488	\$514	\$693
53	\$268	\$510	\$537	\$725
54	\$280	\$532	\$561	\$756
55	\$294	\$559	\$587	\$793
56	\$307	\$584	\$613	\$828
57	\$322	\$612	\$644	\$868
58	\$335	\$637	\$671	\$905
59	\$351	\$668	\$704	\$950
60	\$367	\$697	\$733	\$989
61	\$383	\$729	\$767	\$1,035
62	\$402	\$764	\$803	\$1,085
63	\$420	\$798	\$840	\$1,134
64	\$438	\$834	\$877	\$1,183
65	\$458	\$872	\$917	\$1,238
66 and over	\$480	\$912	\$960	\$1,296

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

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

# BluePreferred Underwritten District of Columbia

In-Network: ■ **\$2,500 Deductible**, 80%/20% Coinsurance, ■ **\$5,000 Out-of-Pocket**  
 Out-of-Network: ■ **\$5,000 Deductible**, 60%/40% Coinsurance, ■ **\$7,500 Out-of-Pocket**  
 Prescription: \$10 Generic Copay, \$25 Preferred Brand Copay, \$45 Non-Preferred Brand Copay  
 \$100 Deductible, \$1,500 Annual Maximum

Monthly Premium Rates Effective: October 1, 2005

AGE AT EFFECTIVE DATE	INDIVIDUAL	INDIVIDUAL & CHILD(REN)	INDIVIDUAL & ADULT	FAMILY
1-5	\$64	-	-	-
6-17	\$57	\$108	\$113	\$153
18-20	\$82	\$156	\$164	\$221
21	\$83	\$159	\$167	\$225
22	\$84	\$161	\$170	\$228
23	\$87	\$167	\$175	\$235
24	\$88	\$170	\$178	\$239
25	\$90	\$171	\$180	\$242
26	\$92	\$176	\$185	\$250
27	\$94	\$179	\$188	\$253
28	\$95	\$182	\$190	\$257
29	\$98	\$186	\$196	\$264
30	\$99	\$189	\$198	\$268
31	\$102	\$194	\$204	\$276
32	\$103	\$196	\$207	\$279
33	\$106	\$201	\$212	\$286
34	\$107	\$204	\$215	\$288
35	\$110	\$209	\$220	\$297
36	\$111	\$212	\$223	\$299
37	\$114	\$217	\$228	\$307
38	\$117	\$222	\$234	\$314
39	\$118	\$224	\$235	\$318
40	\$121	\$230	\$241	\$325
41	\$126	\$240	\$252	\$339
42	\$132	\$252	\$265	\$358
43	\$138	\$263	\$276	\$372
44	\$144	\$275	\$289	\$390
45	\$151	\$287	\$302	\$407
46	\$158	\$300	\$316	\$426
47	\$165	\$313	\$330	\$443
48	\$173	\$328	\$345	\$466
49	\$181	\$344	\$361	\$488
50	\$188	\$358	\$378	\$509
51	\$196	\$373	\$393	\$530
52	\$206	\$391	\$412	\$555
53	\$215	\$409	\$431	\$581
54	\$225	\$427	\$449	\$606
55	\$235	\$448	\$471	\$636
56	\$246	\$468	\$491	\$663
57	\$258	\$490	\$516	\$695
58	\$269	\$510	\$538	\$725
59	\$282	\$536	\$564	\$761
60	\$294	\$558	\$588	\$793
61	\$307	\$584	\$614	\$829
62	\$322	\$612	\$643	\$869
63	\$336	\$640	\$673	\$908
64	\$351	\$668	\$702	\$948
65	\$367	\$698	\$735	\$992
66 and over	\$385	\$731	\$769	\$1,038

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

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Policy Form Numbers:

DC/DP-IEA-9/95 • PPP-A/DC-4/96 • D-CMM/MM ATTB/DB-4/96 • DC/C-DP 4/96 • DC/CF/IND RX3 (R. 1/04) and any attached amendments.