Individual BluePreferred-Saver Application

(Maryland Residents)

CareFirst BlueCross BlueShield

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

OFFICE USE ONLY:

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

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Sign and return this application in the postage-paid return envelope if provided, or mail to:

   APPLICATION PROCESSING
   5965 SANDY RIDGE
   ELKRIDGE, MARYLAND 21075

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.***

FAX COMPLETED APPLICATION TO:
1-877-877-5801 OR 1-410-796-7456

OR MAIL TO:
APPLICATION PROCESSING
5965 SANDY RIDGE
ELKRIDGE, MD 21075

YOU WILL RECEIVE A CONFIRM E-MAIL WITHIN 24-48 HOURS OF RECEIPT

1. APPLICANT INFORMATION (The oldest applicant will be the Subscriber)

Last Name	First Name	Initial	Social Security #

Residence Address: (Number and Street, Apt. #)	City and State	Zip Code (9-digit, if known)

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

Date of Birth	Sex	Marital Status	Height	Weight
/ /	☐ Male ☐ Female	☐ Single ☐ Married ☐ Partner		

Home Phone	Work Phone	E-mail Address
( )	( )	

2. COVERAGE SELECTION: (Check one)

☐ **Individual** - Provides coverage for one person
☐ **Individual & Child(ren)** - Provides coverage for an individual and eligible dependent(s)
☐ **Individual & Adult** - Provides coverage for two eligible adults
☐ **Family** - Provides coverage for two eligible adults and eligible dependent(s)

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

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX	HEIGHT (in.)	WEIGHT (lbs.)
Spouse/Partner						☐M ☐F		
Dependent 1						☐M ☐F		
Dependent 2						☐M ☐F		
Dependent 3						☐M ☐F		
Dependent 4						☐M ☐F		
Dependent 5						☐M ☐F		

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

CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, 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.

4. COVERAGE LEVEL

	Individual Deductible		Coverage Level		Individual Out-of-Pocket Limit	
Check one:	(In-Network)	(Out-of-Network)	(In-Network)	(Out-of-Network)	(In-Network)	(Out-of-Network)
☐	$2,500	$5,000	70%	60%	$5,000	$10,000
☐	$5,000	$10,000	100%	80%	$5,000	$12,500
☐	$10,000	$12,500	100%	80%	$10,000	$15,000

MATERNITY BENEFITS: Check this box if you wish to include benefits for maternity services (additional cost). ..... ☐ Yes

5. OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED. YES NO

1. Is anyone listed on this application eligible for Medicare? ☐ ☐

   If yes, please provide the following:
   Name of family member(s)_____ Medicare No_____ Effective Date _____

2. Is anyone listed on this application covered by other health insurance, including other Blue Cross and Blue Shield coverage? ☐ ☐

   If yes, please provide the following:

   Name of family member(s)_____ Insurance Company_____

   Policy Number and Type_____ Effective Date _____

   If you are accepted, will your new CareFirst BlueCross BlueShield coverage replace your existing policy? ☐ ☐

3. Has anyone listed on this application been without health insurance for the past 12-months or longer? ☐ ☐

   If yes, please list name(s):_____

6. HEALTH EVALUATION

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

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

SECTION 6A — If any person included in this application is presently using or has used medication or prescription drugs in the past 5 years, please provide the following information.

Name of Family Member	Illness or Condition	Medication	Date of Last Treatment	How Often Taken	Attending Physician Name and Address

SECTION 6B — To the best of your knowledge and belief, has any person named in this application had within the last five years, or does such person now have, any of the following: YES NO

1. Cancer, tumor or other growth (malignant or benign)..... ☐ ☐
2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test).... ☐ ☐
3. Kidney stones, kidney or bladder condition, urinary frequency or burning..... ☐ ☐
4. Goiter, thyroid condition, diabetes..... ☐ ☐
5. Seizure disorder, central nervous system disorder, multiple sclerosis..... ☐ ☐
6. Substance abuse (drug or alcohol dependency, abuse or addiction) ..... ☐ ☐

