Welcome to HealthyBlue 2.0

Thank you for choosing HealthyBlue 2.0, the next generation of health benefits from the CareFirst family of health care plans. Enrolling in HealthyBlue 2.0 is an important step toward taking control of your health care.

You now have access to a new health care solution with the flexibility to change as your needs change, while rewarding you for living a healthy life. And remember our commitment to saving you money doesn't end there - you can get preventive care, cancer screenings, diagnostic/lab tests and X-rays at no cost!²

HealthyBlue 2.0, a health care plan focused on you:

➤ Pay nothing for preventive office visits – not even a copay when you use an in-network provider.²
➤ Save money for taking control of your health.
➤ Work toward the same goal as your doctor – getting you healthy & keeping you healthy while giving you a great opportunity to reduce your future health care costs.
➤ Partner with one doctor who knows and understands you – and all of your health care needs.
➤ Choose how you will get your care, each time you need care – it’s up to you.

With HealthyBlue 2.0, you have options to choose from every time you need care. You can also get a Healthy Reward – a financial incentive – by completing 3 easy steps.

We’re committed to providing our members with the highest level of service possible. The information included in this handbook will provide you with an overview that describes some important features to help you manage your health care.

Please take a moment to review this information and keep it in a safe place for future reference. This handbook, along with your Summary of Benefits and enrollment materials, gives you tips on how to receive the highest level of health care benefits. However, this isn’t a contract. A detailed description of specific terms, as well as the conditions and limitations of your coverage, is included in your Evidence of Coverage/Agreement.

As always, please contact Member Services at the phone number listed on the back of your ID card if you have any questions regarding your coverage.

We appreciate your business and look forward to serving you in the future.

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

Emergency Assistance and Medical Advice
Knowing when to get the right care, at the right time and at the right place, is important in managing your health care.

➤ If you or a family member is experiencing a medical emergency, call 911 or go to the emergency room.
➤ If you need routine care or have a health problem you should call your personal, primary care provider (PCP).
➤ If you can't reach your PCP and have questions about your health, an illness, or an urgent medical condition, call FirstHelp™. Registered nurses are available to help you make a decision concerning the most appropriate level of care.

McKesson, Inc. is an independent company that provides 24-hour health care advice services under the name FirstHelp™. McKesson, Inc. does not provide CareFirst BlueChoice products or services. FirstHelp™ is solely responsible for the advice services.

FirstHelp™ Health Care Advice Line – 24 hours a day, 7 days a week
Toll-free: (800) 535-9700

Hospital Authorization/Utilization Management
Your HealthyBlue 2.0 provider should obtain any necessary admission authorizations for covered services.
Toll-free: (866) PREAUTH (773-2884)

Behavioral Health/Substance Abuse Care – 24 hours a day, 7 days a week
Call the phone number on your ID card under the Behavioral Health/Substance Abuse Service and Authorization section.

Additional Telephone Numbers

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

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

Away From Home Care®
(888) 452-6403

BlueCard Worldwide Service Center (inside the U.S.)
(800) 810-BLUE (2583)

BlueCard Worldwide Service Center (outside the U.S.)
1 (804) 673-1177

Member Services
Please call the Member Services phone number listed on your member identification (ID) card.

TTY Telephone Numbers
Maryland Relay Program (toll-free)
(800) 735-2285

National Capital Area TTY
(202) 479-3546

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

Contact Member Services for benefit and contract information. When writing to CareFirst BlueChoice, Inc. (CareFirst BlueChoice), always include your Member Identification Number.

Please address your correspondence to:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

NOTE: Davis Vision, Inc. is an independent company and administers the vision benefits for CareFirst BlueChoice.

* Argus Health Systems is an independent company and administers the Prescription Drug Program on behalf of CareFirst BlueChoice.
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The diagram to the right shows the information on your ID card. Please take a moment to review your card. If any of the information is incorrect, please contact the Member Services phone number on your ID card immediately, so they can assist with correcting any errors.

This is a sample HealthyBlue 2.0 ID card. Please review your personal card, and the cards of your dependents that are covered members, for your ID number and information specific to your coverage.

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

Your ID card identifies you as a HealthyBlue 2.0 member and contains important information about you, your personal primary care provider (PCP), and some of your eligible benefits. This is the card you present to your PCP, specialist or hospital to receive care. Always carry your member ID card with you.
As a HealthyBlue 2.0 member, you’re now part of the health care program that brings together the health benefits you want and the cost savings you need, with the goal of keeping you healthy. And, as you would expect from CareFirst BlueChoice, you have access to a large network of quality providers to partner with.

HealthyBlue 2.0 enables you to choose when, how and by whom your health care is administered. To ensure you receive the highest level of benefit, both in your health and in your wallet, we recommend that you work directly with your CareFirst BlueChoice personal PCP (physician or nurse practitioner). However, as a HealthyBlue 2.0 member, you have 2 choices each time you need care.

In-Network – Biggest savings to you
Use the CareFirst BlueChoice network and save the most money. To ensure you get the most from your in-network benefits, remember to select a personal PCP, who knows and understands all of your health care needs, for you and each member of your family.

➤ Choose any other CareFirst BlueChoice doctor you want - no referrals.
➤ Pay the lowest out-of-pocket costs for all services.
➤ Pay the lowest annual deductible.
➤ For most members, adult and child preventive and sick visits with their CareFirst BlueChoice PCP, cancer screenings, diagnostic/lab tests and X-rays for all covered family members are free – no charge at all.

Out-of-Network – Higher costs with greater flexibility
Receive care from any doctor or facility within the larger CareFirst BlueCross BlueShield PPO network, or from a doctor who doesn’t participate in a CareFirst provider network.

➤ Select any provider for care within the CareFirst Preferred Provider Organization (PPO) network or any out-of-network doctor. You’re not required to get your care or referrals from your personal PCP.
➤ Pay higher out-of-pocket costs with this added flexibility.
➤ Pay a higher annual deductible.
➤ Adult preventive care and sick visits, well-child care visits, cancer screenings,* specialist visits, diagnostic/lab tests and X-rays will require your deductible to be met first, and then a copay will apply (refer to your benefit summary in the What’s Covered section of this book).

Your Out-of-Pocket Maximum**
Your out-of-pocket maximum is the maximum amount you’ll pay for covered services during your benefit period. Should you reach your out-of-pocket maximum, you will no longer be required to pay copayments or your share of the coinsurance for the remainder of that benefit period. Most amounts you pay towards your copays and/or coinsurance will count towards your out-of-pocket maximum.

You’ll have a different out-of-pocket maximum for in-network vs. out-of-network benefits.

If more than one person is covered under your plan, once the family out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan.

Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Evidence of Coverage/Agreement for detailed out-of-pocket maximum information.

* Mammograms and pap smears are not subject to the deductible in the District of Columbia. For more information, please refer to your benefit summary under What’s Covered.

Breast cancer screenings are not subject to the deductible for members with contracts based in Maryland.

** The deductible, coinsurance and copayments for most services may be used to meet out-of-pocket maximum. Review your policy for more details on what applies to your out-of-pocket maximum.
HealthyBlue: The Basics

Your Personal PCP
Better health begins when you select your personal CareFirst BlueChoice PCP and begin to develop a relationship, so choose a PCP if you haven’t already. You, and each of your covered family members, will need to select a PCP or nurse practitioner. The PCP must participate in the CareFirst BlueChoice provider network specializing in family practice, general practice, pediatrics or internal medicine.

HealthyBlue 2.0 was designed to encourage greater interaction between you and your PCP as you both work toward the goal of a healthier you.

Your PCP:
- Knows and understands all your health care needs.
- Is informed about your medical history.
- Provides basic medical care.
- Prescribes medications.
- Works with you to complete your Health and Wellness Evaluation.
- Coordinates care and treatment, with high quality CareFirst BlueChoice specialists and centers of excellence.

Healthy Reward
And Health & Wellness Evaluation Form
Your path to good health and a Healthy Reward begins as soon as you enroll in HealthyBlue 2.0. The sooner you begin, the sooner you’ll qualify for your reward.*

You can qualify for your reward in 3 easy steps!

Step 1: Select a personal PCP.
- If you or your family members didn’t select a CareFirst BlueChoice PCP when you enrolled, select one now by visiting www.carefirst.com/myaccount or call the Member Service phone number listed on your ID card.

Steps 2 & 3: Complete the Health Assessment and the Health and Wellness Evaluation Form. These steps can be completed in any order within 120 days from your effective date.

