

# Supplement-65 Application (Virginia Residents)

(Coverage designed to supplement benefits under Medicare)

For assistance completing this application,

**CALL 1-877-634-1256**



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

**INSTRUCTIONS ▼**

- Please fill out all applicable spaces on this application. Print or type all information.
- Sign this application on page 8 and return it in the postage-paid envelope, if provided.  
Or mail to:  
CareFirst BlueCross BlueShield  
**attn: application processing**  
**5965 Sandy Ridge**  
**Elkridge, MD 21075**  
**or fax to 410-796-7456**
- Send no money with this application. You will be notified by mail of the amount due if this application is accepted.

*Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. If incomplete, the application will be returned and delay your coverage.*

**OFFICE USE ONLY:**

ID #:	EFF DATE:
GROUP #:	CLASS:

▼ PLEASE CORRECT ANY INCORRECT NAME OR ADDRESS INFORMATION BELOW ▼

Last Name       First Name       Middle Initial

Residence Address (Number and Street)

City       State       Zip Code

**1. APPLICANT INFORMATION ▼**

Billing Address, if different from Residence Address: (Number and Street)      (City and State)      (Zip Code-9 digit, if known)

Did you establish permanent residence at the above address within the last 31 days?     Yes     No

Date of Birth:      /      /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married
Home Phone: (      )	Requested Effective Date: /      /	E-mail Address:

Type of Coverage Selected: *(check one)*

Plan A\*     Plan B     Plan C\*     Plan F     High-Deductible Plan F     Plan N

**NOTE: \*If you are under age 65 and have Medicare, you may apply for Plan A or Plan C only.**

Your Social Security (or Railroad Retirement) Number: \_\_\_\_\_

FOR BROKER USE ONLY:	Name:	SSN/Tax ID #:	CareFirst-Assigned ID#:
<b>Contracted Broker:</b>	Pinion Financial Services LLC	75-306-9661	48E
<b>Sub-Agent/Sub-Agency:</b>	J. Motsco		
<b>Writing Agent:</b>	J. Motsco		

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## 2. MEDICARE COVERAGE INFORMATION ▼

Please provide the following Medicare Information as printed on your red, white and blue Medicare identification card. **You must have both Medicare Part A (hospital) and Medicare Part B (medical/surgical) coverage or will obtain Medicare coverage before the effective date of this Supplement-65 policy.**

Are you under the age of 65 and eligible for Medicare by reason of disability?  Yes  No

<b>HEALTH INSURANCE CLAIM NUMBER:</b>	<b>MEDICARE HOSPITAL (PART A) EFFECTIVE DATE:</b> MONTH    DAY    YEAR	<b>MEDICARE MEDICAL/SURGICAL (PART B) EFFECTIVE DATE:</b> MONTH    DAY    YEAR
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## 3. ELIGIBILITY INFORMATION ▼

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS BELOW. Please mark yes or no with an "X" below.**

### To the best of your knowledge or belief:

1. Did you turn age 65 in the last 6 months?  Yes  No
2. (a) Did you enroll in Medicare Part B in the last 6 months?  Yes  No  
(b) If yes, what is the effective date? \_\_\_\_\_
3. Are you covered for medical assistance through the State Medicaid program?  Yes  No  
(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)  
If yes,  
(a) Will Medicaid pay your premiums for this Medicare supplement policy?  Yes  No  
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?  Yes  No
4. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)?  Yes  No  
(a) If yes, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.  
START \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    END \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?  Yes  No  
(c) Was this your first time in this type of Medicare plan?  Yes  No  
(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?  Yes  No

### 3. ELIGIBILITY INFORMATION **continued** ▼

5. Do you have another Medicare supplement policy in force?  Yes  No  
If yes:  
(a) With what company, and what plan do you have? \_\_\_\_\_  
(b) Do you intend to replace your current Medicare supplement policy with this policy?  Yes  No
6. Have you had coverage under any other health insurance within the past 63 days?  
(For example, an employer, union, or individual plan)  Yes  No  
If yes:  
(a) With what company and what kind of policy?  
\_\_\_\_\_  
\_\_\_\_\_  
(b) What are your dates of coverage under the other policy?  
START \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ END \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(If you are still covered under the other policy, leave "END" blank.)

### ADDITIONAL CONSUMER INFORMATION ▼

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

#### 4. PRIOR COVERAGE INFORMATION ▼

##### **WITHIN THE PAST 63 DAY PERIOD WERE YOU ENROLLED UNDER:**

1. An employee welfare benefit plan that supplemented Medicare benefits and the plan terminated or ceased to provide you with all of the supplemental health benefits?  Yes  No
  
2. A Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or you are 65 years of age or older and are enrolled with a Program of All Inclusive Care for the Elderly (PACE) provider under §1894 of the Social Security Act (42 USC §1395), and there are circumstances similar to those described below that would permit discontinuance of an individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan; and:
  - (a) The certification of the organization or plan has been terminated?  Yes  No
  
  - (b) The organization has terminated or otherwise discontinued providing the plan in the area in which you reside?  Yes  No
  
  - (c) You are no longer eligible to elect the plan because of a change in your place of residence or other change in circumstances specified by the Secretary, but not including termination of your enrollment on the basis described in §1851(g)(3)(B) of the federal Social Security Act (42 USC §1395w-21) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under §1856 of the Social Security Act (42 USC §1395w-26), or the plan is terminated for all individuals within a residence area?  Yes  No
  
  - (d) You demonstrate, in accordance with guidelines established by the Secretary, that:
    - (1) The organization offering the plan substantially violated a material provision of the organization's contract under §1859 of the Social Security Act (42 USC §§1395w-21 et seq.) in relation to you, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or  Yes  No
  
    - (2) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to you?  Yes  No
  
3. A Medicare Supplemental policy and your enrollment ceased because:
  - (a) of any involuntary termination of coverage or enrollment under the policy, including termination caused by insolvency of the issuer or by the bankruptcy of an organization providing the plan?  Yes  No
  
  - (b) the issuer of the policy substantially violated a material provision of the policy?  Yes  No
  
  - (c) the issuer (or agent or entity acting on the issuer's behalf) materially misrepresented the policy's provision in marketing the policy?  Yes  No

#### 4. PRIOR COVERAGE INFORMATION, continued ▼

##### WITHIN THE PAST 63 DAY PERIOD WERE YOU ENROLLED UNDER:

4. (a) You were enrolled under a Medicare supplement policy and terminate enrollment and subsequently enroll, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under §1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under §1894 of the Social Security Act (42 USC §1395 eee), or a Medicare Select policy; and  Yes  No
- (b) The subsequent enrollment was terminated by you during any period within the first 12 months of such subsequent enrollment (during which you are permitted to terminate such subsequent enrollment under §1851(e) of the federal Social Security Act) (42 USC §1395w-21)?  Yes  No
5. You, upon first becoming eligible for benefits under Part A of Medicare at age 65, enroll in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under §1894 of the Social Security Act (42 USC §1395) and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment?  Yes  No
6. (a) Medicare Part D plan, and ALSO enrolled under a Medicare supplement policy that covers outpatient prescription drugs?  Yes  No

NOTE: If you answered NO to question 6a, you do not need to answer questions b and 6c below. If you answered YES to 6a, continue with b and c.

