CareFirst

2016 MediGap-65

Why Medicare Supplement Coverage is Important

MARYLAND

Interested in prescription drug coverage?

Contact CareFirst BlueCross BlueShield at 410-356-8123 or 800-275-3802 to learn more.

Welcome

Did you know Medicare was never designed to pay all of your health care expenses? More importantly, the gaps in Medicare could cost you thousands of dollars out of your own pocket each year. A serious illness or lengthy hospital stay could make a big dent in your retirement savings.

Are you prepared to pay:

- The $1,288 Part A deductible[1] for hospitalization? It comes out of your pocket before Medicare pays anything.
- The $322 a day Part A copayment[1] for days 61-90 in the hospital? That's $9,660 if you're in the hospital for that length of time.
- The $644 a day Part A copayment[1] for days 91-150 in the hospital? That works out to over $38,000 in 60 days.

There's more. Even at a doctor's office, you'll pay:

- $166 for the Part B deductible[1] in 2016—before Medicare pays anything, and 20 percent of most medical services—with no out-of-pocket maximum.

That's why it's so important to protect yourself and your hard-earned money with MediGap-65, CareFirst BlueCross BlueShield's (CareFirst's) Medicare Supplement plan. We offer eight plans to choose from and reliable coverage you can count on. With one of CareFirst's Medicare Supplement plans, you'll receive coverage for:

- Medicare's Part A deductible and copayments (including skilled nursing copayments)
- Medicare's Part B deductible and copayments

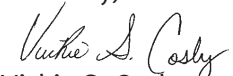
You can also choose a MediGap-65 plan that offers coverage for emergency care when you're traveling in a foreign country—something that Medicare never covers.[2]

Enclosed in this book are CareFirst's MediGap-65 plan brochure and Outline of Coverage, which feature the MediGap-65 family of plans we offer. You'll find all the information you need to help you choose the plan that's right for you.

CareFirst now offers discounted rates to members who elect automated payment via bank withdrawal on the application. To apply for coverage, simply fill out the enclosed application and mail it to us in the enclosed postage-paid envelope.

You owe it to yourself to get your coverage from the company you can trust—CareFirst BlueCross BlueShield.

Sincerely,



Vickie S. Cosby
Vice President, Consumer Direct Sales

[1] *Medicare Part A and Part B amounts are established by Medicare.*

[2] *Medigap plans pay up to 80 percent of billed charges for Medicare-eligible expenses for emergency care received during the first 60 consecutive days of each trip outside the United States. The plan payment is subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.*

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What's Covered

Plan Options

Having Medicare alone could cost you thousands of dollars in health costs each year; costs that Medicare was never designed to cover. Purchasing a MediGap-65 plan will cover the gaps in your Medicare coverage. You can pick from any of the eight plans listed below. See the comparison chart on pages 6–7 to compare plan options.

MediGap-65 Plan A

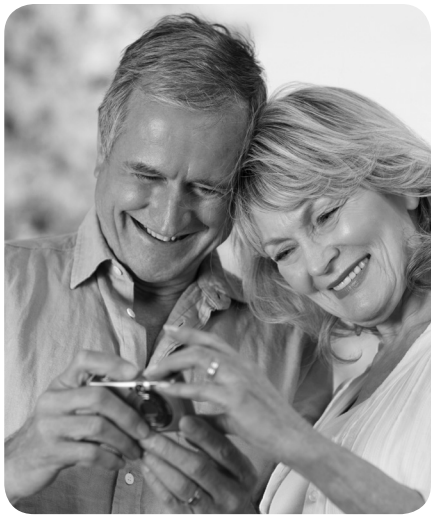
Plan A delivers basic coverage to protect against the financial strain caused by serious illness and lengthy hospital stays. After you've satisfied your Medicare deductible, this plan pays your Part A[1] hospital copayments, your Part B[1] coinsurance, and protects you for a full 365 days of hospital care after your Medicare benefits end.

MediGap-65 Plan B

Plan B is a moderately priced plan that pays your $1,288 Part A hospital deductible and includes the same benefits featured in Plan A. This plan protects against the high cost of hospitalization.

MediGap-65 Plan F*

Plan F offers the broadest protection against high medical expenses and is our most popular plan. In addition to covering your Medicare Part A and Part B deductibles, copayments and coinsurances, Plan F also provides emergency coverage for care you receive in a foreign country,[2] as well as coverage for balance billing.



***Balance Billing Protection —If you see a doctor who does not accept Medicare's reimbursement as payment in full for services (some doctors charge you up to 15 percent more than Medicare allows!), Plan F will cover these extra charges.**

[1] *Medicare Part A and Part B amounts are established by Medicare.*

[2] *Medigap plans pay up to 80 percent of billed charges for Medicare-eligible expenses for emergency care received during the first 60 consecutive days of each trip outside the United States. The plan payment is subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.*

Plan Options

MediGap-65 High-Deductible Plan F*

High-Deductible Plan F is our lowest premium Medigap Plan. If you like to share in more of your health care costs in exchange for a lower monthly premium, consider High-Deductible Plan F. This plan offers the same benefits as regular Plan F, after you have met a $2,180 annual deductible for 2016.