6. HEALTH EVALUATION (Continued)

	YES	NO
7. Use of illicit drugs	☐	☐
8. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition	☐	☐
9. Cataract or other eye condition	☐	☐
10. Tuberculosis, lung condition, asthma, bronchitis	☐	☐
11. Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition	☐	☐
12. Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)	☐	☐
13. (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, breast condition	☐	☐
14. (Female) Is currently pregnant; expected date of delivery: _____/_____/_____	☐	☐
15. (Male) Prostate condition, reproductive system disorders	☐	☐
16. Do you or your spouse/partner have known infertility or any known disorder related to infertility	☐	☐
17. Have you or your spouse/partner received any treatment or diagnostic "work-up" related to infertility	☐	☐
18. Have you been told that you have high or elevated cholesterol, lipids or triglycerides	☐	☐
19. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder	☐	☐
20. Sexually transmitted diseases	☐	☐
21. Anemia, blood disorders	☐	☐
22. Excluding physical examinations, consulted a physician, health care provider, or other individual or facility for medical or surgical treatment, advice, screening for any condition, or prescription medication for a medical condition NOT listed above in items 1-21?	☐	☐
23. Had any known departure from good health not previously mentioned in this questionnaire for which treatment or advice may or may not have been sought?	☐	☐

NOTE: ALL QUESTIONS MUST BE CHECKED "YES" OR "NO" – Or your application will be returned.

SECTION 6C — If you have checked "YES" to any part of SECTION 6B, for each box checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgeries and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

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

Patient's Name	Question Number	Diagnosis or Condition	Duration Dates	Explain treatment including all medications, hospitalizations, surgery and diagnostic test results and physician's/hospital's name.	Recovery (Check only one box)
			FROM: TO:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL

7. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request, from Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst).

This information is subject to verification. To do so I authorize any physician, hospital, pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company to release my "Medical Information" to Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst) or CareFirst's vendors or representatives. I further authorize any vendor who receives "Medical Information" from any physician, hospital, pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company to release my "Medical Information" to CareFirst. I understand that my Medical Information consists of any diagnoses, treatment, prescriptions from a pharmacy, or any other medically related information about me. I authorize CareFirst to use my Medical Information for underwriting and to determine my eligibility for insurance benefits. I understand this authorization will remain in effect for one year from the date signed.

I understand that I have the right to cancel this authorization at any time, in writing, except to the extent that CareFirst has already taken action in reliance on this authorization. I also understand that CareFirst's Notice of Privacy Practices includes information pertaining to authorizations and to requirements of revocation. A copy of the Notice may be obtained by contacting the CareFirst's Privacy Office. CareFirst will not use or disclose the Medical Information for any purposes other than those listed above except as may be required by law. CareFirst is required to tell you by law that information disclosed pursuant to this authorization may be subject to re-disclosure and that under some limited circumstances will no longer be protected by federal privacy regulations.

If CareFirst determines that additional information is needed, I will receive an authorization to release that information. Failure to execute an authorization may result in the denial of my application for coverage. Additionally I understand that failure to complete any section of this application, including signing below, may delay the processing of my application.

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

I will update CareFirst if there have been any changes in health concerning any person listed in this application that occur prior to acceptance of this application by CareFirst.

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

An applicant or dependent whose application is denied by CareFirst due to medical underwriting may not submit a subsequent Application for enrollment within ninety (90) days of the denial.

WARNING: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signature of Applicant 1:* X_____ Date:_____

Signature of Applicant 2: X_____ Date:_____
(Spouse/Partner)

* Rates are based on the age of the Subscriber (oldest applicant).