- (b) When you enrolled in Medicare Part D, did you either terminate enrollment in the drug portion of the Medicare supplement policy OR move to a Medicare supplement policy with NO drug coverage?  Yes  No
- (c) Did you submit evidence of enrollment in Medicare Part D to your Medicare supplement carrier?  Yes  No

**If you answered YES to any of the questions in Section 4, 1) You will NOT have to meet the pre-existing condition waiting period. 2) You must submit evidence of the date of termination or disenrollment of the other plan along with this application. 3) You do NOT have to complete sections 5 or 6 and can skip to section 7.**

#### 5. CREDITABLE COVERAGE INFORMATION ▼

1. At the time of this application, are you within 6 months from the first day of the month in which you first enrolled or will enroll in Medicare Part B?  Yes  No  
**If you answered YES, please go to the next question. If you answered NO, please skip ahead to Section 6.**
2. Are you age 65 or older or will you be age 65 before the effective date of this Supplement-65 policy?  Yes  No  
**If you answered YES, please go to the next question. If you answered NO, please skip ahead to Section 6.**

## 5. CREDITABLE COVERAGE INFORMATION continued ▼

3. At the time of this application, do you have a continuous period of Creditable Coverage of at least 6 months, without a break in this coverage of more than 63 consecutive days?  Yes  No

**If you answered NO, please go to the next question. If you answered YES, you will NOT have to meet the pre-existing condition waiting period. You must submit evidence of the Creditable Coverage along with this application. Please skip ahead to Section 6.**

4. At the time of this application, do you have a continuous period of Creditable Coverage of less than 6 months, without a break in this coverage of more than 63 consecutive days?  Yes  No

**If you answered YES, then the 90 day pre-existing condition waiting period will be reduced by the number of months of your Creditable Coverage. You must submit evidence of the Creditable Coverage along with this application.**

Documents that may be used as evidence of “creditable coverage” in the absence of a certificate include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, paystubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

## DEFINITION OF “CREDITABLE COVERAGE” ▼

**Creditable Coverage means** coverage under any of the following plans: 1) a group health plan; 2) health insurance coverage; 3) Part A or Part B of Title XVIII of the Social Security Act (Medicare); 4) Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits for the distribution of pediatric vaccines; 5) CHAMPUS (Chapter 55 of Title 10 U.S.C.); 6) a medical care program of the Indian Health Service or of a tribal organization; 7) a State health benefit risk pool; 8) the Federal Employees Health Benefit Plan; 9) a public health plan as defined in federal regulations; 10) a health benefit plan Section 5(e) of the Peace Corp Act (22 U.S.C. Section 2504(e)); or 11) individual health insurance coverage.

**Creditable Coverage does not include** any combination of the following: 1) coverage for accident only or disability income insurance, or any combination thereof; 2) coverage issued as a supplement to liability insurance; 3) liability insurance, including general liability insurance and automobile liability insurance; 4) Worker’s Compensation or similar coverage; 5) automobile medical payment insurance; 6) credit-only insurance; 7) coverage for on-site medical clinics; or 8) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

**Creditable Coverage does not include** coverage for the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan of coverage described above: 1) limited scope dental or vision benefits; 2) benefits for long term care; 3) nursing home care; 4) home health care; 5) community based care; 6) any combination of these plans; or 7) other similar limited benefit plans.

**Creditable Coverage does not include** the following plans if offered as independent benefits paid without regard to any other coverage: 1) coverage only for a specific disease or illness; or 2) hospital indemnity or other fixed indemnity insurance.

**Creditable Coverage does not include** the following coverage offered as a separate policy, certificate, or contract of insurance: 1) Medicare Supplemental insurance as defined by the Social Security Act; 2) coverage supplemental to CHAMPUS; 3) similar supplemental coverage provided under a group plan; or 4) Catastrophic insurance that supplements basic coverage.

## 6. HEALTH EVALUATION ▼

1. Are you within 6 months from the first day of the month in which you first enrolled in Medicare Part B and you are age 65 or older?  Yes  No
2. Are you under age 65 and Medicare eligible?  Yes  No
3. Are you applying for Plan A?  Yes  No
4. Did you answer YES to any of the questions in Section 4?  Yes  No

**If you answered YES to any of the questions above please skip ahead to Section 7, you do not need to complete the Health Screening Questionnaire on the following page.**

### HEALTH SCREENING QUESTIONNAIRE

**Please read and check YES or NO for each question.**

#### Part I

To the best of your knowledge and belief, within the last five (5) years, have you consulted or received treatment by a provider for any of the following:

1. Cancer  Yes  No
2. Insulin Dependent Diabetes Mellitus, Diabetes for which you take insulin  Yes  No
3. Cirrhosis or other liver disorders/diseases  Yes  No
4. Kidney disease or disorder  Yes  No
5. Heart condition  Yes  No
6. Cerebrovascular disease, stroke  Yes  No
7. Hospitalized for any psychiatric or psychological disorder  Yes  No
8. Alzheimer's or other brain disorders  Yes  No
9. Circulatory condition or peripheral vascular disease  Yes  No
10. Emphysema or chronic obstructive pulmonary (lung) disease  Yes  No

#### Part II

To the best of your knowledge and belief, have you been hospitalized for any condition within the last year?

Yes  No

**7. CONDITIONS OF ENROLLMENT (PLEASE READ THIS SECTION CAREFULLY) ▼**

I hereby apply for an individual Supplement-65 policy for the plan checked. This application is subject to acceptance, exclusions and all other provisions contained in such policy. I agree to pay the charge for the policy as billed.

I have carefully read this application and agree to the terms specified herein. To the best of my knowledge, the foregoing statements are complete, true and correctly recorded, and are representations made to induce the issuance of, and form part of, the consideration for the policy for which I have applied.

The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

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.

Please sign and date the application.  
This application is not complete unless signed and dated.

(Applicant's Signature – DO NOT PRINT) X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Agent's Signature – DO NOT PRINT) X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

▲ NOTE: MUST BE SIGNED ▲

**BROKER STATEMENT (For Broker Use Only)**

Please list any other health insurance policies you have sold to the applicant:

1. List policies sold which are still in force:

\_\_\_\_\_  
\_\_\_\_\_

2. List policies in the past five years which are no longer in force:

\_\_\_\_\_  
\_\_\_\_\_

(Agent's Signature – DO NOT PRINT) X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



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

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# Medicare Supplemental Coverage Outline

## *Supplement-65 Virginia*

Offered by Group Hospitalization and Medical Service, Inc.\*, d/b/a  
CareFirst BlueCross BlueShield, 840 First Street, NE, Washington, DC 20065

A not-for-profit health service plan.

\*An independent licensee of the Blue Cross and Blue Shield Association

# CareFirst BlueCross BlueShield

## Outline of Medicare Supplement Coverage

- This chart shows the benefits included in each of the standard Medicare supplement plans.
- Every company must make plan “A” available.
- Some plans may not be available in your state.

### Basic Benefits:

**Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

**Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.

**Blood:** First three pints of blood each year.

**Hospice:** Part A coinsurance

A	B	C	D	F	F*
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	Part B Deductible
				Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

\* Plan F also has an option called a High Deductible Plan F. This High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year, \$2,000, deductible. Benefits from High Deductible Plans F will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

# CareFirst BlueCross BlueShield

## Outline of Medicare Supplement Coverage

<b>G</b>	<b>K</b>	<b>L</b>	<b>M</b>	<b>N</b>
Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment of ER
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
Part B Excess (100%)				
Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
	Out-of-pocket limit \$4,620; paid at 100% after limit reached	Out-of-pocket limit \$2,310; paid at 100% after limit reached		

# Take Advantage Of CareFirst BlueCross BlueShield's Competitive Rates

## *Notice About Attained Age Rated Medicare Supplement Policies*

Under Medicare supplement policies or certificates that use attained age rating, premiums automatically increase as you get older. You can expect your premiums to increase each year (or other frequency as established under the policy or certificate) due to changes in age.

Currently, the premiums for all ages under this policy (or certificate) are as follows:

## **Medically Underwritten Monthly Premium Rates Effective January 1, 2011**

**Medically Underwritten Standard Rates**—For subscribers age 65 or older who enter the plan during the Supplement-65 enrollment period (begins on the first day of the month you turn 65 and lasts 6 months) and are enrolled in Medicare Part B. However, subscribers more than 6 months from their Medicare Part B effective date must also pass medical underwriting.