MediGap-65 Plan G*

Plan G offers the same coverage as Plan F, at a lower monthly premium—you are just responsible for the Medicare Part B[1] deductible.

MediGap-65 Plan L

With Plan L, you share in the costs for Medicare-covered services in exchange for a lower premium—but are rewarded with the added protection of an out-of-pocket limit that caps your costs at $2,480 during the calendar year. Most basic benefits are covered at 75 percent, including the Part A[1] deductible. After the Part A deductible is met, your hospitalization is covered at 100 percent.

MediGap-65 Plan M

Plan M is a moderately-priced plan that starts with the benefits of Plan A and adds coverage for half of your $1,288 Part A hospital deductible. Plus, it covers skilled nursing copayments and emergency care received in a foreign country.[2]

MediGap-65 Plan N

Plan N offers the broad coverage of Plan F at a lower premium by incorporating cost-sharing features to help you manage your costs. Just like Plan F, Plan N covers 100 percent of your Part A deductible and copayments, your skilled nursing facility copays and emergency care received in a foreign country.[2] It costs less because you are responsible for the $166 Part B deductible and a small copay for office and emergency room visits. Plan N does not cover part B excess charges[3] that are covered under Plan F.

What is not covered

MediGap-65 policies are designed to work hand-in-hand with the federal Medicare program. They are not intended to be classified as long-term care policies, and do not pay for most custodial care. MediGap-65 plans do not cover expenses for services and items excluded from coverage under Medicare, or expenses for services and items that would duplicate Medicare payments.

***Balance Billing Protection —If you see a doctor who does not accept Medicare's reimbursement as payment in full for services (some doctors charge you up to 15 percent more than Medicare allows!), Plans High-Deductible F and G will cover these extra charges.**

[1] Medicare Part A and Part B amounts are established by Medicare.

[2] Medigap plans pay up to 80 percent of billed charges for Medicare-eligible expenses for emergency care received during the first 60 consecutive days of each trip outside the United States. The plan payment is subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.

[3] Part B excess charges are the difference between the doctor's actual charge and Medicare's approved amount. This would apply if you go to a doctor who does not accept assignment and bills you more than Medicare's approved amount.

Plan Options

Coverage is available on a guaranteed issue basis.

If you are within six months of your Medicare Part B effective date (Open Enrollment) or during a Guaranteed Issue Period (please refer to the Additional Information section located in the back of this book), your acceptance into your choice of CareFirst's eight MediGap-65 plans is guaranteed! There is no health screening or medical exam.

During your Open Enrollment or Guaranteed Issue Period, you will automatically receive our lowest Level 1 premiums.

What's more, as long as you've had continuous health coverage for the past six months, with no more than a 63-day break, you will have no waiting period for pre-existing conditions. That means all medical conditions will be covered the day your policy goes into effect!*

Coverage is available on an underwritten basis.

If you are over six months from your Medicare Part B effective date (Open Enrollment) and are NOT applying during a Guaranteed Issue Period, you will need to answer questions regarding your medical history on the enclosed application. This assessment will determine your acceptance and the premium you will receive. Please refer to the Outline of Coverage for current pricing.

You risk nothing by applying today. If accepted, we'll send you a Certificate of Coverage. Please read it carefully.

If you're not satisfied with the coverage described, do not pay your bill. Your coverage will not go into effect, and you'll be under no further obligation.

Switching plans.

- If you're switching your coverage, we'll give you full credit for every dollar you've already spent toward your Medicare Part B deductible.
- We'll also give you full credit for time you've already spent on your previous policy toward the waiting period for pre-existing health conditions on your new CareFirst policy when applicable.
- You may be subject to a review of your medical history through medical underwriting if you are outside of your Open Enrollment or Guaranteed Issue period.

** If you have had more than a 63-day break in health insurance coverage and are applying for Plans **A, B, F, High-Deductible F**, or **N**, you may be subject to a waiting period of up to 90 days for any condition for which medical advice or treatment was recommended by or received from a physician within six months before the effective date of the policy for which you are applying.*

If you are applying for Plans G, L or M, there is NO pre-existing condition waiting period for any condition for which medical advice or treatment was recommended by or received from a physician within six months before the effective date of the policy for which you are applying.