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

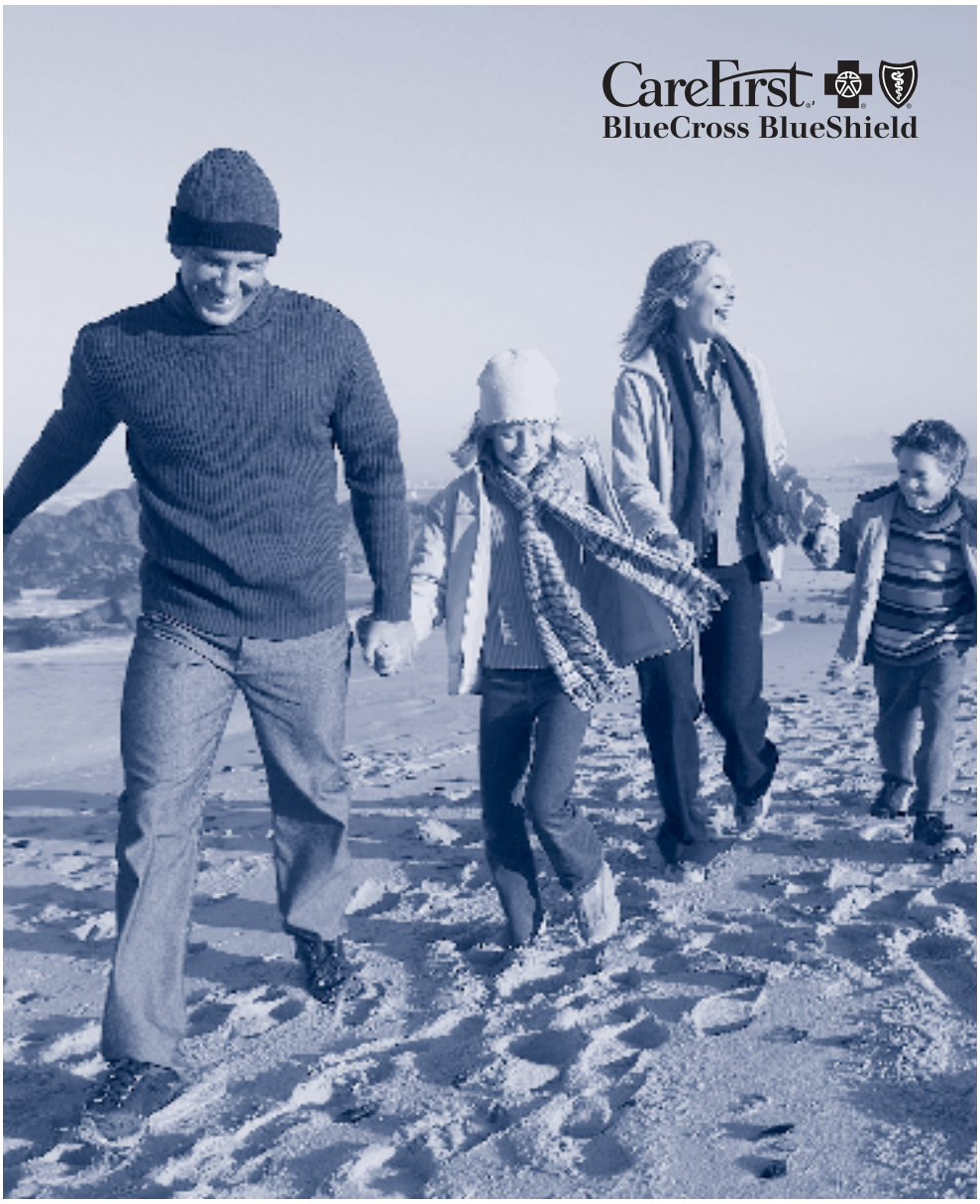
Parent or Legal Guardian's Signature: X_____ Date:_____

FOR OFFICE USE ONLY:

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

Signature of Applicant 1: X_____ Date:_____

Signature of Applicant 2: X_____ Date:_____
(Spouse/Partner)



BluePreferred-Saver

Maryland

More to feel good about.