- To qualify for the Healthy Reward, you must complete the online Health Assessment (Adults 18+) and consent to sharing the information with your PCP.

- Register online for My Account at www.carefirst.com/myaccount. Have your member ID number handy and click “Register now” to create your username and password. Then answer some health and lifestyle questions – it’s simple. Remember to check the consent box to share the information with your PCP.

- If you don’t have Internet access, call (866) 454-5375 to request a paper copy of the Health Assessment.

- Work with your PCP to complete the Health and Wellness Evaluation – then submit it to CareFirst BlueChoice!

When you go for the Health and Wellness Evaluation visit with your PCP, be sure to bring the Health and Wellness Evaluation Form with you. You can download a copy from www.carefirst.com/healthyblue. Your PCP can’t complete your assessment without this important form.

So that you’re familiar with what the form looks like, below is a snapshot:

* Children under 2 are not eligible to earn the reward.
HealthyBlue: The Basics

HealthyBlue 2.0 Prescription Benefits
Your coverage may include benefits for prescription drugs. Please review your Evidence of Coverage/Agreement to determine whether or not you have benefits for your prescription medications under your CareFirst BlueChoice plan.

CareFirst BlueChoice uses a Preferred Drug List and a Preferred Preventive Drug List (called a Formulary), which is a list of generic (Tier 1) and certain Preferred Brand-Name (Tier 2) drugs. Drugs that aren’t on these formularies are called Non-Preferred (Tier 3) and are covered as part of your plan, although you’ll have to pay higher out-of-pocket costs for these drugs.

If you’re prescribed a non-preferred brand-name drug, discuss with your doctor some lower-cost alternatives that are on the Preferred Drug List from Tier 1 or Tier 2.

You can rest easy knowing your medications have been reviewed for quality, effectiveness, safety and cost by a committee of doctors and pharmacists who serve in the CareFirst BlueChoice region. The Preferred Drug List changes frequently in response to the Food and Drug Administration (FDA) requirements and is also adjusted when a generic drug is introduced for a brand name drug. When that happens, the generic will be added to Tier 1, and the brand name drug will automatically move from Tier 2 to Tier 3. For the most current Preferred Drug List, please visit www.carefirst.com/rx.

Prior authorization
Some prescriptions require advance approval before they can be filled. As a result, a prior authorization is used to ensure you meet the necessary medical criteria to obtain a particular drug.

For the most up-to-date prior authorization list, visit www.carefirst.com/rx.

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

How to manage medication costs
Your prescription drug benefit already saves you money because CareFirst BlueChoice negotiates discount rates with pharmacies in our network. However, you may have alternatives to lower your costs even more while getting medicines that treat your condition. Here are simple steps you can take:

➤ Ask your doctor. Talk to your doctor to see if there are generic options available for your medication(s). And, if the drug your doctor is prescribing is brand name only, ask if there are other generics in the same class or less expensive alternatives that work the same way.

➤ Ask your pharmacist. When you fill your prescription, ask the pharmacist if there is a generic alternative. Your doctor may not be aware of other available options.

➤ Check the Preferred Drug List at www.carefirst.com/rx and click on “Tools.” Bring a copy of the list to your doctor or pharmacist and ask them to help you find generics that can save you money.

➤ Use a participating pharmacy. There are more than 64,000 participating pharmacies nationwide, so you can choose one that’s convenient, but remember to shop around. You can find one at www.carefirst.com/rx under Tools. Some pharmacies charge more than others and if you haven’t met your deductible yet, you could pay more out-of-pocket costs at one pharmacy over another.

➤ Don’t forget your member ID card. To help ensure you receive proper service, the pharmacist will need your member ID card and a prescription from your doctor.

QUESTIONS:
If you have any questions about your prescription drug coverage, please call CareFirst Pharmacy Member Services at (800) 241-3371 or visit the Prescription Drug section in the Members & Visitors area of www.carefirst.com.
Frequently Asked Questions

Why is my ID card important?
Your card is important in getting the most out of your health plan. Your card identifies you and information about your HealthyBlue 2.0 plan to your provider. You should carry your member ID card with you at all times and present your card when you receive care.

How can I find out if my provider is a primary care provider (PCP) with CareFirst BlueChoice?
You can access our CareFirst BlueChoice Provider Directory on our website at www.carefirst.com/doctor. You can also call Member Services at the telephone number on your member ID card to request a CareFirst BlueChoice Provider Directory or have a Member Services Representative access this information for you.

For more information, see the “CareFirst BlueChoice & PPO Network Providers” section on page 11 of this handbook.

How do I obtain in-network specialty care?
Your PCP can recommend specialists who participate in the CareFirst BlueChoice network—no referrals are needed. You can also easily find an in-network specialist by going to www.carefirst.com/doctor. Our online provider directory is updated weekly. To be considered “in-network,” the specialist must participate in the BlueChoice provider network.

For more information, see the “CareFirst BlueChoice & PPO Network Providers” section on page 11 of this handbook.

How do I know when I should see a specialist instead of my PCP? Can I use any specialist listed in the CareFirst BlueChoice Provider Directory?
You should contact your PCP to determine if the services of a specialist are necessary. You may contact Member Services to make sure coverage exists for the specialty care you are seeking.

Keep in mind, with your HealthyBlue 2.0 plan, you have the option of receiving care:
- In-network— from any CareFirst BlueChoice PCP or specialist; or
- Out of network— from the CareFirst PPO network or from any non-participating provider.

Can I change my personal primary care provider (PCP)?
Yes, you can change your personal primary care provider (PCP). The quickest way to change your PCP is online at www.carefirst.com/myaccount. Once logged in, you can search for and select a PCP and a new ID card containing your new PCP’s name will be sent to you. Enrolling in My Account is quick and easy. All you’ll need is your ID card for the registration process.

If you don’t have access to the Internet, just call Member Services and a representative will assist you with changing your PCP. CareFirst BlueChoice must be notified and must process the PCP change prior to the time you receive care from the new PCP.

For more information, see the “Changing Your Personal PCP” section on page 11 of this handbook.

How can I find out if I have a particular benefit?
Your benefits are detailed in your Evidence of Coverage/Agreement. You may also contact Member Services to obtain specific information on contract benefits such as medical care, vision care, dental care, prescription benefits, etc.

If you have a group plan through your employer, you should contact your Human Resources Department to find out details on a particular benefit.

I will be traveling out of town. What coverage do I have?
When you are outside of the service area, in-network benefits are available for emergency or urgent care only.

With HealthyBlue 2.0, if you are traveling and need non-emergency or non-urgent treatment, you’ll only have out-of-network benefits available to you.

If you or a covered dependent will be living away from home for more than 90 days, you may be eligible for the Away From Home Care® Program.

For more information, see the sections “Emergency and Urgent Care” on pages 12-13, “The Away From Home Care® Program” on page 15 and “Filing a Claim for Reimbursement” on page 23 of this handbook.
Frequently Asked Questions

If I need in-area emergency care, what should I do?
If your situation is a medical emergency, call 911 or seek help immediately at the nearest emergency or urgent care facility.

In an urgent situation, we recommend that you contact your PCP for advice. If you are unable to reach your PCP, you may contact FirstHelp™, our 24-Hour Emergency Assistance and Medical Advice Service at (800) 535-9700.

For more information, see the “Emergency and Urgent Care” section on pages 12-13 of this handbook.

I have a dependent who will be going away to college. What coverage does he or she have?
Students who will be out of the area for 90 or more days may be eligible for the Away From Home Care® Program. For more information, see the “Away From Home Care®” section on page 15 of this handbook.

If the college is outside of the CareFirst BlueChoice service area and an HMO is not available near the college, or the student is not out of the area for more than 90 days, in-network coverage is limited to emergency or urgent care only. For more information, see the section “Emergency and Urgent Care” on pages 12-13 of this handbook.

Please note, in order to qualify for the Healthy Reward, your dependent must have their Health Assessment performed by a local CareFirst BlueChoice PCP. The Health Assessment cannot be completed by a PCP your dependent visits while away at college or anywhere outside of the local plan area.

Where should I go for covered laboratory services?
Members must go to LabCorp® for any laboratory services in order to obtain in-network coverage for those services, which will save you money. LabCorp® is contracted to provide services for CareFirst BlueChoice members throughout Maryland, Northern Virginia and Washington, DC.

Obtaining laboratory services from a laboratory other than LabCorp® will result in coverage at the out-of-network level and will cost you more out-of-pocket.