**Medically Underwritten Discounted Rates**—For subscribers who qualify for the Standard Rate but are also within 3 years of their Medicare Part B effective date.

Age	Plan B				Plan C			
	Male Standard Rate	Male Discounted Rate	Female Standard Rate	Female Discounted Rate	Male Standard Rate	Male Discounted Rate	Female Standard Rate	Female Discounted Rate
65	\$113.45	\$96.43	\$102.64	\$87.24	\$195.87	\$166.49	\$177.21	\$150.63
66	\$119.13	\$101.26	\$107.78	\$91.61	\$205.63	\$174.79	\$186.05	\$158.14
67	\$121.59	\$103.35	\$110.01	\$93.51	\$209.91	\$178.42	\$189.92	\$161.43
68	\$124.11	\$105.49	\$112.29	\$95.45	\$214.26	\$182.12	\$193.85	\$164.77
69	\$126.68	\$107.68	\$114.61	\$97.42	\$218.67	\$185.87	\$197.86	\$168.18
70	\$142.87	\$121.44	\$129.26	\$109.87	\$246.67	\$209.67	\$223.16	\$189.69
71	\$145.83	\$123.96	\$131.94	\$112.15	\$251.74	\$213.98	\$227.77	\$193.60
72	\$148.85	\$126.52	\$134.67	\$114.47	\$256.96	\$218.42	\$232.48	\$197.61
73	\$151.94	\$129.15	\$137.46	\$116.84	\$262.28	\$222.94	\$237.31	\$201.71
74	\$155.08	\$131.82	\$140.31	\$119.26	\$267.71	\$227.55	\$242.22	\$205.89
75	\$162.36	\$138.01	\$146.90	\$124.87	\$280.27	\$238.23	\$253.58	\$215.54
76	\$165.71	\$140.85	\$149.93	\$127.44	\$286.09	\$243.18	\$258.82	\$220.00
77	\$169.15	\$143.78	\$153.03	\$130.08	\$292.00	\$248.20	\$264.19	\$224.56
78	\$172.65	\$146.75	\$156.21	\$132.78	\$298.03	\$253.33	\$269.66	\$229.21
79	\$176.23	\$149.80	\$159.45	\$135.53	\$304.23	\$258.60	\$275.24	\$233.95
80	\$179.87	\$152.89	\$162.75	\$138.34	\$310.52	\$263.94	\$280.95	\$238.81
81	\$183.60	\$156.06	\$166.11	\$141.19	\$316.94	\$269.40	\$286.75	\$243.74
82	\$187.40	\$159.29	\$169.56	\$144.13	\$323.50	\$274.98	\$292.70	\$248.80
83	\$191.28	\$162.59	\$173.07	\$147.11	\$330.21	\$280.68	\$298.76	\$253.95
84	\$195.24	\$165.95	\$176.64	\$150.14	\$337.05	\$286.49	\$304.95	\$259.21
85 and over	\$199.28	\$169.39	\$180.31	\$153.26	\$344.04	\$292.43	\$311.27	\$264.58

# Take Advantage Of CareFirst BlueCross BlueShield's Competitive Rates

## Medically Underwritten Monthly Premium Rates Effective January 1, 2011

Age	Plan F				High Deductible Plan F			
	Male Standard Rate	Male Discounted Rate	Female Standard Rate	Female Discounted Rate	Male Standard Rate	Male Discounted Rate	Female Standard Rate	Female Discounted Rate
65	\$156.34	\$132.89	\$141.44	\$120.22	\$63.54	\$54.01	\$57.49	\$48.87
66	\$164.16	\$139.54	\$148.52	\$126.24	\$66.72	\$56.71	\$60.36	\$51.31
67	\$167.55	\$142.42	\$151.59	\$128.85	\$68.10	\$57.89	\$61.61	\$52.37
68	\$171.02	\$145.37	\$154.74	\$131.53	\$69.51	\$59.08	\$62.89	\$53.46
69	\$174.57	\$148.38	\$157.94	\$134.25	\$70.95	\$60.31	\$64.19	\$54.56
70	\$196.87	\$167.34	\$178.12	\$151.40	\$80.01	\$68.01	\$72.39	\$61.53
71	\$200.96	\$170.82	\$181.82	\$154.55	\$81.67	\$69.42	\$73.90	\$62.82
72	\$205.12	\$174.35	\$185.58	\$157.74	\$83.36	\$70.86	\$75.42	\$64.11
73	\$209.37	\$177.96	\$189.43	\$161.02	\$85.09	\$72.33	\$76.99	\$65.44
74	\$213.71	\$181.65	\$193.35	\$164.35	\$86.85	\$73.82	\$78.58	\$66.79
75	\$223.73	\$190.17	\$202.43	\$172.07	\$90.93	\$77.29	\$82.27	\$69.93
76	\$228.36	\$194.11	\$206.61	\$175.62	\$92.81	\$78.89	\$83.97	\$71.37
77	\$233.09	\$198.13	\$210.88	\$179.25	\$94.73	\$80.52	\$85.71	\$72.85
78	\$237.92	\$202.23	\$215.26	\$182.97	\$96.70	\$82.20	\$87.49	\$74.37
79	\$242.85	\$206.42	\$219.72	\$186.76	\$98.70	\$83.90	\$89.30	\$75.91
80	\$247.87	\$210.69	\$224.27	\$190.63	\$100.74	\$85.63	\$91.15	\$77.48
81	\$253.01	\$215.06	\$228.91	\$194.57	\$102.83	\$87.41	\$93.03	\$79.08
82	\$258.24	\$219.50	\$233.65	\$198.60	\$104.95	\$89.21	\$94.96	\$80.72
83	\$263.59	\$224.05	\$238.49	\$202.72	\$107.13	\$91.06	\$96.93	\$82.39
84	\$269.05	\$228.69	\$243.42	\$206.91	\$109.35	\$92.95	\$98.93	\$84.09
85 and over	\$274.61	\$233.42	\$248.47	\$211.20	\$111.61	\$94.87	\$100.98	\$85.83

# Take Advantage Of CareFirst BlueCross BlueShield's Competitive Rates

## Medically Underwritten Monthly Premium Rates Effective January 1, 2011

Age	Plan N			
	Male Standard Rate	Male Discounted Rate	Female Standard Rate	Female Discounted Rate
65	\$109.70	\$93.25	\$99.25	\$84.36
66	\$115.18	\$97.90	\$104.21	\$88.58
67	\$117.57	\$99.93	\$106.37	\$90.41
68	\$120.00	\$102.00	\$108.58	\$92.29
69	\$122.49	\$104.12	\$110.82	\$94.20
70	\$138.14	\$117.42	\$124.98	\$106.23
71	\$141.01	\$119.86	\$127.58	\$108.44
72	\$143.92	\$122.33	\$130.22	\$110.69
73	\$146.91	\$124.87	\$132.91	\$112.97
74	\$149.95	\$127.46	\$135.66	\$115.31
75	\$156.99	\$133.44	\$142.04	\$120.73
76	\$160.23	\$136.20	\$144.97	\$123.22
77	\$163.56	\$139.03	\$147.97	\$125.77
78	\$166.94	\$141.90	\$151.04	\$128.38
79	\$170.40	\$144.84	\$154.17	\$131.04
80	\$173.92	\$147.83	\$157.36	\$133.76
81	\$177.53	\$150.90	\$160.62	\$136.53
82	\$181.20	\$154.02	\$163.95	\$139.36
83	\$184.95	\$157.21	\$167.34	\$142.24
84	\$188.78	\$160.46	\$170.80	\$145.18
85 and over	\$192.69	\$163.79	\$174.35	\$148.20

## Non-Medically Underwritten Monthly Rates Effective January 1, 2011

**Non-Medically Underwritten Rates** – For subscribers who have not passed medical underwriting. **If you are under age 65 and have Medicare, you may apply for Plan A or Plan C only.**

Age	Plan A	Plan B	Plan C	Plan F	High Ded. F	Plan N
Under 65	\$600.25	N/A	\$870.70	N/A	N/A	N/A
65-70	\$429.39	\$174.53	\$444.46	\$343.26	\$97.75	\$168.76
71-75	\$452.15	\$183.78	\$468.02	\$361.45	\$102.93	\$177.70
76 and over	\$549.19	\$223.22	\$568.46	\$439.03	\$125.02	\$215.84

# CareFirst BlueCross BlueShield

## Premium Information

CareFirst BlueCross BlueShield (CareFirst) can only raise your premium if we raise the premium of all policies like yours in this Commonwealth.