Plan Options

Comparison chart

What You Pay with Original Medicare vs. What You Pay with CareFirst MediGap-65 plans					
	With Original Medicare alone, You Pay:	**Choose MediGap-65 Plan A and You Pay:**	**Choose MediGap-65 Plan B and You Pay:**	**Choose MediGap-65 Plan F and You Pay:**	**Choose MediGap-65 High-Deductible Plan F* and You Pay:**
Hospital Services (Part A)					
Inpatient hospital deductible	$1,288	$1,288	$0	$0	$0 after plan deductible
Hospital days 61-90	$322/day	$0	$0	$0	$0 after plan deductible
Hospital days 91-150 (lifetime reserve)	$644/day	$0	$0	$0	$0 after plan deductible
365 days after hospital benefits stop	All Costs	$0	$0	$0	$0 after plan deductible
Skilled nursing facility days 21-100	$161/day	$161/day	$161/day	$0	$0 after plan deductible
Medical Expenses (Part B)					
Medical expense deductible	$166	$166	$166	$0	$0 after plan deductible
Medical expenses after deductible	20%	0%	0%	0%	$0 after plan deductible
Excess charges above Medicare approved amounts	100%	100%	100%	$0	$0 after plan deductible
Other Expenses					
Foreign country emergency care (beginning the first 60 days of each trip outside the USA)	100%	100%	100%	$250 deductible, then 20%***	$250 deductible after plan deductible, then 20%***

Dollar amounts shown are the 2016 deductibles, copayment and coinsurance. These amounts may change on January 1, 2017.

**With High-Deductible Plan F, there is an annual plan deductible of $2,180; after you meet the $2,180 annual plan deductible, you pay $0.*

***With Plan L, there is an Out-of-Pocket limit of $2,480; After you meet $2,480 in out-of-pocket expenses, you pay $0.*

****Up to $50,000 lifetime maximum.*

Plan Options

Comparison chart

What You Pay with Original Medicare vs. What You Pay with CareFirst MediGap-65 plans				
	Choose MediGap-65 Plan G and You Pay:	**Choose MediGap-65 Plan L** and You Pay:**	**Choose MediGap-65 Plan M and You Pay:**	**Choose MediGap-65 Plan N and You Pay:**
Hospital Services (Part A)				
Inpatient hospital deductible	$0	$322	$644	$0
Hospital days 61-90	$0	$0	$0	$0
Hospital days 91-150 (lifetime reserve)	$0	$0	$0	$0
365 days after hospital benefits stop	$0	$0	$0	$0
Skilled nursing facility days 21-100	$0	Up to $40.25/day	$0	$0
Medical Expenses (Part B)				
Medical expense deductible	$166	$166	$166	$166
Medical expenses after deductible	0%	5%	0%	Office visit: up to $20 ER visit: up to $50
Excess charges above Medicare approved amounts	0%	100%	100%	100%
Other Expenses				
Foreign country emergency care (beginning the first 60 days of each trip outside the USA)	$250 deductible, then 20%***	100%	$250 deductible, then 20%***	$250 deductible, then 20%***

The CareFirst Advantage

District office locations and business hours

Annapolis District Office
151 West Street, Suite 101
Annapolis, MD 21401
410-268-6488
8:30 a.m–4:30 p.m.

Cumberland District Office
10 Commerce Drive
Cumberland, MD 21502
301-724-1313
8:30 a.m–4:30 p.m.

Easton District Office
301 Bay Street Plaza
Suite 401
Easton, MD 21601
410-822-1850
8:30 a.m–4:30 p.m.

Frederick District Office
100 Buckeystown Pike
Westview Village
Suite 215
Frederick, MD 21704
301-663-3138
8:30 a.m–4:30 p.m.

Hagerstown District Office
182–184 Eastern
Boulevard North
Hagerstown, MD 21740
301-733-5995
8:30 a.m–4:30 p.m.

Salisbury District Office
224 Phillip Morris Drive
Suite 106
Salisbury, MD 21804
410-742-3274
8:30 a.m–4:30 p.m.

Consider the advantages

Carry the card that's recognized nationwide

Once enrolled, you'll experience the security of knowing your CareFirst BlueCross BlueShield card is accepted for medical treatment by health care providers throughout the state of Maryland and beyond. You'll have peace of mind knowing you can get the care you need—where and when you need it.

Get local service from a local company

CareFirst BlueCross BlueShield is a local company. That means you'll talk to local customer service representatives over the phone. Or, you can use our walk-in neighborhood service offices throughout Maryland. Either way, you'll receive courteous, friendly service from dedicated, experienced representatives—they may even be your neighbors!

Call 410-581-3411 or toll-free 800-843-4280 to locate a service office near you.

Get rid of claim forms

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

Save time and money

CareFirst offers a discount of $2 off your monthly rate if you elect automated payments via bank withdrawal. That's a savings of $24 a year. End the worry of getting your payment in the mail on time—and the hassle of buying stamps. See Section 6 of your application to elect automated payment via bank withdrawal for your monthly premium payments.