What can I do to ensure I pay the lowest copay for my prescription?
To ensure that you are paying the lowest copay for a prescription, you should check the status of the drug on the CareFirst BlueChoice Preferred Drug List before you:

➤ Talk with your doctor about a refill or a change in your medication.
➤ Call the pharmacy to order a refill.
➤ Order a prescription through mail order.

For more information on how to cut prescription drug costs, see the “HealthyBlue 2.0 Prescription Benefits” section on page 7 of this handbook.

What is Health + Wellness?
Health + Wellness is CareFirst BlueChoice’s Care Management program that provides you with the tools and resources to help you stay healthy or make you well.

Our prevention tools are designed to help you stay strong and healthy. Utilization Management helps ensure you receive the right care at the right time in the right place. Case Management provides support to members when it is needed most.

For more information and to learn how Health + Wellness can work for you, see pages 19-21 in this handbook.

What is the Health and Wellness Evaluation Form and how do I submit it?
The Health and Wellness Evaluation Form is found online at www.carefirst.com/healthyblue. You should bring this form with you when you visit your PCP for the Health and Wellness Evaluation. During this visit, your PCP will evaluate your baseline health by reviewing cancer screenings, immunizations and other specific health factors such as cholesterol, body mass index and blood pressure and record that information on the Health and Wellness Evaluation Form.

After completing the form with the provider, and after you both sign it, you submit the form to CareFirst using the instructions on the form.
Why do PCPs look for particular health factors?
The health factors were selected based on research by the American Journal of Preventive Medicine. Research shows that factors such as smoking status, blood pressure, cholesterol, and body mass index, as well as cancer screenings and immunizations, are most indicative of future health care outcomes.

Will my personal health information be shared with my company?
Personal health information from the online Health Assessment and the Health and Wellness Evaluation will never be given to an employer - this information is confidential.

What is the Healthy Reward?
For group members who qualify, the Healthy Reward is a reduction of the member’s annual deductible. If the member meets the deductible before they complete the 3 steps, the member will receive a check for the difference.

For individual members who qualify, the Healthy Reward is a pre-funded reward card that can be used to help maintain their healthy lifestyle. Use it to pay for your premium, deductibles or copays - or use it for gym memberships, athletic equipment and other wellness or fitness-related items.

What kind of information can I find on My Account?
When you visit My Account on www.carefirst.com, you can find information about your HealthyBlue 2.0 plan including who and what is covered, claims status, and how much has been applied to your deductible. In addition, our secure e-mail feature will enable you to send inquiries to us. You’ll also be able to review your Health Assessment and Health & Wellness Evaluation results.

To use My Account:
➤ Go to www.carefirst.com/myaccount
➤ Register using the membership number located on your ID card.

What kind of information can I find on www.carefirst.com?
At www.carefirst.com you can:
➤ Find the latest member news and updates
➤ Download claim forms and privacy forms
➤ Learn how to get discounts on alternative therapies, vision and hearing services, fitness centers and more through the Options discount program
➤ Find a doctor who participates in your plan using our searchable provider directory
➤ Look up health and wellness information at My Care First
➤ Get Member Services phone numbers
➤ Read answers to more of your frequently asked questions
➤ Find benefit and eligibility information on My Account
➤ Request a new member ID card on My Account
➤ Download, print and submit your Health and Wellness Evaluation form
➤ Check the status of your Healthy Reward
➤ Access Online Coaching and other tips to get the most out of your plan
Changing Your Personal PCP

You can change your personal PCP during your benefit year – just go to My Account.

To get started, visit www.carefirst.com/myaccount. Make sure you have your membership ID number handy, which is located on the front of your HealthyBlue 2.0 ID card. If you haven’t already registered with My Account, just click on “Register now” to follow the easy steps for creating your user name and password.

If you don’t have access to the Internet, please contact Member Services at the phone number on your ID card and give the representative the name of the PCP you’d like to see.

If the change is requested prior to the 20th of the current month, it will be effective on the 1st of the following month. Requests received after the 20th of the current month will be effective on the 1st day of the 2nd month following your request.

For example, a request received on January 10 would be effective February 1. A request received on January 21 would be effective March 1.

Once your PCP change request has been made, you’ll soon receive a new ID card with your new PCP’s name. Please destroy your old ID card once the change becomes effective.

It’s important to mention that the highest level of benefits may not be available to you if you see your new PCP before the effective date of that change. You should wait until your PCP change is effective before visiting your new PCP. Also, if you require urgent medical care and can’t wait until your new PCP becomes effective, seek care from your previous PCP.

Scheduling Appointments with a CareFirst BlueChoice or PPO Provider

CareFirst BlueChoice and CareFirst PPO doctors see patients in their own offices. Always call for an appointment before visiting your provider and identify yourself as a HealthyBlue 2.0 member. Don’t forget to bring your ID card to your appointment and present the card to the receptionist. You should always present your ID card whenever you seek care.

CareFirst BlueChoice and CareFirst have set goals for providers in our participating networks regarding appointment availability and office waiting times. For non-symptomatic visits, such as preventive care or routine wellness, we expect the provider to schedule the appointment within 4 weeks.

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

Canceling Appointments with a CareFirst BlueChoice or PPO Provider

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

Your Medical Records

Each provider’s office keeps a copy of your medical records. If you’re a new member, we encourage you to transfer your previous medical records to your PCP’s office. Transferring your records to your PCP’s office will give your provider easier access to your medical history. Your previous provider may charge you a fee for this transfer of records. Your medical records are kept in confidence and will only be released as authorized by law.

Please refer to the “Confidentiality” section on page 27 of this handbook for our guidelines on the release of medical information.
Emergency and Urgent Care

When you have a medical emergency, your health care coverage isn’t the first thought that comes to mind. We encourage you to become familiar with this section so you’ll know how to get the maximum benefits available under the plan if you have a medical emergency. All medically necessary emergency and urgent care will be covered at the in-network benefit level regardless of the provider.

**MEDICAL EMERGENCIES**

If the situation is a medical emergency:

Call 911

or

Go directly to the nearest emergency facility

**Emergency Services** means, with respect to an Emergency Medical Condition:

A. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

B. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

**Emergency Medical Condition** means the sudden and unexpected onset of a medical condition of sufficient severity, including severe pain, when the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

➤ Serious jeopardy to the mental or physical health of the individual; or

➤ Danger of serious impairment of the individual's bodily functions; or

➤ Serious dysfunction of any of the individual's bodily organs or parts; or

➤ In the case of a pregnant woman, serious jeopardy to the health of the fetus.

**URGENT CARE**

An “Urgent Condition” is a condition that is not a threat to life or limb, but does require prompt medical attention. If the situation is urgent:

➤ Contact your PCP. If your PCP is unavailable or if you are unsure about the meaning or seriousness of the symptoms, you can call FirstHelp™ at (800) 535-9700 for medical advice.

➤ Go directly to an urgent care center. A list of participating CareFirst BlueChoice Urgent Care Centers can be found in the CareFirst BlueChoice Provider Directory or on our website at www.carefirst.com/doctor.

**Urgent Care Centers**

Urgent Care Centers are walk-in medical facilities equipped to handle minor emergencies. Most urgent care centers have evening and weekend hours if a condition requires immediate attention and you’re unable to reach your PCP. Urgent care centers are typically more conveniently located and often allow you to be seen more quickly than in an emergency room. You may refer to the list of urgent care centers in your CareFirst BlueChoice Provider Directory or call FirstHelp™, toll-free at (800) 535-9700 for a participating urgent care center near you.

**Follow-Up Care**

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

You can always refer to your Evidence of Coverage/Agreement or contact Member Services to determine whether you’re following the correct procedures to receive the highest level of benefits.
Emergency and Urgent Care

FirstHelp™
24-Hour Health Care Advice Line – (800) 535-9700
You can speak with a FirstHelp™ nurse anytime, day or night. 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 PCP for advice. If your PCP isn’t available, and you have symptoms and don’t know exactly what they mean or how serious they are, CareFirst BlueChoice provides you with FirstHelp™.

Here’s how it 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 a participating urgent care center, an appointment at your PCP’s office, or self-care.
4. If the nurse recommends self-care, he or she will educate you about your condition, explain what to do for pain or symptom relief, tell you what to expect or watch out 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 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 HealthyBlue 2.0 plan
➤ Information on your claims
➤ Pre-authorizations

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

If your urgent condition is related to behavioral health or substance abuse, see the section on “Seeing Behavioral Health Specialists” on page 16 in this handbook.