## Medically Underwritten Standard and Discounted Rates

You will receive a premium increase on your renewal. You will also receive an additional premium increase on renewal as you change from one age band to another, as shown on the monthly rate tables on page 3.

The discounted rate will be available for 3 years from the effective date of your policy. Once this 3-year period expires, your rate will increase on your renewal date by the amount of the discount plus any applicable rate increases, including changes from one age band to another.

## Non-medically Underwritten Rates

You will receive a premium increase on your renewal. You will also receive an additional premium increase on renewal as you change from one age band to another, as shown on the monthly rate tables on page 5.

## Notice About Attained Age Rated Medicare Supplemental Policies

The premiums for other Medicare Supplement policies that are issue age or community rated do not increase due to changes in your age.

**While the cost for a Medicare Supplement policy based on attained age may be lower than the cost of a Medicare Supplement policy that is issue age or community rated at your present age, it is important to compare the potential cost of these policies over the life of your policy.**

## Disclosures

Use this outline to compare benefits and premiums among policies.

**This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums.**

## Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance

contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

## Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to:

**Group Hospitalization and Medical Services, Inc.  
d/b/a CareFirst BlueCross BlueShield  
840 First Street, NE  
Dept. AF23  
Washington, DC 20065**

If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

## Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

## Notice

This policy may not fully cover all of your medical costs. Neither CareFirst BlueCross BlueShield or its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

## Complete Answers Are Very Important

When you fill out the application for your new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

## Guaranteed Annual Renewal of Policy

If you have paid your subscription charges on time, the policy automatically will renew at the end of the term for another 12 consecutive calendar months, unless you notify CareFirst in writing at least 30 days in advance that you do not want to renew the policy. Subscription charges may be adjusted based on your age at the time of renewal.

# Supplement-65: PLAN A

## Medicare Part A Hospital Services Per Benefit Period

Services	Medicare Pays	Plan A Pays	You Pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$0	\$1,132 (Part A Deductible)
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after:			
■ While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used:			
■ Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
■ Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$141.50 a day	\$0	Up to \$141.50 a day
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Supplement-65: PLAN A

## Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	Plan A Pays	You Pay
<b>Medical Expenses-In or Out of Hospital and Outpatient Hospital Treatment</b>			
Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services</b>			
Tests for diagnostic services	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>Home Health Care</b>			
Medicare-approved Services			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	\$0	\$0
■ First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

# Supplement-65: PLAN B

## Medicare Part A Hospital Services Per Benefit Period

Services	Medicare Pays	Plan B Pays	You Pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A Deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after:			
■ While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used:			
■ Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
■ Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$141.50 a day	\$0	Up to \$141.50 a day
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Supplement-65: PLAN B

## Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	Plan B Pays	You Pay
<b>Medical Expenses-In or Out of Hospital and Outpatient Hospital Treatment</b>			
Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services</b>			
Tests for diagnostic services	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>Home Health Care</b>			
Medicare-approved Services			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	\$0	\$0
■ First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

# Supplement-65: PLAN C

## Medicare Part A Hospital Services Per Benefit Period

Services	Medicare Pays	Plan C Pays	You Pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A Deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after:			
■ While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used:			
■ Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
■ Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Supplement-65: PLAN C

## Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	Plan C Pays	You Pay
<b>Medical Expenses-In or Out of Hospital and Outpatient Hospital Treatment</b>			
Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$162 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services</b>			
Tests for diagnostic services	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>Home Health Care - Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	\$0	\$0
■ First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B Deductible)	\$0
■ Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Other Benefits Not Covered by Medicare</b>			
<b>Foreign Travel-Not Covered by Medicare</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

\* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

# Supplement-65: PLAN F

## Medicare Part A Hospital Services Per Benefit Period

Services	Medicare Pays	Plan F Pays	You Pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A Deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after:			
■ While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used:			
■ Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
■ Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Supplement-65: PLAN F

## Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	Plan F Pays	You Pay
<b>Medical Expenses-In or Out of Hospital and Outpatient Hospital Treatment</b>			
Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$162 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services</b>			
Tests for diagnostic services	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>Home Health Care - Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	\$0	\$0
■ First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B Deductible)	\$0
■ Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Other Benefits Not Covered by Medicare</b>			
<b>Foreign Travel-Not Covered by Medicare</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

\* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

# Supplement-65: High-Deductible PLAN F\*

## Medicare Part A Hospital Services Per Benefit Period

Services	Medicare Pays	Plan F Pays	You Pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies		<b>After you pay \$2,000 deductible**, High Deductible Plan F pays</b>	<b>In addition to \$2,000 deductible**, you pay</b>
First 60 days	All but \$1,132	\$1,132 (Part A Deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after:			
■ While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used:			
■ Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0***
■ Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* This High Deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

\*\*\* Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Supplement-65: High-Deductible PLAN F\*

## Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	Plan F Pays	You Pay
<b>Medical Expenses-In Or Out Of Hospital And Outpatient Hospital Treatment.</b> Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:		<b>After you pay \$2,000 deductible**, High Deductible Plan F pays</b>	<b>In addition to \$2,000 deductible**, you pay</b>
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$162 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services</b>			
Tests for diagnostic services	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>Home Health Care - Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	\$0	\$0
■ First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B Deductible)	\$0
■ Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Other Benefits Not Covered by Medicare</b>			
<b>Foreign Travel-Not Covered by Medicare</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

\* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

\*\* This High Deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

# Supplement-65: PLAN N

## Medicare Part A Hospital Services Per Benefit Period

Services	Medicare Pays	Plan N Pays	You Pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A Deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after:			
■ While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used:			
■ Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
■ Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Supplement-65: PLAN N

## Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	Plan N Pays	You Pay
<b>Medical Expenses-In or Out of Hospital and Outpatient Hospital Treatment</b>			
Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services</b>			
Tests for diagnostic services	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>Home Health Care - Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	\$0	\$0
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

# Supplement-65: PLAN N

## Medicare Part B Medical Services Per Benefit Period

Services	Medicare Pays	Plan N Pays	You Pay
<b>Other Benefits Not Covered by Medicare</b>			
<b>Foreign Travel-Not Covered by Medicare</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum





These benefits described are issued under policies:

SUVMVAAP (1/10)

VA/CF/MG PLAN A (6/10)  
VA/CF/MG PLAN B (6/10)  
VA/CF/MG PLAN C (6/10)  
VA/CF/MG PLAN F (6/10)  
VA/CF/MG PLAN HI DED F (6/10)  
VA/CF/MG PLAN N (6/10)  
as amended

VA/CF/MG UW PLAN B (6/10)  
VA/CF/MG UW PLAN C (6/10)  
VA/CF/MG UW PLAN F (6/10)  
VA/CF/MG UW PLAN HI DED F (6/10)  
VA/CF/MG UW PLAN N (6/10)  
as amended

VA/CF/MG PLAN HI F SOB (6/10)  
as amended

Neither CareFirst BlueCross BlueShield nor its agents represent, work for or receive compensation from any federal, state or local government agency.



CareFirst BlueCross BlueShield  
Individual Market Division  
840 First Street, NE, Washington, DC 20065  
[www.carefirst.com](http://www.carefirst.com)

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.