Call 1-877-634-1256 with Questions...

BluePreferred-Saver is a product for people like you:

people who know they need health coverage, but don't want to spend a lot of money for it. ***With BluePreferred-Saver's design, you save money, even if you don't visit the doctor very often.***

- **Save with lower monthly premiums,** and rest assured: you're covered for life's sudden health emergencies.
- **Save at the doctor's office.** Your expense is limited to a copay for the first two office visits each year (excluding preventive care). All of your preventive care visits in-network are covered with a copay and no deductible.
- **Save on prescription drugs.** After meeting a lower deductible, you pay only a $15 copay for generic drugs, and get discounts on brand name prescriptions.

Save your hard-earned money, in the event of a medical emergency, and let CareFirst BlueCross BlueShield (CareFirst) cover you. With BluePreferred-Saver, you know what your maximum out-of-pocket expenses will be in any given year. Once you reach the out-of-pocket limit, which is the maximum an individual on your policy spends toward coinsurance and deductibles per year, CareFirst pays 100% of your covered medical expenses (excluding prescriptions) for that benefit year. And, you can rest assured knowing that your BluePreferred-Saver coverage has a $3,000,000 lifetime benefit maximum for covered medical services.

A health plan that actually gives you opportunities to save while keeping you covered, at a competitive price.

Individuals under the age of 30 can get coverage for less than $100 a month! Choose a plan with a higher deductible, and you'll pay even less for your coverage.

As a member, you'll get built-in cost savings from one of the region's leading health insurers, CareFirst BlueCross BlueShield. And, you'll be able to count on the negotiating power of CareFirst, by receiving discounts on medical care, prescriptions and a host of other programs designed to help you maintain your good health.

- **Save more by using in-network doctors.**
  You can see any doctor you like. However, you'll notice significant savings when you use doctors within CareFirst's Preferred Provider Network, which includes more than 29,000 providers and 42 hospitals locally.

- **Save time by avoiding cumbersome paperwork.**
  You won't need referrals. And you'll have few, if any, claim forms.

- **Save with discounts on health-related programs.**
  As a CareFirst member, you are entitled to discounts on alternative therapies and health and wellness programs such as chiropractic, acupuncture, massage, yoga, Pilates, tai chi, qi gong, guided imagery and fitness centers. Also, this program offers discounts on Weight Watchers® Online and Jenny Craig®, mail order contacts, laser-vision correction, hearing aids, and eldercare management. Since this program is in addition to your medical plan rather than a benefit, there are no claim forms, paperwork or referrals.

Choose the deductible level right for you

With BluePreferred-Saver, you have three plans to choose from. The choice is yours. The higher your deductible, the lower your premium and member coinsurance. Tailor your coverage to your budget.

Option 1: $2,500 Deductible

	In-Network	Out-of-Network
Deductible	Individual: $2,500	Individual: $5,000
	Family: $5,000	Family: $10,000
Member Coinsurance	30%	40%
Out-of-Pocket Limit	Individual: $5,000	Individual: $10,000
	Family: $10,000	Family: $20,000

Option 2: $5,000 Deductible

	In-Network	Out-of-Network
Deductible	Individual: $5,000	Individual: $10,000
	Family: $10,000	Family: $20,000
Member Coinsurance	0%	20%
Out-of-Pocket Limit	Individual: $5,000	Individual: $12,500
	Family: $10,000	Family: $22,500

Option 3: $10,000 Deductible

	In-Network	Out-of-Network
Deductible	Individual: $10,000	Individual: $12,500
	Family: $20,000	Family: $25,000
Member Coinsurance	0%	20%
Out-of-Pocket Limit	Individual: $10,000	Individual: $15,000
	Family: $20,000	Family: $27,500

How the Plan Works:

- You pay up to the deductible, when applicable. Families never pay more than two times the individual deductible in a benefit year. Remember, for just a $30 copay per visit, your first two in-network office visits (excluding preventive care) are covered.
- Once the deductible has been met, BluePreferred-Saver pays a percentage (100% or 70% for in-network providers) of the allowed amount. This is called the coverage level. The percentage that you pay (0% or 30% for in-network providers) is referred to as coinsurance.
- Unlike many other plans, your deductible and most coinsurance payments are included as part of your out-of-pocket limit, which is the maximum an individual on your policy spends toward coinsurance and deductibles per year.
- Once your out-of-pocket limit is reached, no further coinsurance or deductibles will be required in that calendar year.*
- Eligible expenses of all covered members can be combined to satisfy the family out-of-pocket limit. An individual family member cannot contribute more than the individual out-of-pocket limit toward meeting the family out-of-pocket limit.

**Please note that the prescription program deductible, copayments and limits are separate from the medical deductible, copayments and limits.*

In-Network Benefits at a Glance

Medical Benefits	You Pay (In-Network)
Preventive Services	
Routine Adult Physical	$30 per visit (no deductible)
Well-Child Care Including Exams and Immunizations	$30 per visit (no deductible)
Routine OB/GYN Visits	$30 per visit (no deductible)
PAP test, Mammograms, Prostate Screening & Colorectal Screening	No charge
Office Visits, Labs and Testing	
Office Visits (excluding preventive care) 1-2 visits 3+ visits	 $30 per visit (no deductible) Deductible & Coinsurance
X-ray and Lab Tests	Deductible & Coinsurance
Allergy Treatments	Deductible & Coinsurance
Emergency Care	
Emergency Room	Deductible & Coinsurance
Urgent Care Center	Deductible & Coinsurance
Ambulance (when medically necessary)	Deductible & Coinsurance
Hospitalization	
Inpatient Facility Services	Deductible & Coinsurance
Inpatient Physician Services	Deductible & Coinsurance
Outpatient Facility Services	Deductible & Coinsurance
Outpatient Physician Services	Deductible & Coinsurance
Vision Services	
Routine Annual Exam (administered by Davis Vision)	$10
Prescription Drug Benefits	
Deductible	$150
Generic Copay	$15
Preferred Brand Copay	Discount
Non-Preferred Brand Copay	Discount
Annual Maximum (per person)	$1,500 (generic drugs)

Care received out-of-network is subject to higher deductibles and coinsurance.
There is a 10-month pre-existing condition exclusion period.

Optional Extended Maternity Services may be added for you or your covered spouse or domestic partner. For an additional $126 a month, you'll receive benefits for covered pre- and postnatal care as well as covered services associated with the delivery. **If you add maternity coverage, at any time, and you are pregnant on the effective date of your coverage, there will be a 10-month pre-existing condition exclusion period for extended maternity and related services. If you become pregnant after your effective date, then CareFirst will begin covering extended maternity and related services immediately.**

When You Need Care

UTILIZATION MANAGEMENT

When you need to be hospitalized or need therapy, your doctor will work with the Utilization Management team to ensure you receive the right care in the right place at the right time.

Hospital Precertification and Review

Any time you face non-emergency surgery or hospitalization, the Hospitalization Precertification and Review program works with your provider to determine if the hospital is the most appropriate place for your procedure and recovery. If you are hospitalized, a Utilization Management nurse will review your information and assist with discharge planning or approve additional inpatient hospital days if necessary.

Maximizing Your Drug Benefit

To help you and your family face the challenge of the rising cost of prescription drugs, CareFirst has developed drug utilization programs to encourage the use of drugs that are effective and cost-efficient in order to maximize the value of your prescription drug benefit. In addition, we frequently update the preferred drug list (Formulary) which can be found at Here you can also find tools to help you get the most from your prescription dollar such as learning how to save money with generic alternatives, finding participating pharmacies and much more.