Emergency & Urgent Care When Traveling
Seek medical attention immediately in the case of emergencies and urgent conditions.

If you’re unsure about the meaning or seriousness of the symptoms, call FirstHelp™ for medical advice.

For assistance in locating Blue Cross and Blue Shield providers and hospitals when outside of the CareFirst BlueChoice service area, call BlueCard Access at (800) 810-BLUE (2583). The BlueCard program allows members who receive care outside of the CareFirst service area to benefit from most claims-filing and hold-harmless agreements that other BlueCross and BlueShield plans have with their local participating providers.
BlueCard Network — Across the Country and Worldwide

You can take your health care benefits with you – across the country and around the world*. BlueCard, a program from the Blue Cross and Blue Shield Association, allows you to receive out-of-network benefits while living or traveling outside of the CareFirst BlueChoice service area (Maryland, Washington DC, and Northern Virginia).

Your ID card enables you and your family members to receive inpatient and outpatient hospital care and physician services when you’re traveling or living outside the CareFirst BlueChoice service area. The BlueCard Network program includes medical assistance services and an expanded network of health care providers throughout the world.

When a member is outside the CareFirst BlueChoice service area, only emergency and urgent care services are available in-network. The BlueCard Network includes more than 6,100 hospitals and 600,000 providers nationally. While you can see any provider in the BlueCard Network, this is an out-of-network program. So, make sure you understand your level of coverage and the out-of-pocket expenses associated with visiting an out-of-network provider.

For more information on BlueCard Network, call the Member Services phone number on your ID card.

How BlueCard Network Works

1. When you leave for your next trip outside of the CareFirst BlueChoice service area, be sure to take your HealthyBlue member ID card with you.

2. To locate information on the availability of local providers and hospitals in your travel destination, use your HealthyBlue 2.0 ID card and call the BlueCard Access line at 800-810-BLUE (2583). (You can use the toll-free number outside of the U.S. by using an AT&T Direct® Access Number.) You can also visit http://www.bcbs.com/coverage/bluecard/bluecard-when-traveling.html for information on BlueCard Network® when traveling inside the U.S.

3. If you require medical attention while you’re traveling or living outside the U.S., show your HealthyBlue 2.0 ID card and call BlueCard Access at (800) 810-BLUE (2583). A medical assistance coordinator, in conjunction with a nurse, will arrange hospitalization, if necessary, or make an appointment with a physician. In an emergency, you should bypass this step and go directly to the nearest hospital. You can also visit www.bcbs.com/coverage/bluecard/bluecard-worldwide.html for information on BlueCard Network® when traveling outside the U.S.

4. Once you arrive at the hospital, show them your HealthyBlue 2.0 ID card. By providing your ID card to the hospital staff, you can avoid paying up-front for your inpatient participating hospital services, other than any out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). You also won’t need to complete a claim form; the hospital will do that for you. For outpatient hospital care or physician services, you will pay the hospital or physician, complete an international claim form (if you’re outside of the U.S.) and send it to the BlueCard Worldwide® Service Center. To receive an international claim form, call (800) 810-BLUE (2583).

5. If you are admitted to the hospital, your care will be monitored throughout your hospital stay.

For more information on BlueCard Worldwide®, call our Member Services department at the telephone number on your member ID card. AT&T Direct is a registered trademark of AT&T. BlueCard and BlueCard Worldwide are registered service marks of the Blue Cross and Blue Shield Association, an association of independent, locally-owned Blue Cross and Blue Shield Plans.

*Please note: certain plans only cover emergency services when traveling outside the United States. Please refer to your Evidence of Coverage/Agreement for more details.
Coverage Outside the Area

Away From Home Care® Program

If you or your covered dependents are planning to be outside the CareFirst BlueChoice service area (Maryland, Washington DC, Northern Virginia) for at least 90 consecutive days, you can take advantage of a special program called Away from Home Care. This program allows temporary benefits through other Blue Cross Blue Shield plans. It provides coverage for routine services and is perfect for extended out-of-town business travel, semesters at school or families living apart.

Your copay and benefits will be those of the affiliated HMO in the area where you are visiting. You will be treated as though you are actually a member of the affiliated plan. This may result in higher costs for you, depending on the affiliated plan.

Obtaining more information and enrolling in the Away From Home Care® program

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

The Coordinator will:

➤ Check your CareFirst BlueChoice eligibility.
➤ Obtain the appropriate information (e.g., destination, duration of stay).
➤ Determine if there is a participating affiliated HMO available in the area where you or your dependents are visiting. **This program is only available if there is a participating affiliated HMO in the area where you’ll be staying.**
➤ Explain how the program works if there is an affiliated HMO available in the destination area.
➤ Send the application to you for your signature and once the signed application is returned, submit it to the affiliated HMO.
Seeing Behavioral Health Specialists

Your health care coverage includes behavioral health and substance abuse benefits and they may be subject to day and/or visit limitations. Please consult your Evidence of Coverage/Agreement for specific information about your particular coverage, or call Member Services for more information.

Staying in-network will provide you with the richest behavioral health benefits with the lowest out-of-pocket costs. If you choose to seek out-of-network care, you’ll have the most flexibility but you’ll be paying the highest cost for care.

How to Obtain In-Network Behavioral Health Care
In-network benefits are available for mental health and substance abuse services; please refer to your Evidence of Coverage/Agreement for details on how to access care.

We encourage you to coordinate behavioral health and substance abuse services with your PCP so they can remain informed about your care. Your PCP may contact our behavioral health and substance abuse administrator on your behalf.

If you receive ongoing care from a behavioral health practitioner, we suggest you have this practitioner send regular reports regarding your treatment directly to your PCP. This is especially important if you’re taking medications, since your PCP will then be able to monitor potential interactions related to any other medications that may be prescribed for you.

By working with your PCP and other practitioners, you can assist in the continuity and effective coordination of your health care.

How to Obtain Out-of-Network Behavioral Health Care
With HealthyBlue 2.0 you have the option to seek care out-of-network with either a CareFirst PPO Network provider or a provider that doesn’t participate with CareFirst. Please note that if you seek care outside of the CareFirst BlueChoice provider network you may be balance billed by the provider. So be sure to check with the out-of-network provider to understand what your out-of-pocket costs may be.

However, you may need to contact our behavioral health and substance abuse administrator for authorization for inpatient hospital admissions. Please check your Evidence of Coverage/Agreement for specific requirements.

Exclusions
➤ Depending on your contract, benefits might not be available for the services rendered by all providers listed in the CareFirst BlueChoice Provider Directory.
➤ Please refer to your Evidence of Coverage/Agreement for specific information regarding exclusions from your coverage.
**Dental Benefits**

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

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

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

Your dental coverage may also include orthodontia.

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

The following is a list of dental plans you may be eligible for if you purchase coverage through your employer. If you purchased your dental policy directly from CareFirst BlueChoice, you have other plan options that are detailed in your enrollment brochure or you can call (800) 544-8703 to learn more.

**Traditional Dental**

Traditional Dental allows you the freedom to seek dental care from any dentist and the opportunity to reduce out-of-pocket costs. When you visit a participating dentist, you have no claims to file and are only responsible for applicable deductibles and coinsurance. If you seek care from a non-participating dentist, you will be required to file claims yourself and you may incur higher out-of-pocket costs. More than 4,000 dentists participate with CareFirst BlueChoice, so you may already be seeing a CareFirst participating dentist.

**Preferred (PPO) Dental**

Preferred (PPO) Dental offers both savings and choice. CareFirst has developed a network of 3,600 preferred dentists who have agreed to provide care at a discount. Once you meet your annual deductible, you can save money by paying a lower coinsurance amount when using a dentist in the Preferred network, and have no claim forms to file. If you receive care outside the Preferred network, you may have to file your own claim forms and pay more out-of-pocket for your care.

**Dental HMO**

As a Dental Health Maintenance Organization (DHMO) member, you choose a Primary Care Dentist (PCD) from a carefully selected network. All dental services are provided for the cost of a copay – there are no deductibles to meet, no claim forms to file and no annual maximums. If you have not selected a PCD or have questions about your DHMO dental coverage, please contact Dental Services at (410) 847-9060 or (888) 833-8464.

**Vision Benefits**

**BlueVision and BlueVision Plus**

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

Your coverage includes benefits for vision care under BlueVision or BlueVision Plus. Please review your Evidence of Coverage/Agreement to determine which vision plan you have.