# Supplement-65 Virginia

*Why Medicare Supplement Coverage is Important*

Offered by Group Hospitalization and Medical Services, Inc.\*

\*An independent licensee of the Blue Cross and Blue Shield Association

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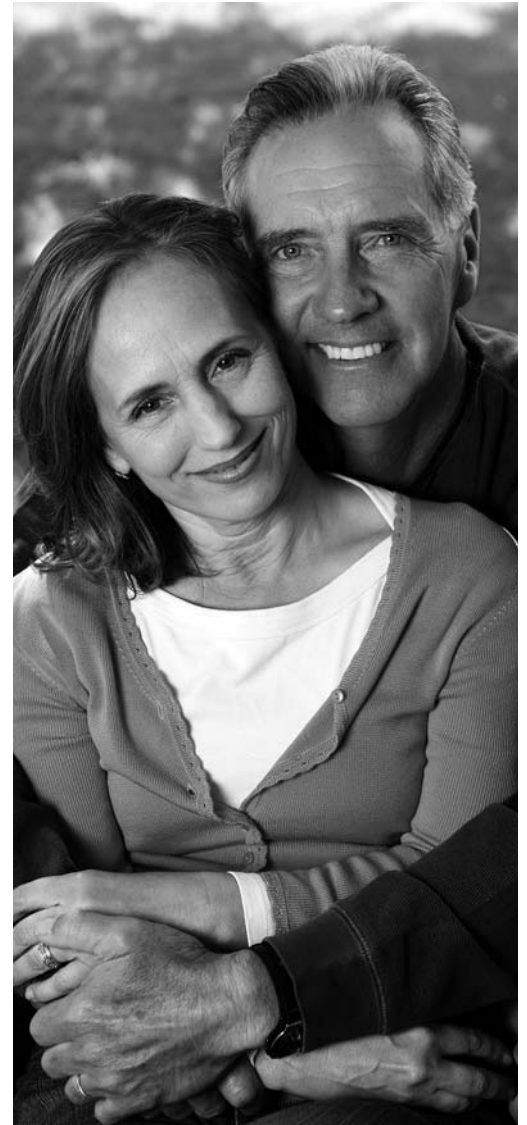
# Welcome

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## Supplement-65 Virginia

Medicare was never designed to cover all of your health care costs. In fact, it began in 1967 as a way to cover some of the costs incurred during an illness – some of the inpatient hospital costs and the doctor costs. But it has never covered all of the costs. Every year Medicare requires you to pay significant deductibles and copayments. That is money out of your pocket each year before Medicare begins paying for your health care.

That's why it's so important for you to purchase a Medicare Supplement plan. A Medicare supplement plan does just what its name suggests: supplements the gaps in coverage left by Medicare. It doesn't duplicate your Medicare coverage or replace it. It simply gives you protection against those important costs Medicare doesn't cover – costs that can add up to thousands of dollars each year.



# Coverage You Need

Medicare's gaps are what you could pay each year:

Part A deductible: \$1,132	Medicare requires you to pay the Part A hospital deductible. You pay the first \$1,132 for charges if you are hospitalized, each benefit period.
Part A copayments: up to \$8,490	If you're in the hospital for more than 60 days, Medicare requires you to pay \$283 a day for days 61-90.
Lifetime reserve days: up to \$33,960	Medicare gives you 60 "lifetime reserve days." If you are in the hospital for 91-150 days, you will pay \$566 a day.
Hospital days over 150: unlimited	After 150 days of hospitalization, Medicare pays nothing at all.

You can see that with a lengthy hospitalization, Medicare could leave you with a bill for over \$43,500. With a longer hospitalization, you'll pay even more. Now look at what you'll pay for other health care services each year:

Part B deductible: \$162	Medicare requires you to pay the first \$162 of outpatient services each year.
Part B copayments: 20% of charges	You must pay 20% of all outpatient charges, after you pay your deductible.
Part A Skilled Nursing Care: up to \$11,320	Medicare only pays for the first 20 days in a skilled nursing facility. After that, you must pay \$141.50 a day for days 21-100.
Care in a foreign country: all charges	Medicare does not pay for emergency care in a foreign country. You are responsible for all charges.
Part A Hospice Care: limited copayments/coinsurance	You are responsible for a copayment of no more than \$5 for outpatient prescription drugs and 5% coinsurance for inpatient respite care.

It's easy to see how having Medicare alone can add up to thousands of dollars in costs out of your pocket each year. That's why your enrollment today in a CareFirst BlueCross BlueShield (CareFirst) Supplement-65 plan is so important.

# From the Company You Trust

Your health and your money are important. Make sure you entrust them to a worthy company: CareFirst BlueCross BlueShield.

## Consider the advantages

### **Carry the card that's recognized nationwide**

Once enrolled, you'll experience the security of knowing that your CareFirst BlueCross BlueShield card is accepted for medical treatment by health care providers throughout the state of Virginia and beyond. It's your assurance of the care you need...where and when you need it.

### **Get local service from a local company**

CareFirst BlueCross BlueShield is a local company. That means you'll talk to local customer service representatives over the phone. You'll receive courteous, friendly service from dedicated, experienced representatives—they may even be your neighbors!

### **Get rid of claim forms**

As a CareFirst member, you'll rarely, if ever, have to file a claim to receive benefits. In fact, once Medicare processes your claim, it's automatically sent to us for payment. It couldn't be easier.

### **Have online access to claims and out-of-pocket costs**

You can view real-time information on your claims and out-of-pocket costs online, whenever you need to with My Account. Simply log on to [www.carefirst.com/myaccount](http://www.carefirst.com/myaccount) to:

- Find out the effective date of your coverage.
- Check your deductible and out-of-pocket costs for your current and previous plan year.

- View claims status and review up to one year of medical claims – total charges, benefits paid and costs for a specific date range.
- Check the average retail cost of a drug, as well as find out if a generic equivalent is available.
- Request a replacement medical ID card and/or Print Verification of Coverage.
- Update information about any other health care coverage you may have.

### **Signing up for My Account is easy.**

Visit [www.carefirst.com/myaccount](http://www.carefirst.com/myaccount), click on “First Time User – Register Now” and set up your User ID and password. Your log-in information is completely secure. Have your member ID card handy as you will need information from your card to sign up.

### **24-Hour 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.

If you believe a situation is a medical emergency, call 911 immediately or go to the nearest emergency facility.

In an urgent situation, contact your doctor for advice. If your doctor isn't available, you have symptoms and don't know exactly what they mean or how serious they are, CareFirst provides you with FirstHelp.

### Here's how FirstHelp™ works:

1. Call FirstHelp™ at (800) 535-9700. The phone number is also listed on the back of your ID card. Your call will be answered promptly by an experienced registered nurse.
2. If the nurse determines your situation is a medical emergency, he or she will advise you to seek immediate medical care. NOTE: If taking the time to call FirstHelp™ would seriously jeopardize your health, call 911 or go to an emergency facility immediately.
3. If your condition isn't an emergency situation, you'll be asked about your symptoms. The nurse will make recommendations to help you decide the safest and most appropriate course of action, whether it's going to an urgent care center, making an appointment at your doctor's office, or self-care.
4. If the nurse recommends self-care, he or she will educate you about your condition, explain what to do for pain or symptom relief, tell you what to expect or watch for. You may be called by the nurse the next day to check on your condition.

Now you have the option to securely contact FirstHelp™ about less urgent medical issues on the Internet. Simply log on to *My Account* at [www.carefirst.com/myaccount](http://www.carefirst.com/myaccount) and click on "Ask Our Nurses" to submit your question. Within 24 hours, you will receive an e-mail stating that a response from a registered nurse is available at *My Account*.

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

- Your benefits and what is covered by your plan
- Information on your claims

If you have questions about your benefits or claims, please call the Member Services number listed on the back of your ID card.



### Receive discounts on health and wellness

Once you're enrolled in Supplement-65, you'll automatically become a member of our Options Discount Program,\* available only to CareFirst members. Your free membership in Options gives you exclusive discounts on services such as hearing screenings and hearing aids, fitness club memberships, contact lenses and laser vision correction, acupuncture, chiropractic care and more.