CASE MANAGEMENT

When faced with a serious diagnosis or condition, you and your family have many tough choices and decisions to make. The Case Management program can help you navigate the complex health care system and provide support during your time of need.

Some of the conditions most frequently case managed include:

- serious trauma
- rehabilitation
- cancer
- special needs

Our case managers will:

- Work closely with you and your doctors to identify a treatment plan
- Coordinate necessary services
- Contact you regularly to see how you are doing
- Answer any of your questions
- Suggest community resources that may be available

DISEASE MANAGEMENT

Our disease management programs can help you avoid or delay the complications related to chronic conditions.

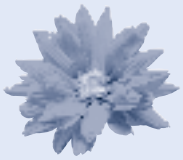
We have programs for:

- Diabetes
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure
- Coronary heart disease

When you enroll, you will:

- Receive information on how to manage your condition
- Be able to call a toll-free number 24 hours a day, seven days a week, to speak with a registered nurse
- Have access to a Web site that has information about your condition
- Be able to email questions to a registered nurse

Options Discount Program



Options discount program provides you with discounts on laser vision correction, hearing care services, fitness club memberships and mail order contact lenses, as well as alternative therapies such as acupuncture, massage therapy and chiropractic care. CareFirst BluePreferred members can also receive discounts on tai chi, qi gong, pilates, yoga, nutrition counseling, guided imagery, meditation instruction, mind-body instruction and personal training.

It's Easy to Apply

To be eligible for BluePreferred-Saver coverage, each family member applying must be a resident of Maryland and complete a medical questionnaire.

Just follow these easy steps to apply.

1. **Choose what type of coverage you need. You can select:**
   - Individual
   - Individual and Child(ren)*
   - Individual and Adult**
   - Family [Two eligible adults and eligible dependent(s)]

   *"Child" means your unmarried, *eligible* child up to age 25. Eligibility requirements are defined in the BluePreferred contract.

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

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

2. **Choose the plan that best fits your needs.** The enclosed rate charts for each plan, coverage type, and age will help you identify your monthly premium.

3. **Locate the application form in this packet.** Be sure to answer all questions honestly and completely, and don't forget to sign your application. Make sure you check "yes" in the Maternity benefit selection area, if you wish to elect optional extended maternity benefits.

4. **Mail your application in the enclosed envelope.** Send no money at this time. We'll begin processing your application right away! The review process takes about 4-6 weeks. Once you have submitted your application, you can call the Application Status Hotline at 1-877-634-1256 with questions. Your coverage will become effective the first of the month following the month in which we approve your application. Once effective, you'll receive your ID cards and everything else you need.

Coverage Available from CareFirst BlueCross BlueShield:

Our Product Specialists can provide information regarding a wide variety of other insurance programs from CareFirst BlueCross BlueShield and its affiliates, to meet your individual needs, including:

BluePreferred & BluePreferred HSA**

A Preferred Provider Organization (PPO) Plan providing freedom of provider choice with a variety of options including three high-deductible options to lower your premiums including health savings account-compatible plans.

Personal Comp** & Personal Comp HSA**

Indemnity coverage that gives you the freedom to choose any doctor or hospital and a wide range of deductible levels including health savings account-compatible plans.

MediGap-65

Traditional coverage to supplement your Medicare policy offered by CareFirst of Maryland, Inc. For more information about this plan, please call our Product Specialists toll free at 1-877-634-1256

Other Coverage Available

CareFirst BlueChoice* & BlueChoice-Saver**

Flexible HMO coverage offering four plans including a low-premium option (offered by an affiliated HMO).

* The Dental Network and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

** Medical questionnaire must be completed.

Policy Form Numbers:
IEA OE/DP MD as amended; DOCS-PPO/M ; MD/CF/Low Cost 70% Option SOB (1/05); MD/CF_Low Cost 100% Option SOB (1/05); MD/CF/IND DRUG (1/05); MD/BP/DB/ES (10/07)

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.

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

BRC6443-9S (8/08)