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

The CareFirst Advantage

24-hour Health Care Advice Line

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

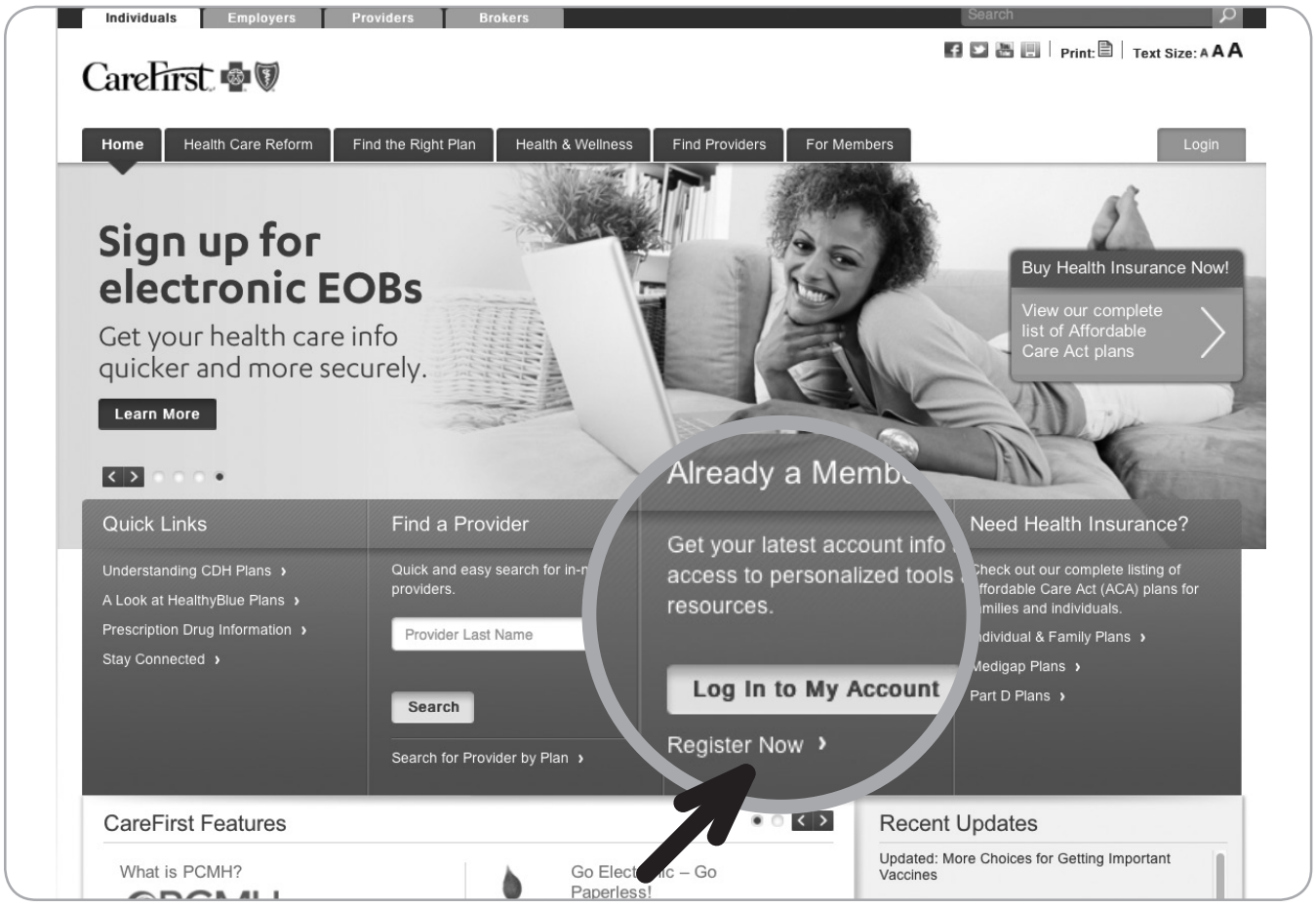
Have online access to claims and out-of-pocket costs

With *My Account*, you can get up-to-date information and resources. Log in to *My Account* and you can:

- Find out the effective date of your coverage.
- Check your deductible and out-of-pocket costs for your current and previous plan year.
- View claims status and review up to one year of medical claims — total charges, benefits paid and costs for a specific date range.
- Request a replacement medical ID card and/or print Verification of Coverage.
- Update information about other health care coverage you may have.