Just take a look at the Options Discount Program information for more details on this exclusive plan.

*\* This program is not an insurance product, nor is it offered as an inducement to purchase a policy of insurance from CareFirst BlueCross BlueShield.*

# CareFirst BlueCross BlueShield's Family of Plans

Having Medicare alone could cost you thousands of dollars in health costs each year; costs that Medicare was never designed to cover. Purchasing a Supplement-65 plan from CareFirst BlueCross BlueShield will cover the gaps in your Medicare coverage.

## Supplement-65 Plan A

Plan A delivers basic coverage to protect against the financial strain caused by serious illness and lengthy hospital stays. After you've satisfied your Medicare deductibles, this plan pays your Part A hospital copayment, your Part B coinsurance, and protects you for a full 365 days of hospital care after your Medicare benefits end.

## Supplement-65 Plan B

Plan B is a moderately priced plan that pays your \$1,132 Part A hospital deductible in addition to the same benefits featured in Plan A. This plan protects against the high cost of hospitalization.

## Supplement-65 Plan C

For solid Medicare Supplement protection at an attractive rate, choose Plan C. Plan C gives you great protection by covering the Part A deductible and copayments; 100% of hospital charges for 365 days after you've used your "lifetime reserve days"; the Part B deductible and copayments; skilled nursing copayments; and emergency care you receive in a foreign country.

## Supplement-65 Plan F

Plan F offers the broadest protection against high medical expenses. If you see doctors who do not accept Medicare's reimbursement as payment in full for services, consider Plan F. These doctors may charge you up to 15% more than Medicare allows. Plan F will cover these extra charges from non-Medicare doctors, plus all the things Plan C covers.

## Supplement-65 High Deductible Plan F

If you like to share in more of your health care costs, in exchange for a lower monthly premium, consider High-Deductible Plan F, which offers the same benefits as regular Plan F, after you have met a \$2,000 annual deductible for 2011.

## Supplement-65 Plan N

Plan N offers broad protection at a moderate price. It covers the Part A deductible and copayments and 100% of hospital charges for 365 days after you've used your "lifetime reserve days." For Part B, you have a \$162 deductible and then a small copay of up to \$20 for an office visit and up to \$50 for a visit to the emergency room.

# CareFirst BlueCross BlueShield's Family of Plans

## Comparison Chart

### What Medicare Does Not Pay    The Protection You Get With Supplement-65

Part A Hospital Services	Plan A	Plan B	Plan C	Plan F	High Deductible Plan F*	Plan N
\$1,132 inpatient hospital deductible		Covered	Covered	Covered	Covered	Covered
\$283 a day copayment for hospital days 61-90	Covered	Covered	Covered	Covered	Covered	Covered
\$566 a day copayment for hospital days 91-150 (Lifetime Reserve Days)	Covered	Covered	Covered	Covered	Covered	Covered
100% of Medicare allowable expenses for additional 365 days after Medicare hospital benefits stop completely	Covered	Covered	Covered	Covered	Covered	Covered
First three pints of blood	Covered	Covered	Covered	Covered	Covered	Covered
\$141.50 a day for days 21-100 in a skilled nursing facility			Covered	Covered	Covered	Covered
<b>Part B Outpatient Services</b>						
\$162 Part B deductible			Covered	Covered	Covered	
20% of outpatient charges	Covered	Covered	Covered	Covered	Covered	\$20 office visit \$50 ER
100% of charges over Medicare's allowed amount				Covered	Covered	
<b>Other Expenses</b>						
Medically necessary emergency care received in a foreign country (\$250 deductible; \$50,000 lifetime maximum)			Covered	Covered	Covered	Covered

\* **High-Deductible Plan F** pays the same benefits as Plan F, but you must first meet an annual deductible (\$2,000 for 2011) before Supplement-65 begins paying for your other covered benefits. Your out-of-pocket expenses can include costs that would normally be paid by the policy, such as Medicare deductibles for Parts A and B, but not the plan's separate foreign travel emergency deductible.

# Your Acceptance is Guaranteed\* – With No Risk!

So that everyone can enroll in these important benefits, Supplemental-65 is available two different ways

## Coverage is available on a guaranteed issue basis.

If you are enrolled in Medicare Part B, your acceptance into your choice of CareFirst's Supplement-65 plans is guaranteed! There is no health screening or medical exam. What's more, as long as you've had continuous health coverage for the past 6 months, with no more than a 63-day break, you will have no waiting period for pre-existing conditions. That means all medical conditions will be covered the day your policy goes into effect!\*

## Coverage is available on an underwritten basis.

By answering a few questions on the enclosed application, you may find you qualify for our lower, medically-underwritten rates. The guidelines for this coverage were established by the federal Medicare program – and may save you an additional \$900 - \$1,900 per year on your premium for coverage.

You are automatically eligible for the lower, underwritten rates if you will be age 65 or older when your Supplement-65 coverage begins, and if your Supplement-65 coverage will begin within six months from the first day of your Medicare Part B effective date.

Please refer to the Outline of Coverage included in this package for current pricing.

## Early Enrollment Discount

Did you know that you may qualify for an early enrollment discount? Applicants must meet all of the following criteria:

- Be a resident of the state of Virginia,
- Age 65 or older, AND
- Within 3 years of your Medicare Part B effective date.\*

\* *If you are more than 6 months from Medicare Part B effective date, you must also pass medical underwriting.*

The Supplement-65 discount will only be available for three years from the effective date of your policy. Once this period expires, your rate will increase by the amount of the discount plus any applicable rate increases.

You risk nothing by applying today. After you mail your application, we'll send you a Certificate of Coverage. Please read it carefully. If you're not satisfied with the coverage described, do not pay your bill. Your coverage will not go into effect. And you'll be under no further obligation.

If you're switching your coverage from another carrier, there's also no risk. We give you full credit for every day you've already spent toward your waiting period for pre-existing health conditions on your previous policy. Plus, we'll give you full credit for every dollar you've already spent toward your Medicare Part B deductible.

\* *If you have had more than a 63-day break in health insurance coverage, you may be subject to a waiting period of up to 90 days for any medical condition you had prior to enrollment in this plan.*

# It's Easy to Apply!

## Applying for a Supplement-65 plan couldn't be easier

### Just follow these easy steps:

1. Complete your paper application or for faster enrollment, apply online at [www.carefirst.com](http://www.carefirst.com). Click on [Medigap Plans](#) under "Need to Buy Insurance?"
2. Be sure to indicate the Supplement-65 plan of your choice.
3. Carefully read Sections 4 and 5 of your application to see if you automatically qualify for the lowest rates.
4. If you answer NO to the questions in Section 4 and 5, simply complete Section 6 of your application to find out if you qualify for the lowest underwritten rates.
5. Don't forget to sign your application.

6. Mail your application in the enclosed, postage-paid envelope.

Send no money now. We'll process your application quickly, and soon you'll be enjoying all the benefits of being a member of CareFirst BlueCross BlueShield, one of the most recognized names in health care. It's that simple!

## What is not covered

Supplement-65 policies are designed to work hand-in-hand with the federal Medicare program. They are not intended to be classified as long-term care policies, and do not pay for most custodial care.

Supplement-65 plans do not cover expenses for services and items excluded from coverage under Medicare, or expenses for services and items that would duplicate Medicare payments.