**BlueVision**

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

**BlueVision Plus**

BlueVision Plus provides an extended benefit that includes an eye examination (including dilation) and coverage for eyeglasses or contact lenses once per benefit period. Eyeglass frames and lenses are covered in full when you choose from the Davis Vision Collection of approximately 270 frames or you can receive an allowance toward any other frame.
Additional Benefits: Dental & Vision

You can also receive full coverage for contact lenses in lieu of eyeglasses if contact lenses from the Davis Vision Collection are dispensed or you can receive an allowance towards other contact lenses. The choice is yours! Additionally, Davis Vision offers discounts on laser vision correction surgery, additional lens treatments and coatings. Refer to your Evidence of Coverage/Agreement to find out what benefits you have under your plan.

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

How to Access In-Network Vision Care
➢ Call (800) 783-5602 for a list of providers nearest you, or access the network through www.carefirst.com/doctor.
➢ Call the Davis Vision provider of your choice and schedule an appointment.
➢ Identify yourself as a CareFirst BlueChoice member and a Davis Vision plan participant.
➢ Provide the office with the member’s ID number and the year of birth of any covered dependents needing services.
➢ The provider’s office will verify your eligibility for services and no claims forms are required.

How to Access Out-of-Network Vision Care
Out-of-network care varies according to plan. Some plans allow out-of-network care while others don’t. Refer to your Evidence of Coverage/Agreement to find out what benefits you have under your plan.

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

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

Only one claim per service may be submitted for reimbursement each benefit cycle. To print claim forms, visit the “Members & Visitors” section of www.carefirst.com and click on “Forms” or call (800) 783-5602 to request claim forms.
Take Charge of Your Health
Whether you're looking for health and wellness tips, guidance during a pregnancy or support to manage a health condition – you'll find it with Health + Wellness.

With our Health + Wellness Program you can:
➤ Stay healthy by identifying habits that could put your health at risk.
➤ Get healthy with programs that target specific health or lifestyle issues.
➤ Deal with unexpected health issues or medical emergencies by accessing our case management program.
➤ Live with a condition with the help of a coordinated health care team, by participating in our Patient Centered Medical Home program.

Health Assessment
Start by taking the online Health Assessment. The assessment is a confidential survey with questions regarding your lifestyle choices and includes topics such as nutrition, physical activity and tobacco use. You can also record your health measurements, including blood pressure, cholesterol, blood sugar and body mass index. After completing the Health Assessment, you will receive a personalized health report that provides a snapshot of your current health status. The report will identify your health risk factors and discuss your likelihood of developing chronic conditions, such as heart disease, high blood pressure and diabetes. The goal of the health assessment is to give you the information and tools you need to make positive lifestyle choices that will improve your health and quality of life.

Telephonic Health Coaching
Depending on the results of your health assessment, a health coach may contact you. The health coaching program is designed to help you build confidence as you learn new skills and positive lifestyle behaviors. You can interact with your coach through a secure web-based message board and by telephone. You and your coach will work together to develop a personal health plan with milestones for achieving goals. Your coach will monitor your progress and provide guidance and support as needed.

Choose from these focus areas:

**Physical Activity**
➤ Aerobic exercise
➤ Flexibility
➤ Strength

**Healthy Eating**
➤ Unhealthy fats
➤ Fruits
➤ Overeating
➤ Skipping meals
➤ Sodium
➤ Sugary drinks
➤ Vegetables
➤ Whole grains

**Healthy Living**
➤ Smoking cessation
➤ Stress management

**Online Health Coaching**
To help you meet your health goals, take advantage of our free, confidential online health coaching program to help you improve in the following areas:

**Lifestyle Management Programs**
➤ Weight management
➤ Smoking cessation
➤ Stress management
➤ Physical activity
➤ Nutrition
➤ Blood pressure management
➤ Cholesterol management

**Behavioral Health Programs**
➤ Overcoming depression
➤ Overcoming insomnia
➤ Overcoming binge eating

**Self-management Skills for Chronic Conditions:**
➤ Chronic condition management
➤ Back pain management
➤ Diabetes management
➤ Hip pain management
➤ Chronic pain management
The Online Coaching program includes a virtual coach feature. The virtual coach gives you the feel of working with a live counselor.

Plus, the program offers interactive tools to keep you on track and inspired to improve your health. The program includes an online health library, healthy recipes, exercise planners, quizzes, videos and links to health information.

Health Advising
After you complete the health assessment, a health advisor may call you to answer your questions and discuss your results. Health advisors are specially trained professionals who can help you take the necessary steps to improve your health. During the 10-15 minute health advising session, the health advisor will review each health measurement value, if provided, such as blood pressure and cholesterol reading, and tell you where your results fell compared to the ideal value. The health advisor will tell you how each health measure can impact your health and specific ways you can improve your numbers. The health advisor can also refer you to the appropriate resources, tools, care management and health coaching programs to help guide you in the right direction.

Rx Personal Advisor
This service provides you with the extra attention you need to keep your medication therapy on the right track. By meeting with a specially-trained pharmacist, you can learn to better manage your care and the costs associated with prescription medications.

Case Management
If you’re faced with a serious diagnosis or severe condition, we have a Case Management program to help you navigate through the health care system and provide support.

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’re doing.
➤ Answer any of your questions.
➤ Suggest available community resources.

The program is voluntary and confidential. To enroll or to find out more information, call (888) 264-8648.

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

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

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

Patient Centered Medical Home (PCMH)
Our PCMH program promotes higher quality health care, while striving to control health care costs over time. PCMH was designed to provide your PCP* – whether a physician or a nurse practitioner – with a more complete view of your health needs, as well as the care you receive from other providers. This enables the PCP to better manage your health risks, while encouraging you to maintain better health and ultimately produce better outcomes. For more information about PCMH, visit www.carefirst.com/memberpcmh.

* The doctors and other medical providers are independent providers making their own medical determinations and are not employed by CareFirst BlueChoice.

Utilization Management
Transition of Care Program
If you’re in the hospital for certain conditions, a CareFirst Hospital Transition Coordinator will contact you before you go home. This nurse will support you and help you get the care you need after your discharge. She/he can work with you, your doctor and other health care providers, including Case Management, Behavioral Health, home health and medication management. The coordinator will help to make sure that you receive all the follow-up care that you need in order to assist in your recovery.

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

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

Great Beginnings – Support During Your Pregnancy
Available to HealthyBlue 2.0 members, Great Beginnings is a Prenatal Care Management Program that helps expectant mothers have a healthy pregnancy and deliver healthy babies. If you have a medical condition that may put you at risk for a complicated pregnancy, your case will be referred to a Great Beginnings Case Manager. The Case Manager will work directly with you and your obstetrician to help you follow a plan specific to your needs. To enroll, call (888) 264-8648. For more information, please visit www.carefirst.com/greatbeginnings.

Options Discount Program/Blue365 Program
As a member, you have access to discounts on alternative therapies and health and wellness programs such as fitness centers, acupuncture, massage, chiropractic care, nutritional counseling, laser vision correction, and more! Visit www.carefirst.com/options to learn more.

My Care First Website
Take an active role in managing your health and visit My Care First at www.carefirst.com/mycarefirst. Find nearly 300 interactive health-related tools, a multi-media section with more than 400 podcasts, and recipes to search by food group or dietary restrictions. Plus, there are videos and tutorials on chronic diseases and an encyclopedia with information on more than 3,000 conditions.

Vitality Magazine
Our member magazine has the tools to help you achieve a healthier lifestyle. Vitality provides you with updates to your health care plan, a variety of health and wellness topics, including food and nutrition, physical fitness and preventive health.

Health News
Sign up for our monthly electronic member newsletter to receive health-related articles and recipes via email. Visit www.carefirst.com/healthnews to subscribe to information on:

➤ Making healthy choices
➤ Adding physical activity to your day
➤ Preparing nutritious and delicious recipes
➤ Getting the best health care
➤ Managing chronic conditions
Discounts on Health & Wellness Services

Take advantage of the special offers and discounts available to HealthyBlue 2.0 members at www.carefirst.com/options. With our Options Discount Program and the Blue365 Program, you can save on a variety of services.

Options Discount Program
The Options Discount Program is free to all HealthyBlue 2.0 members. Because it’s a discount program and not a benefit under your medical plan, there is no paperwork involved. Simply show your HealthyBlue 2.0 ID card when you visit a wellness provider or make a purchase.