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

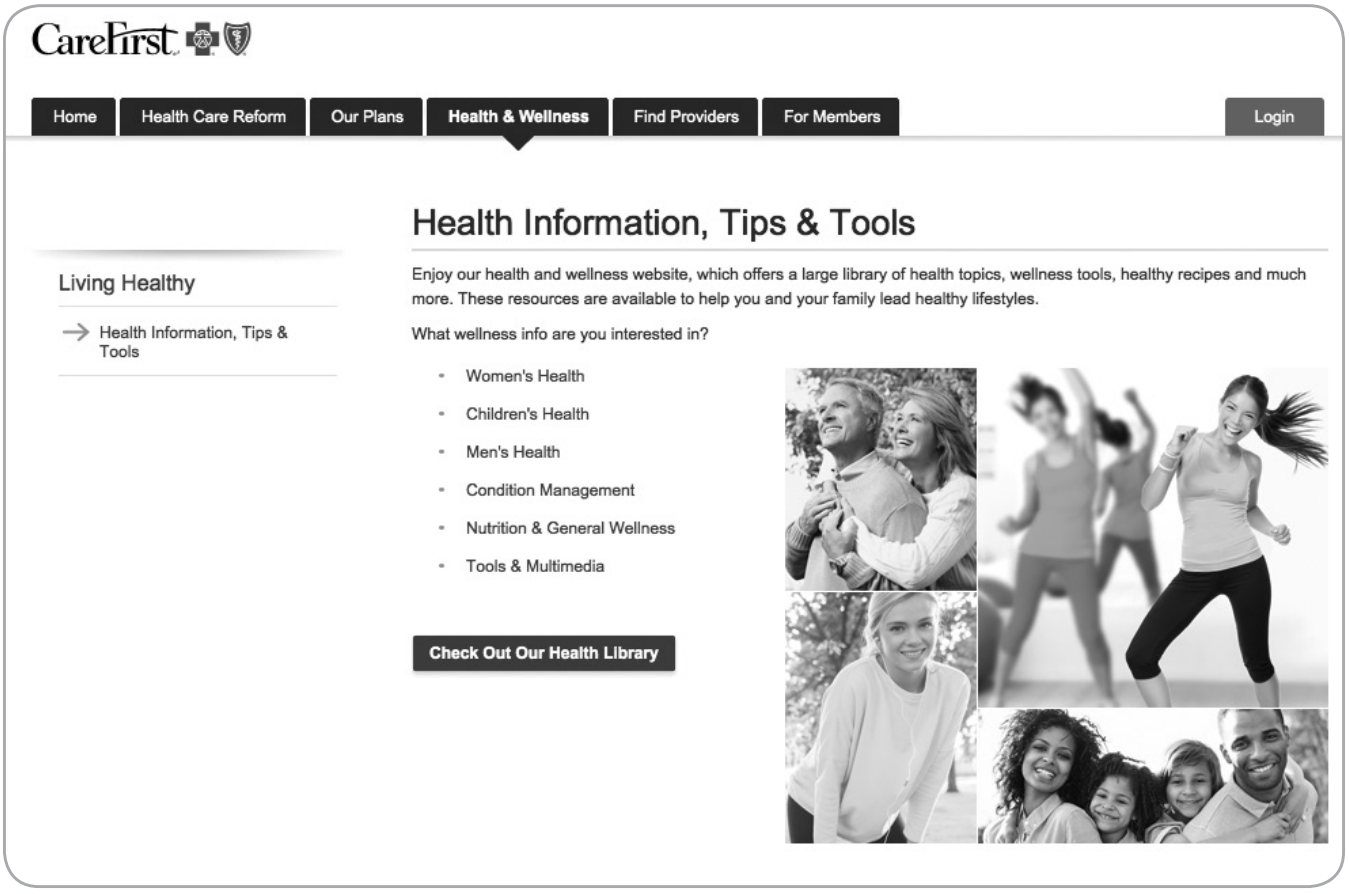
In an urgent situation, contact your doctor for advice. If your doctor isn't available, you can call FirstHelp. Our registered nurses can help you determine what your symptoms mean and if they are serious.



health+wellness

Visit **www.carefirst.com/livinghealthy** to access health tools that are fun and easy to use.

- Interactive quizzes, assessments and calculators
- Personalized features that let you record your health goals, reminders and medical history on our secure server
- Healthy cooking videos and recipes divided by category, including low-sodium, heart-healthy and diabetes-friendly
- A library of articles about diseases, health conditions, wellness tips, tests and procedures
- A multimedia section with videos, podcasts and tutorials about a variety of health topics
- Preventive guidelines
- Information on chronic conditions, nutrition, smoking cessation, stress, weight management and more



Health + Wellness

Wellness discount program

Blue365 is an exciting program that offers exclusive health and wellness deals that will keep you healthy and happy, every day of the year. Blue365 delivers great discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and much more. Visit **www.carefirst.com/wellnessdiscounts** to learn more.