The screenshot shows the CareFirst BlueCross BlueShield website. At the top left is the logo. To the right are navigation links: About Us, Careers, Community, Contact Us, Glossary, Media, and a search bar. Below the logo is a vertical menu with categories: MEMBERS & VISITORS, EMPLOYERS & BENEFITS MANAGERS, PROVIDERS & PHYSICIANS, and BROKERS & AGENTS. In the center is a 'HealthyBlue' banner with the tagline 'Focused on You.' and a 'Learn More' link. To the right is a 'News & Updates' section with two articles: 'CareFirst Awards \$3 Million for Maternal and Child Health' and 'Health Care Reform and You'. Below the banner is a 'Solution Center' with two columns of links. The right column includes 'Health Care Reform and You', 'Options Discount Program -- Alternative Therapies, LASIK, Fitness Centers and other Wellness Services', 'Federal Employee?', 'Federal Employee Program (FEP)', 'Federal BlueChoice HMO', and 'CareFirst En Español'. At the bottom right is a 'Need to Buy Insurance?' section with a list of options: Individual & Family Plans, Medigap Plans (circled in blue with an arrow pointing to it), Preferred Provider Organizations, and DC Open Enrollment. The background of this section features a photo of a smiling man and woman.

### Exclusions

1. Any service, supply or item that is not a Medicare eligible expense as determined by Medicare.
2. Unless stated otherwise in the plan, any service, supply or item for which no actual determination was made by Medicare that the specific service, supply or item is a Medicare-eligible expense.
3. Any amount that duplicates benefits actually provided on your behalf by Medicare.
4. Any amount that exceeds the Medicare fee schedule or limiting charge set by the Medicare program.
5. For care furnished by or received as a result of a provider referral that is prohibited by law

# Dental and Vision Coverage

## Other Important Coverage from CareFirst

You've already turned to us for Supplement-65 coverage, which provides security for the gaps in Medicare coverage. Now you can look to CareFirst for your dental and vision needs.

### Choices for Your Dental Health

Regular preventive dental care is an important part of staying healthy. That's why CareFirst members have the option of purchasing a separate dental plan – you can choose either an Individual Select Preferred plan or Individual Select Dental HMO plan.

#### Individual Select Preferred

Comprehensive coverage of preventive services, in-network discounts on major procedures, and your choice of over 3,900 participating dental providers.

Individual Select Preferred combines the freedom to select any dental provider from a large regional network with comprehensive coverage of preventive and diagnostic dental services such as:

- Examinations
- Cleanings
- X-rays

These services are covered in full when visiting an in-network provider. You'll also have the option to seek routine treatment from non-participating providers and continue to receive benefits.\*

Additionally, Individual Select Preferred members get discounts on additional dental procedures, including fillings, crowns, and orthodontia just by showing your dental card. To take advantage of these reduced rates, you must visit a participating dentist.\*\*

\* *NOTE: CareFirst payments are based on the CareFirst Allowed Benefit. Participating dentists accept 100% of the Allowed Benefit from CareFirst as payment in full for covered services. If you visit a non-participating dentist for routine services, you must submit a claim form to CareFirst for reimbursement. CareFirst will still pay the Allowed Benefit but you will be responsible for the difference between the CareFirst Allowed Benefit and a non-participating provider's full charges.*

\*\* *This portion of the plan is not an insurance product, it is a dental discount program. Member charges are based on CareFirst allowances with the participating providers. Since rates may vary by provider, members should check with their participating dentist to determine the costs of specific procedures. Members must pay these reduced rates directly to the provider during the office visit.*

# Dental and Vision Coverage

## Individual Select Dental HMO

Maximum savings on major dental services and access to a network of over 1,000 participating dental providers

Individual Select Dental HMO offers you reliable dental care with predictable copayments for routine and major dental services such as:

- Preventive and diagnostic dental care
- Surgical extractions
- Root canal therapy
- Comprehensive orthodontic treatment

You'll select a general dentist from a network of participating providers to coordinate all of your dental care needs. When specialized care is needed, your general dentist will recommend a specialist within the Dental HMO network.

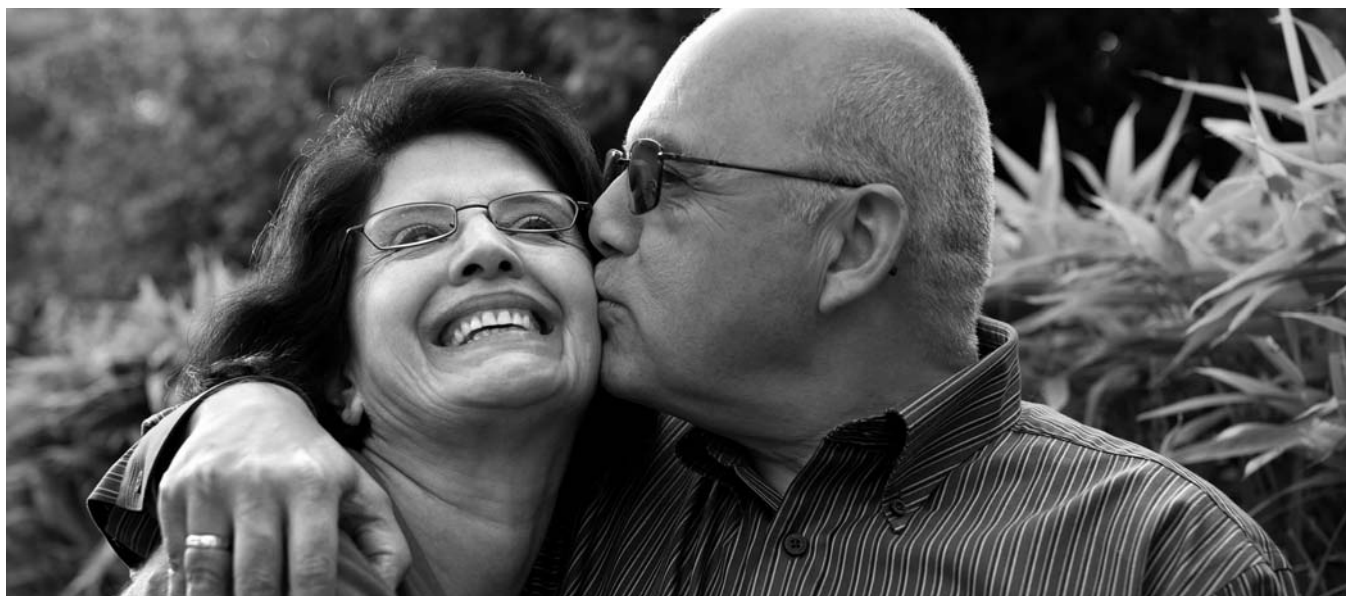
## Your Vision Option

You have the option of purchasing a separate vision plan through our network administrator, Davis Vision, Inc. Benefits include annual eye examinations with dilation at participating providers for a \$10 copay at the time of service and discounts of approximately 30% on eyeglass frames and lenses or contact lenses. For medical eye care, please follow your normal medical procedures.

To locate a vision provider, contact Davis Vision, Inc. at (800) 783-5602 or visit [www.carefirst.com](http://www.carefirst.com).

**NOTE:** The dental and vision plans referenced above are not part of your Supplement-65 policy. In order to receive coverage for dental or vision services, you must apply separately to these plans. The plans are not offered as an inducement to purchase a Supplement-65 policy from CareFirst BlueCross BlueShield.

**You cannot be turned down for CareFirst's dental or vision plans. If you have questions or would like to apply for a dental or vision plan, please contact a product specialist at (800) 544-8703.**



# Prescription Drug Coverage

## Available through Anthem BlueCross BlueShield\*\*

Neither Medicare nor Supplement-65 cover prescription drugs. Yet most of us need prescription drugs at one time or another; many of us rely on them everyday for our health and well-being. Now you can get help paying for the high cost of prescription drugs.

Anthem Blue Cross Blue Shield has partnered with CareFirst Blue Cross Blue Shield and contracted with the federal government to provide Medicare Prescription Drug Coverage (sometimes called Part D). You'll find that the plan works with your Medicare and Supplement-65 to give you well-rounded coverage. Call our Product Specialists at 1-888-784-0790 for more details. TTY users should call 1-888-784-0868. Specialists are available 8am – 8pm, 7 days a week. Or, visit [www.medi-carefirst.com](http://www.medi-carefirst.com) for more information.