Blue365
Blue365 provides health and wellness information, support and services you need – while at the same time enjoying special member savings. As a HealthyBlue 2.0 member, you automatically have access to the content, tools and discounted offers available through Blue365.

Discounts are available at www.carefirst.com/options under “Blue365.” Download coupons or purchase online to receive a discount.

Enjoy discounts
Discounted products and services include:
- Acupuncture
- Chiropractic care
- Fitness centers
- Fitness footwear and apparel
- Hearing and vision care including laser vision correction
- Massage therapy
- Nutritional counseling
- Personal training
- Spa services
- Sporting and fitness equipment
- Travel
- Weight loss programs

New products and services are added frequently, so visit us online at www.carefirst.com/options for the latest list.

Save money while you’re getting healthy!
Administration of Your Plan

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

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

Individual contract members must notify CareFirst BlueChoice in writing to make enrollment changes.

Filing a Claim for Reimbursement
Typically, when you see a non-participating provider, you'll be responsible for filing your own claims.

All CareFirst BlueChoice providers are required to submit claims. All you have to do is pay any necessary copayment and/or deductible at the time of the visit. If you need to submit a claim for services rendered by a provider who doesn’t participate in the CareFirst BlueChoice network (such as emergency care received outside the service area), you may contact Member Services for a CareFirst BlueChoice Health Benefits Claim Form or print one from our website at www.carefirst.com.

Be sure to attach a complete itemized bill prepared by the provider of service that includes the charges for each service along with the medical condition for which the treatment was performed. Submit the completed claim form and attachments to:

   Mail Administrator
   P.O. Box 14114
   Lexington, KY 40512-4114

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

Provider Reimbursement
CareFirst BlueChoice providers are paid on a fee-for-service basis meaning they receive payments according to a fee schedule for covered services they perform. CareFirst PPO Network providers are paid the allowed amount for services rendered. You may contact Member Services to obtain additional information about provider payment arrangements.

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

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

We update our COB information periodically, so make sure we have your most current information or if your other insurance changed. When our records are up-to-date we’re able to pay your claims as quickly and accurately as possible.

Even if you don’t have other insurance, it’s important you provide that information to us so we may keep your records current. To supply this information, you may call our COB department at (866) 285-2611, or download a COB form in the “Forms” section of our website at www.carefirst.com. Rules to determine how benefits are coordinated are outlined in your Evidence of Coverage/Agreement.
How to voice a complaint
CareFirst BlueChoice wants to hear your concerns and/or complaints so they may be resolved. We have procedures that address medical and non-medical issues. If a situation should occur for which there is any question or difficulty, here’s what to do:

➤ If your comment or concern is regarding the quality of service received from a CareFirst BlueChoice representative or administrative problems (e.g., enrollment, claims, bills, etc.) you should contact Member Services. To write to us directly with a quality of care or service concern, you can either:
  n Send an email to: quality.care.complaints@carefirst.com
  n Fax a written complaint to (301) 470-5866
  n Write to:
    CareFirst BlueCross BlueShield
    Quality of Care Department
    P.O. Box 17636
    Baltimore, MD 21297

If you send your comments to us in writing, please include your ID number and provide us with as much detail as possible. Please include your daytime phone number so we may contact you directly if we need additional information.

➤ For concerns or complaints about the quality of care or quality of service received from a specific provider, contact Member Services at the phone number listed or your ID card. A representative will record your concern and may request a written summary of the issues. You can also submit a complaint by sending an e-mail to quality.care.complaints@carefirst.com. A written complaint can be faxed to (301) 470-5866. Please include your ID number and provide us with as much detail as possible regarding any events. Please include your daytime phone number so we may contact you directly if we need additional information. The substance of the complaint will be investigated as appropriate and action taken will be thoroughly documented.

These procedures are also outlined in your Evidence of Coverage/Agreement.

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

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

**Maryland:**
Maryland Insurance Administration Inquiry and Investigation, Life and Health
200 St. Paul Place, Suite 2700
Baltimore, MD 21202-2272
(410) 468-2244 or (800) 492-6116
Fax: (410) 468-2270
www.mdinsurance.state.md.us

**District of Columbia:**
District of Columbia Department of Insurance, Securities, and Banking
810 First Street, NE, Room 701
Washington, DC 20002
(202) 727-8000

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

For assistance in resolving a billing or payment dispute with the health plan or a health care provider, contact the Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General at:
Step 1: Inquiry and discussion of the problem

Often, Member concerns can be most effectively handled and resolved through informal discussions and information gathering. If your question or concern is regarding our handling of a claim or other administrative action, the member or the member’s authorized representative should discuss the matter with the CareFirst BlueChoice Member Services Department. The CareFirst BlueChoice Member Services Department Customer Service Representative will contact the appropriate individuals and gather information needed to answer the question. In many instances, the matter can be quickly resolved.

Step 2: Appeal process

If your concern is not resolved through an informal discussion with a CareFirst BlueChoice Customer Service Representative, you or your authorized representative may make a formal request for an appeal.

This appeal request should be in writing, addressed to our Member Services Department and state the reason(s) for the request. In the event the member or the member’s authorized representative cannot put the request in writing, a Customer Service representative can assist you. The request for an appeal must be made within six (6) months or at least 180 days from the date of the notification of denial of benefits. A decision by the Plan shall be made within 30 calendar days for a pre-service appeal, or 45 working days for a post service appeal.

The appeal of a medical necessity decision shall be reviewed, as appropriate, by a physician of the same or similar specialty as the treatment under review. The physician review of the appeal will be performed by a physician who was not part of the original denial.

An expedited appeal process has been established in the event that a delay in a decision would be seriously detrimental to your health or the health of a covered family member. Expedited appeals involve care that has not yet occurred or is currently occurring (pre-service or concurrent care). In an expedited appeal, a decision shall be made within 24 hours of receipt. The physician review of the appeal will be performed by a physician who was not part of the original denial decision.

The expedited appeal review will be, as appropriate, reviewed by a physician in the same or similar specialty as the treatment under review.

All appeal decisions will be communicated in writing to the member, and include a detailed explanation as to the reason for the decision, and any supporting documentation to show how the decision was made. If the decision remains a denial of the benefits, a detailed explanation that references the rule, policy or guideline used in making the appeal decision will be included. Also included in this written appeal decision will be an explanation of the appropriate next steps a member or the authorized member representative may take if they are not satisfied with the appeal decision.

Members have a right to an independent external review of any final appeal determination.

If you wish, you may contact the insurance regulatory department in your area to file a complaint or an appeal regarding a denial or reduction of benefits. Refer to your Evidence of Coverage/Agreement for more specific information regarding initiating an external review of a final appeal determination or a complaint.
Ending or Continuing
Your Coverage

Ending Your Coverage
Your coverage or your dependents’ coverage with CareFirst BlueChoice may automatically end for certain reasons. These reasons may include but are not limited to:
➤ You are no longer employed by the company that carries your CareFirst BlueChoice coverage;
➤ Your employer cancels coverage with CareFirst BlueChoice;
➤ Divorce from a policyholder; or
➤ A covered dependent turned 26 years of age.

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

Continuing Your Coverage
If you are changing jobs or your dependents’ status changes, please speak to your employer, your payroll office or Member Services about the options available to you and your eligible dependents to continue health care benefits. The options available are specified in your Evidence of Coverage/Agreement.

If your group coverage ends, you and your dependents may be eligible under state and federal laws to continue your coverage with CareFirst BlueChoice at your own expense under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar state program. Your former employer is responsible for supplying eligible beneficiaries with the details about COBRA coverage.

You and your dependents may also be eligible under state laws to continue your coverage with CareFirst BlueChoice at your own expense. Contact your employer or Member Services for additional information.

Another option may be a CareFirst BlueChoice conversion policy. See your Evidence of Coverage/Agreement for information. A conversion policy is a non-group policy offered to members who are losing their group benefits under certain conditions. A conversion policy is a contract that provides individual or family medical coverage. Dental, vision and prescription plans cannot be added to the conversion policy.

Eligible Maryland and District of Columbia members must enroll for conversion coverage within 31 days after their eligibility for group coverage ends. Eligible Virginia members must enroll for conversion coverage within 31 days after written notification but no later than 60 days following the termination date. Members who end or lose their group coverage may be entitled to a conversion policy in the following situations:
➤ The policyholder’s eligibility for his or her current group coverage ends;
➤ Termination of spouse’s and dependents’ eligibility due to the policyholder’s death;
➤ Termination of marriage to the policyholder;
➤ Termination of the group agreement if the group has not provided for continued coverage through another plan, and termination is not a result of the group’s failure to pay premiums; or
➤ Termination of dependent’s eligibility due to reaching the age limit or marriage.