The Blue365 program is not offered as an inducement to purchase a policy of insurance from CareFirst. CareFirst does not underwrite this program because it is not an insurance product. No benefits are paid by CareFirst under this program. The discount program listed above is not guaranteed by CareFirst BlueCross BlueShield and may be discontinued at any time.

We're here to answer your questions.

If you have any questions about the plans described in this book, or if you'd like assistance, just call 800-275-3802 (in the Baltimore area call 410-356-8123). You'll receive courteous, knowledgeable assistance from one of our dedicated product consultants.

Dental and Vision

Dental coverage (optional)

We're happy you're considering us for MediGap-65 coverage which provides security for the gaps in Medicare coverage. Now you can look to CareFirst for your dental needs. You have the option of purchasing a separate dental plan from CareFirst or The Dental Network.

Choices for your dental health

We offer four dental options*:

- Individual Select Dental HMO
- Individual Select Preferred Dental
- Individual Select Preferred Dental Plus
- BlueDental Preferred

Individual Select Dental HMO offers you dental care with lower, predictable copayments for routine and major dental services such as preventive and diagnostic dental care, surgical extractions, root canal therapy and orthodontic treatment.

As a member of our Dental Health Maintenance Organization (Dental HMO) plan, you'll select a general dentist from a network of 600+ participating providers to coordinate all of your dental care needs. When specialized care is needed, your general dentist will recommend a specialist within the Dental HMO network.

Individual Select Preferred Dental offers a larger dental network of over 5,000 participating providers, 100 percent coverage for preventive and diagnostic dental care, and potential in-network savings for major procedures. And, there are no deductibles to meet.

Individual Select Preferred Dental Plus and BlueDental Preferred offer a large dental network of over 5,000 providers across Maryland, D.C. and Northern Virginia. Plus you have access to a national dental network, which includes 123,000 dental providers across the country. And, you can see any provider you want – no referrals are necessary. No charge for oral exams, cleanings and X-rays when you visit an in-network provider. And if you select BlueDental Preferred you'll receive the added benefit of no benefit waiting periods.

Guaranteed acceptance – no claim forms!

All of our dental plans are guaranteed acceptance and require no claim forms when you stay in-network.

Note: The dental plans referenced are not part of your MediGap-65 policy. In order to receive coverage for dental services, you must apply separately for this plan. The plans are not offered as an inducement to purchase a Medigap policy from CareFirst BlueCross BlueShield.

Regular preventive dental care is an important part of staying healthy.

**Individual Select Dental HMO is underwritten by The Dental Network, Inc.*
Individual Select Preferred Dental is underwritten by Group Hospitalization and Medical Services, Inc.
Individual Select Preferred Dental Plus is underwritten by CareFirst of Maryland Inc. or Group Hospitalization and Medical Services, Inc.
BlueDental Preferred is underwritten by CareFirst of Maryland, Inc. or Group Hospitalization and Medical Services, Inc.

Dental and Vision

BlueVision (optional)

With your CareFirst MediGap-65 enrollment you have the option of purchasing a separate vision plan from CareFirst, which is administered by Davis Vision, Inc.* Benefits include annual eye examinations with dilation at participating providers for a $10 copay at the time of service plus discounts of about 30 percent on eyeglass frames and lenses or contact lenses from certain participating providers. For medical eye care, please follow your normal medical procedures.

To locate a vision provider, contact Davis Vision, Inc. at 800-783-5602 or visit **www.carefirst.com**.

Guaranteed acceptance – no claim forms!

You cannot be turned down for CareFirst's vision plan. If you have questions or would like to apply for a vision plan, please contact a product consultant at 410-356-8123 or toll-free at 800-275-3802.

Note: The vision plan referenced is not part of your MediGap-65 policy. In order to receive coverage for vision services, you must apply separately for this plan. The plan is not offered as an inducement to purchase a Medigap policy from CareFirst BlueCross BlueShield.

**Davis Vision is an independent company that provides administrative services for vision care to CareFirst BlueCross BlueShield members. Davis Vision is solely responsible for the services it provides.*

It's easy to apply for CareFirst dental coverage!

To request an application for Individual Select Preferred Dental Plus, Individual Select Dental HMO, Individual Select Preferred Dental, or BlueDental Preferred please contact one of our product consultants at 410-356-8123 or toll-free at 800-275-3802. Or detach and mail the Free Information Request Card located on the following page.

Mail this card for free information

YES, please rush me more information about the plan(s) that I've checked below. I understand this information is free and I am under no obligation.