*\*\* Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. of Virginia and is an independent licensee of the Blue Cross and Blue Shield Association.*

**You'll be happy to know that as a CareFirst member, you will have access to additional health care services from a Blue Cross and Blue Shield affiliate.**



# Options Health and Wellness Program

*Discounts on a Variety of Wellness Services*

## **FREE to You as a Carefirst Member!**

The Options Discount Program opens the door to discounts on a broad range of alternative therapies and wellness services.

Options is a free program for CareFirst members. Because it is a discount program, not a benefit under your medical plan, there are no claim forms, referrals or paperwork to fill out.

To save, just show your health plan ID card and pay the provider's fee at the time of service or visit [www.carefirst.com/options](http://www.carefirst.com/options) for the latest provider list and more information on each provider's discount or service.

This program is not offered as an inducement to purchase a policy of insurance from CareFirst. CareFirst does not underwrite this program because this program is not an insurance product. No benefits are paid by CareFirst under this program.



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

- Healthcare Resources
- Healthy Choices
- Recreation and Travel

Want to know more about what Blue365 has to offer? Look for the list of Blue365 vendors and resources on a special Web site designed just for CareFirst members. It's all available at:

[www.carefirst.com/options](http://www.carefirst.com/options)

You can also call Member Services for more information on Blue365.

**Please check [www.carefirst.com/options](http://www.carefirst.com/options) for the most current list of services and discounts.**

# Options Health and Wellness Program

## Discounts on a Variety of Wellness Services

### Hearing Care Services

Better hearing enriches your quality of life. Take advantage of the many discounted services offered by **Beltone Hearing Care Centers** and **TruHearing**. With **Beltone**, Medi-CareFirst members receive free hearing screenings and a 25% discount off the cost of Beltone hearing aids. All Beltone hearing aids include free batteries for one year, a two-year warranty, free cleaning and minor repairs and adjustments for the life of the hearing aid.

**TruHearing** offers free hearing screenings and discounts of up to 60% off quality digital instruments for Medi-CareFirst members, their children, parents and grandparents. TruHearing also offers an extended two-year warranty and a 45-day money back guarantee. All hearing tests are performed using the latest diagnostic equipment.

### Weight Loss Assistance Programs

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

Join **Jenny Craig** and receive a FREE 30-day program\*. Jenny Craig will design a personalized comprehensive program with one-on-one support that fits your lifestyle. You can also enjoy

up to 50% off the On Track 6-month program\* or 20% off the Jenny Rewards 1-year program\*.

*\* Does not include the cost of food. Discounts apply to membership fee only. Offer valid at participating centers only.*

### Fitness and Spa Club Memberships

Through two different networks, Options offers flexibility in choosing a gym that is right for you.

**Healthways WholeHealth Networks** offers a nationwide network of more than 10,000 fitness centers and spas. With your Medi-CareFirst plan, you can receive discounts on the following:

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

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

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

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

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

# Options Health and Wellness Program

## *Discounts on a Variety of Wellness Services*

### Medical IDs

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

### ElderCare Information & Referral Program

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

### Laser Vision Correction & Contact Lenses

Through **TruVision**, CareFirst members can receive 10% off of LASIK or PRK procedures. All pricing includes a pre-operative exam, the Laser Vision Correction procedure, post-operative care and

a one-year enhancement warranty. Discounts are also available on Custom LASIK, IntraLase Bladeless procedures, and some centers offer lifetime re-treatment plans. Members can also receive discounts of up to 50% off most brands of contact lenses ordered through the Mail and receive free shipping and handling.

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

### Prescription Drug Discounts

Though not a part of Options, members receive valuable discounts on prescription drugs at over 63,000 pharmacies nationwide through Argus Health Systems (Argus). With this program, members are guaranteed the lowest price available in that pharmacy at the time of purchase. Show your Argus prescription card at a participating pharmacy and save. Even if you have Medicare Prescription Drug coverage this card can be used for drugs that the Medicare Drug Plan does **not** cover.

Minimum 14% discount  
Argus Toll Free: 1-888-850-2405

# CareFirst's Privacy Practices

## *Our Commitment to Our Members*

The following statement applies to CareFirst BlueCross BlueShield and its affiliates, CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. (doing business as CareFirst BlueCross BlueShield), CareFirst BlueChoice, Inc., (collectively, CareFirst).

When you apply for any type of insurance, you disclose information about yourself and/or members of your family. The collection, use and disclosure of this information are regulated by law. Safeguarding your personal information is something that we take very seriously at CareFirst. CareFirst is providing this notice to inform you of what we do with the information you provide to us.

## Categories of Personal Information We May Collect

We may collect personal, financial and medical information about you from various sources, including:

- Information you provide on applications or other forms, such as your name, address, social security number, salary, age and gender.
- Information pertaining to your relationship with CareFirst, its affiliates or others, such as your policy coverage, premiums and claims payment history.
- Information (as described in preceding paragraphs) that we obtain from any of our affiliates.

- Information we receive about you from other sources, such as your employer, your provider and other third parties.

## How Your Information Is Used

We use the information we collect about you in connection with underwriting or administration of an insurance policy or claim or for other purposes allowed by law. At no time do we disclose your personal, financial and medical information to anyone outside of CareFirst unless we have proper authorization from you or we are permitted or required to do so by law. We maintain physical, electronic and procedural safeguards in accordance with federal and state standards that protect your information.

In addition, we limit access to your personal, financial and medical information to those CareFirst employees, brokers, benefit plan administrators, consultants, business partners, providers and agents who need to know this information to conduct CareFirst business or to provide products or services to you.

## Disclosure of Your Information

In order to protect your privacy, affiliated and nonaffiliated third parties of CareFirst are subject to strict confidentiality laws. Affiliated entities are companies that are a part of the CareFirst corporate family and include health maintenance organizations, third party administrators, health insurers, long-term care insurers and insurance agencies.

# CareFirst's Privacy Practices

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In certain situations related to our insurance transactions involving you, we disclose your personal, financial and medical information to a nonaffiliated third party that assists us in providing services to you. When we disclose information to these critical business partners, we require these business partners to agree to safeguard your personal, financial and medical information and to use the information only for the intended purpose, and to abide by the applicable law. The information CareFirst provides to these business partners can only be used to provide services we have asked them to perform for us or for you and/or your benefit plan.

## Changes in Our Privacy Policy

CareFirst periodically reviews its policies and reserves the right to change them. If we change the substance of our privacy policy, we will continue our commitment to keep your personal, financial and medical information secure – it is our highest priority. Even if you are no longer a CareFirst customer, our privacy policy will continue to apply to your records. You can always review our current privacy policy online at [www.carefirst.com](http://www.carefirst.com)





## We're here to answer your questions.

If you have any questions about the plans described in this booklet, or if you'd like assistance, just call 1-800-275-3802. You'll receive courteous, knowledgeable assistance from one of our dedicated Product Specialists.

The benefits described are issued under policies:

VA/CF/MG PLAN A (6/10)  
VA/CF/MG PLAN B (6/10)  
VA/CF/MG PLAN C (6/10)  
VA/CF/MG PLAN F (6/10)  
VA/CF/MG PLAN HI DED F (6/10)  
VA/CF/MG PLAN HI F SOB (6/10)  
VA/CF/MG PLAN N (6/10)

VA/CF/MG UW PLAN B (6/10)  
VA/CF/MG UW PLAN C (6/10)  
VA/CF/MG UW PLAN F (6/10)  
VA/CF/MG UW PLAN HI DED F (6/10)  
VA/CF/MG UW PLAN N (6/10)

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.

Neither CareFirst BlueCross BlueShield nor its agents represent, work for or receive compensation from any federal, state or local government agency.



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[www.carefirst.com](http://www.carefirst.com)

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.