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

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

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

All health plans and providers must provide information to members and patients regarding how their information is protected. You will receive a notice of privacy practices from CareFirst BlueChoice or your Health Plan, and from your providers as well, when you visit their office. CareFirst BlueChoice has policies and procedures in place to protect the confidentiality of member information. Your confidential information includes Protected Health Information (PHI) and other nonpublic financial information. Because we are responsible for your insurance coverage, making sure your claims are paid, and that you can obtain any important services related to your health care, we are permitted to use and disclose (give out) your information. Sometimes we are even required by law to disclose your information in certain situations. You also have certain rights to your own protected health information, and there are some requirements you will have to follow to allow other people to obtain your information on your behalf.

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

Notice of Privacy Practices
CareFirst BlueChoice is committed to keeping the confidential information of members private. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to send our Notice of Privacy Practices to members of fully insured groups only. The notice outlines the uses and disclosures of protected health information, the individual’s rights and CareFirst BlueChoice’s responsibility for protecting the member’s health information.

To obtain a copy of our Notice of Privacy Practices, please visit our website at www.carefirst.com or call Member Services at the telephone number on your member ID card. Members of self-insured groups should contact their Human Resources department for a copy of their Notice of Privacy Practices. If you don’t know whether your employer is self-insured, please contact your Human Resources department.

Your Rights
You have the following rights regarding your own Protected Health Information. You have the right to:

➤ Request that we restrict the PHI we use or disclose about you for payment or health care operations;
➤ Request that we communicate with you regarding your information in an alternative manner or at an alternative location if you believe that a disclosure of all or part of your PHI may endanger you;
➤ Inspect and copy your PHI that is contained in a designated record set including your medical record;
➤ Request that we amend your information if you believe that your PHI is incorrect or incomplete;
➤ An accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations; and
➤ Give us written authorization to use your protected health information or disclose it to anyone not listed in this notice.
Member’s Rights and Responsibilities

Rights of Members
CareFirst BlueChoice promotes members’ rights by providing mechanisms to ensure:
➤ Protection of confidential information;
➤ Accurate and understandable information about benefit plans, customer service and accessing health care services;
➤ Continuity and coordination of medical and/or behavioral health or substance abuse care by participating providers;
➤ Professional and responsive customer service;
➤ Timely and complete resolution of customer complaints and appeals.

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

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

Eligible Individuals’ Rights
Statement Wellness and Health Promotion Services
➤ Eligible individuals have a right to receive information about the organization, including wellness and health promotion services provided on behalf of the employer or plan sponsors; organization staff and staff qualifications; and any contractual relationships.
➤ Eligible individuals have a right to decline participation or disenroll from wellness and health promotion services offered by the organization.
➤ Eligible individuals have a right to be treated courteously and respectfully by the organization’s staff.
➤ Eligible individuals have a right to communicate complaints to the organization and receive instructions on how to use the complaint process that includes the organization’s standards of timeliness for responding to and resolving complaints and quality issues.

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

The information provided in this section is specifically for members of CareFirst’s HealthyBlue 2.0 BlueFund HSA, BlueFund HRA, Compatible HSA and Compatible HRA Plans. It’s intended to provide an overview and doesn’t represent your specific HealthyBlue 2.0 benefits, whether you're a group or individual member. If you're unsure whether this information applies to you and your benefits please refer to your Evidence of Coverage/Agreement.

Health Savings Account (HSA)

Certain members enrolled in CareFirst BlueChoice’s HealthyBlue 2.0 BlueFund or Compatible HSA health plans have the option to participate in a Health Savings Account to pay for qualified medical expenses with tax-free dollars. If you are enrolled in a HealthyBlue 2.0 BlueFund HSA plan, your employer will arrange for your HSA to be opened through the BlueFund program. If you are enrolled in a Compatible HSA plan, you will need to open your HSA on your own. HSA health plans are always high deductible health plans (HDHPs) with a deductible that applies to both your medical and drug benefits.

For all services other than the ones mentioned earlier in this section at no cost, you’ll first need to meet your plan year deductible, before your full HealthyBlue 2.0 HSA coverage begins. You then pay a copayment or coinsurance for all covered services, including prescription drugs. The funds in your HSA can also be used to pay for these out-of-pocket expenses.

How your HSA works

A Health Savings Account is a tax-exempt medical savings account that can be used to pay for your eligible medical expenses. HSAs enable you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. You own and control the money in your HSA. Unlike a Flexible Spending Account, there is no “use it or lose it” rule. Funds that are not used for current health expenses are saved for future use. The funds in your HSA earn interest, and when a certain balance is reached, can even be invested in a wide variety of investment options. Each year you, your employer (if applicable) or both make a contribution toward your HSA. You then use the money in your account to pay the full or discounted cost of covered services until you reach your benefit year deductible.

Please consult with your tax advisor regarding any tax questions.
HSA and HRA Plans

The money in the HSA always belongs to you
Your HSA is your personal account and is entirely portable. If you are a member of an employer-based plan, this means that, should you leave your current employer, you can take the money with you. An HSA can be an excellent way to put money aside for any qualified health care expenses that might not be covered by your plan today. And if you don’t spend it, it’s also a tax-free way to prepare for future expenses – such as the need to cover retiree health premiums (excluding Medicare Supplement plans) or to pay for future non-covered health care expenses.

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

How your deductible works
While HealthyBlue 2.0 covers you at no cost for certain care, all other services are subject to an annual deductible that you must satisfy before your health coverage begins. This means that, if your plan includes a $1,500 annual deductible, for example, you will be required to meet the $1,500 deductible each year before your full health care benefits begin.

Until you reach your annual deductible, you may use the money in your medical savings account to pay for the eligible health care expenses. For example, if you go to the doctor because you are sick, the cost of that visit will contribute towards your deductible and you can use your HSA funds to pay for that service. Be sure your doctor’s office submits a claim to CareFirst so the claim can be counted toward your deductible.

Funds rollover from year to year
Depending on the amount of qualified health care expenses you incur in a given year, you may not need to use all of the funds in your HSA. In this event, the remaining balance in your HSA will automatically roll over to the following benefit year. HSAs are available to members of employer-based health plans, as well as members who purchase a qualifying high deductible health plan on their own.
HSA and HRA Plans

HSA: Questions and Answers

How do I contribute to my HSA?
If you are a member of an employer group plan and your employer has arranged for you to open a HSA, your HSA contributions are normally made through pre-tax payroll deductions. If you purchased your health plan on your own and have set-up your own HSA, you can make contributions to your HSA at anytime, up to the allowable amount determined by the IRS.

Are there limits to how much can be contributed to my HSA?
The IRS stipulates that your HSA funding cannot exceed $3,100* if you have individual coverage, and $6,250* if you have family coverage in a tax-year. For additional information, you can visit the IRS web site at: www.IRS.gov or call (800) 829-3676.

*This amount applies to year 2012 only.

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

These expenses can be paid out of your HSA by using your HSA debit card or HSA checks (if applicable). By seeking services from primary care providers (PCP), your responsibility will be limited to the discounted amount or plan allowance that our PCPs agree to accept as payment in full.

Your pharmacist will charge you CareFirst BlueChoice’s discounted cost for prescription drugs until you reach your benefit year deductible except for the certain generic drugs that are available at no charge. These expenses can also be paid directly from your HSA using your debit card or HSA fund checks.

Since prescription deductible information is automatically transmitted to CareFirst BlueChoice so that we may track your deductible balances, it is important for you to pick up your prescription drugs from the pharmacy as soon as possible. Pharmacies have their own guidelines for returning medications to their inventory stock.

If the pharmacy returns your prescription drugs to their inventory stock, any applicable deductible will be retracted. Each of these deductible and retracted deductible transactions will be recorded on your HSA account.

What happens when HSA funds have been exhausted before the annual deductible’s been met?
If you use all the money in your HSA before meeting your annual deductible, you’ll then be responsible for a limited out-of-pocket amount, called the “bridge.” The bridge is the difference between the amount in your HSA and your deductible.

The amount of money you and/or your employer have contributed to your HSA will determine how much of a “bridge” you have before your HealthyBlue 2.0 HSA coverage becomes available.

You can use future funds that go into your HSA to reimburse yourself for expenses during the bridge period, as long as the HSA was opened at the time the expenses were incurred.