Dental Plan Options
☐ BlueDental Preferred
☐ Dental HMO
☐ Preferred Dental
☐ Preferred Dental Plus

O65DEN2016

NAME:

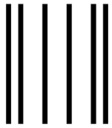
ADDRESS:

CITY:

STATE: ZIP:

CareFirst

The CareFirst BlueCross BlueShield family of health care plans



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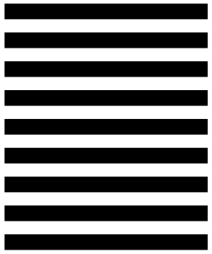

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CAREFIRST BLUECROSS BLUESHIELD
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OWINGS MILLS MD 21117-9782

Outline of Coverage

CareFirst

Medicare Supplemental Coverage Outline

MediGap-65 Maryland

PLANS A, B, F,

HIGH-DEDUCTIBLE F,

G, L, M AND N

Offered by CareFirst of Maryland, Inc.*, d/b/a CareFirst BlueCross BlueShield, 10455 Mill Run Circle, Owings Mills, Maryland 21117-5559. Offered by Group Hospitalization and Medical Services, Inc.*, d/b/a CareFirst BlueCross BlueShield, 840 First Street, NE, Washington, DC 20065. A not-for-profit health service plan.

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

CareFirst BlueCross BlueShield

Outline of Medicare Supplement coverage

- This chart shows the benefits included in each of the standard Medicare supplement plans.
- Every company must make Plan A available.
- Some plans may not be available in your state.
- CareFirst offers plans A, B, F, High-Deductible F, G, L, M and N as shaded below.

Basic Benefits:

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

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

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

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

** Plan F also has an option called a High-Deductible Plan F. This High-Deductible Plan pays the same benefits as Plan F after one has paid a calendar year $2,180 deductible. Benefits from High-Deductible Plan F will not begin until out-of-pocket expenses exceed $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.*

G	K	L	M	N
Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
Part B Excess (100%)				
Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
	Out-of-pocket limit $4,960; paid at 100% after limit reached	Out-of-pocket limit $2,480; paid at 100% after limit reached		

What Will My Premiums Be?

The premium you pay will be based on:

- Your gender
- Your age when coverage becomes effective
- When you enrolled in Medicare Part B
- Whether you are in a Guaranteed Issue Period
- The plan you select
- Your tobacco use (ONLY if you are applying more than six months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period)
- A review of your medical history through medical underwriting (ONLY if you are applying more than six months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period)
- Your payment option for monthly premiums – if you elect automated payments via bank withdrawal, you will receive a $2 discount off your monthly premium

Please note

- If you are applying within six months of your Medicare Part B Effective Date (Open Enrollment) or during a Guaranteed Issue Period, the Level 1 Rate applies and is dependent on the plan you selected, your age and gender. You are **not** required to answer any health or tobacco use questions found in Section 4 of the application. Therefore, the tobacco use and health screening questions will not be used in determining your rate.
- If you are applying more than six months past your Medicare Part B effective date and are **not** applying during a Guaranteed Issue Period, your medical history will be reviewed (medical underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 Rate, depending upon the review of your medical history information. Your rate will also be based on the plan you selected, your age, gender and tobacco use.

	Guaranteed Issue Period
If you apply within six months of your Medicare Part B effective date, or during a Guaranteed Issue Period, you will receive:	**Level 1 Rate**

Example: Mary is 67 years old. Her Medicare Part B effective date is October 1, 2016, as found on her red, white and blue Medicare identification card. She is applying for MediGap-65 Plan F coverage on November 1, 2016, which is within six months of her Medicare Part B effective date. Because this is her Open Enrollment Period, Mary gets a Level 1 Rate of $194, and tobacco use and health screening questions are not used in determining her rate.

	Rates Based on Tobacco Use and Review of Medical History
If you apply over six months past your Medicare Part B effective date, and are not applying during a Guaranteed Issue Period, you will receive:	**Level 2 Tobacco or Non-Tobacco Rate** **Level 3 Tobacco or Non-Tobacco Rate**

Competitive Rates

Take advantage of CareFirst BlueCross BlueShield's competitive rates

If you are applying within six months of your Medicare Part B effective date (Open Enrollment) or during a Guaranteed Issue Period, the Level 1 Rate applies and is dependent on the plan you selected, your age and gender. You are not required to answer any health or tobacco use questions found in Section 4 of the application. Therefore, tobacco use and health screening questions will not be used in determining your rate.

You can receive a discount of $2 off your monthly rate if you elect automated payment via bank withdrawal. See Section 6 of your application.