Who administers the Health Savings Account?
Your HSA plan can be administered differently from someone else’s plan, so it all depends on the type of coverage that you have. There are two possible scenarios:

➤ You are a member of an employer group and your employer has chosen the CareFirst BlueFund program to administer your Health Savings Account. In this case, you will receive your HSA information, as well as your HSA debit card and personal checks (if applicable) directly from BlueFund and CareFirst’s preferred HSA custodian.

➤ You are a member of an employer group and your employer has chosen another financial institution to administer your Health Savings Account. In this case, you will receive information regarding your HSA directly from your employer or your employer’s preferred financial institution.
HSA and HRA Plans

Who's eligible to participate in an HSA?
To be eligible to enroll in a Health Savings Account, you must be covered by a high deductible health plan (HDHP), such as HealthyBlue 2.0 HSA.

To enroll in a health savings account you cannot be:

➤ Covered by any medical plan other than an IRS-qualified high deductible health plan (dental and vision are not included in this restriction).
➤ Enrolled in Medicare Part A or Part B.
➤ Claimed as a dependent on another individual’s tax return.

How can I track my health benefits?
The more you know, the better you can manage your health care needs. With a HealthyBlue 2.0 HSA plan, you can tap into the power of the Internet to help you manage your benefits.

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

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

Your HSA funds are available to pay for qualified health care expenses covered under your CareFirst BlueChoice HealthyBlue 2.0 coverage.

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

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

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

Please Note: HSA funds can also be spent on some qualified expenses that are not covered by your HealthyBlue 2.0 plan. These expenses will not be applied toward your benefit year deductible. Only covered expenses will be applied toward your benefit year deductible.
HSA and HRA Plans

Health Reimbursement Arrangement (HRA)  
(Group plan members only)

How your HRA works
A Health Reimbursement Arrangement (HRA) is an employer-funded medical savings account that provides funds to help pay for eligible health care expenses.

Each year, your employer will fund your HRA. You may then use the money in your HRA to pay the full or discounted cost of covered services that are subject to your plans’ deductible, copays or coinsurance. Since an HRA is funded exclusively by your employer, your employer can determine the expenses that are covered by the HRA.

Funds rollover from year to year
In many cases, the money your employer allocates to your HRA plan may be more than you’ll use on health care during the plan year. Unlike other medical savings accounts, (such as a Flexible Spending Account) any money you don’t spend may stay in your account for future use, as long as the program is offered and you remain enrolled. Because each funding arrangement is different, please check with your company’s HR representative for specific details about your HRA plan’s rollover rules.

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

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

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

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

Please consult with your tax advisor regarding any tax questions.
HRA: Questions and Answers

How do I contribute to my HRA?
Funds in your HRA account can only be deposited by your employer. You are not eligible to make any additional contributions toward your HRA.

What happens when HRA funds have been exhausted?
If you use all the money in your HRA before meeting your annual deductible, you will then be responsible for a limited out-of-pocket amount, called the “bridge.” The bridge is the difference between the amount in your HRA and your deductible.

The amount of money your employer has contributed to your HRA will determine how much of a “bridge” you have before your HealthyBlue 2.0 coverage becomes available. In some cases, the HRA program may be designed so that the bridge comes first, before the HRA funds can be used. This requires the member to pay out-of-pocket before using the HRA funds. Please refer to your company’s HR representative for specific details about your HRA plan’s rollover rules.

What happens if I leave my employer?
Should you leave your current employer, all funds that remain in your HRA will generally revert to the employer.

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

Benefits of the BlueFund HRA
These deductible, coinsurance and copayment amounts will be automatically transferred to your HRA account and eligible expenses will automatically be reimbursed to you on a weekly basis. If your employer has selected another custodian for HRA funds, these rules will apply.

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

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

Since prescription deductible information is automatically transmitted to CareFirst BlueChoice so that we may efficiently track your deductible balances, it is important for you to pick up your prescription drugs from the pharmacy as soon as possible. Pharmacies have their own guidelines for returning medications to their inventory stock.

If the pharmacy returns your prescription drugs to their inventory stock, any applicable deductible will be retracted. Each of these deductible and retracted deductible transactions will be recorded on your HRA account.

What is the definition of a “Qualified Medical Expense”?
Your HRA funds are available to pay for qualified medical services covered under your HealthyBlue HRA plan, as well as any additional health care expenses deemed acceptable by your employer.
HSA and HRA Plans

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

How can I obtain HRA reimbursement for qualified health care expenses not covered by my HealthyBlue 2.0 plan?
If you have a BlueFund plan, qualified health care services and items not covered by your HealthyBlue 2.0 HRA plan can be reimbursed through your HRA by faxing or mailing a claim along with the supporting documentation to our BlueFund Administration office. You can obtain an HRA Reimbursement Claim form from our web site at www.carefirst.com. Complete the form and fax or mail it along with any necessary documentation to:

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

You will have 90 days from the end of your benefit year to submit claims or have claims automatically processed for reimbursement through your HRA for services received during the ending benefit year. Be sure to contact your health care provider and request that he/she submit their claims to CareFirst BlueChoice before the 90 days expire for services that need to be processed through your HealthyBlue 2.0 HRA coverage. Any claims for the ending benefit year posted to your HRA after this 90-day period will not be reimbursed to you. You’ll be able to see exactly where your money goes, so you can make the best decision. Visit our Web site at www.carefirst.com for more information.

If you have a HRA plan with another custodian, your reimbursement will be handled differently.

How can I track my health benefits?
The more you know, the better you can manage your health care needs. With a HealthyBlue 2.0 HRA plan, you can tap into the power of the Internet to help you manage your benefits.

CareFirst online tools, available at www.carefirst.com, allow you to:
➤ Keep track of your HRA balance
➤ Check the status of a claim
➤ Compare hospitals
➤ Compare prescription drug costs
➤ Request an ID card
➤ Confirm or review eligibility
➤ Find a doctor
➤ Access health and wellness information
Definition of Terms

**Appeal**
A protest filed by a member or a health care provider under CareFirst BlueCross BlueShield/ CareFirst BlueChoice’s internal appeal process regarding a coverage decision.

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

**Balance Billing**
The practice of billing a member for the difference between the allowed amount and the actual charge.

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

**Coinsurance**
Means the percentage of the allowed benefit allocated between CareFirst BlueChoice and the Member whereby CareFirst BlueChoice and the Member share in the payment for covered services (e.g., 20 percent for lab services or X-rays).

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

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

**Copayment (Copay)**
The dollar amount that a member must pay for certain covered services.

**Deductible**
The dollar amount of incurred covered expenses that the member must pay before CareFirst BlueChoice makes payment.

**Dependent**
A member who is covered under the Plan as the spouse, domestic partner or eligible child of a Subscriber.

**Evidence of Coverage/Agreement**
A document reflecting an individual’s or group’s agreement for health care coverage with CareFirst BlueChoice.

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

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

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

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

Indemnity
Traditional insurance plans under which the health plan reimburses the provider and the member on a fee-for-service basis after the patient has satisfied any applicable deductible. These plans typically have the highest out-of-pocket expenses, but they give you the flexibility to seek treatment from any covered provider.

In-Network
A physician, health care professional or health care facility that has contracted with CareFirst BlueChoice, Inc. to render Covered Services to Members.

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

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

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

Primary Care Provider
A CareFirst BlueChoice provider selected by or on behalf of, the member to provide primary care to the member and to coordinate and arrange other required services.

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

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

Specialist
A licensed health care provider to whom a member can be referred by a PCP.

Subscriber
A member who is covered under the Plan as an eligible employee or member of the group, rather than as a dependent or the Member to whom the Evidence of Coverage/Agreement is issued.
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Policy Form Numbers

DC HealthyBlue 2.0 Group
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DC/CFC/HB2 DOCS (10/11)
DC/CFC/HB2 SOB (10/11)
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DC/BC/OOP/VISION (R. 6/04)
DC/BC/DHMO RIDER (6/09)
DC/BC/DHMO RIDER (7/03)
DC/BC/DHMO SCHBEN 10 CP (R. 10/07)
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DC/CFC/HB2 SOB (10/11)
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DC/CFC/HB INCENTIVE (4/10)
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DC/BC/DHMO RIDER (7/03)
DC/BC/DHMO SCHBEN 20 CP (R. 10/07)
And any amendments

VA HealthyBlue 2.0 - Direct Bill
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And any amendments

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And any amendments

And any Amendments