MediGap-65 Maryland: Level 1, Female Rates

Monthly Premium Rates Effective January 1, 2016

	Plan A	Plan B	Plan F	High-Ded F	Plan G	Plan L	Plan M	Plan N
Under 65	$177	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65					$139	$108	$128	
66					$145	$113	$133	
67	$162	$172	$194	$46	$151	$117	$138	$113
68					$156	$121	$143	
69					$162	$126	$149	
70					$169	$131	$155	
71					$175	$136	$161	
72	$191	$203	$229	$55	$181	$140	$166	$133
73					$187	$145	$172	
74					$193	$150	$177	
75					$198	$154	$182	
76					$203	$158	$187	
77	$225	$239	$270	$64	$209	$162	$192	$157
78					$215	$167	$197	
79					$221	$171	$203	
80					$225	$174	$206	
81					$228	$177	$210	
82	$266	$283	$319	$76	$232	$180	$214	$185
83					$236	$184	$217	
84					$240	$187	$221	
85					$245	$190	$225	
86					$248	$192	$228	
87	$306	$325	$367	$87	$251	$195	$230	$213
88					$254	$197	$233	
89					$257	$199	$236	
90 & Older					$260	$202	$239	

Competitive Rates

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If you are applying within six months of your Medicare Part B effective date (Open Enrollment) or during a Guaranteed Issue Period, the Level 1 Rate applies and is dependent on the plan you selected, your age and gender. You are not required to answer any health or tobacco use questions found in Section 4 of the application. Therefore, tobacco use and health screening questions will not be used in determining your rate.

You can receive a discount of $2 off your monthly rate if you elect automated payment via bank withdrawal. See Section 6 of your application.

MediGap-65 Maryland: Level 1, Male Rates

Monthly Premium Rates Effective January 1, 2016

	Plan A	Plan B	Plan F	High-Ded F	Plan G	Plan L	Plan M	Plan N
Under 65	$183	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$167	$177	$200	$48	$146	$113	$134	$116
66					$152	$118	$140	
67					$159	$124	$146	
68					$166	$129	$153	
69					$174	$135	$160	
70	$207	$220	$248	$59	$181	$140	$166	$144
71					$188	$146	$173	
72					$195	$152	$180	
73					$203	$158	$187	
74					$211	$164	$194	
75	$253	$269	$303	$72	$219	$170	$201	$176
76					$226	$176	$208	
77					$234	$182	$215	
78					$243	$188	$223	
79					$251	$195	$231	
80	$305	$324	$366	$87	$257	$200	$237	$213
81					$264	$205	$242	
82					$270	$210	$249	
83					$277	$215	$255	
84					$284	$221	$261	
85	$327	$347	$392	$93	$291	$226	$268	$228
86					$295	$229	$271	
87					$298	$232	$274	
88					$302	$234	$277	
89					$305	$237	$281	
90 & Older					$309	$240	$284	

Competitive Rates

Take advantage of CareFirst BlueCross BlueShield's competitive rates

If you are applying more than six months past your Medicare Part B effective date, and are NOT applying during a Guaranteed Issue Period, your medical history will be reviewed (medical underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 Rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco use.

You can receive a discount of $2 off your monthly rate if you elect automated payment via bank withdrawal. See Section 6 of your application.

MediGap-65 Maryland: Level 2, Non-Tobacco Female Rate

Monthly Premium Rates Effective January 1, 2016

	Plan A	Plan B	Plan F	High-Ded F	Plan G	Plan L	Plan M	Plan N
Under 65	$194	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65					$174	$135	$160	
66					$178	$138	$164	
67	$194	$206	$233	$55	$182	$141	$167	$135
68					$185	$144	$170	
69					$190	$148	$175	
70					$196	$152	$180	
71					$201	$156	$185	
72	$220	$233	$263	$63	$206	$160	$189	$153
73					$211	$164	$194	
74					$216	$168	$198	
75					$218	$169	$200	
76					$224	$174	$206	
77	$248	$263	$297	$71	$230	$179	$211	$173
78					$236	$183	$217	
79					$243	$188	$223	
80					$247	$192	$227	
81					$251	$195	$231	
82	$292	$311	$351	$84	$256	$198	$235	$204
83					$260	$202	$239	
84					$265	$205	$243	
85					$269	$209	$247	
86					$272	$211	$250	
87	$336	$357	$404	$96	$276	$214	$253	$234
88					$279	$217	$256	
89					$282	$219	$259	
90 & Older					$286	$222	$263	

Competitive Rates

Take advantage of CareFirst BlueCross BlueShield's competitive rates

If you are applying more than six months past your Medicare Part B effective date, and are NOT applying during a Guaranteed Issue Period, your medical history will be reviewed (medical underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 Rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco use.

You can receive a discount of $2 off your monthly rate if you elect automated payment via bank withdrawal. See Section 6 of your application.

MediGap-65 Maryland: Level 2, Non-Tobacco Male Rate

Monthly Premium Rates Effective January 1, 2016

	Plan A	Plan B	Plan F	High-Ded F	Plan G	Plan L	Plan M	Plan N
Under 65	$201	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$200	$213	$240	$57	$182	$141	$167	$139
66					$187	$145	$172	
67					$193	$149	$177	
68					$198	$154	$182	
69					$203	$158	$187	
70	$238	$253	$285	$68	$210	$163	$193	$166
71					$216	$168	$199	
72					$223	$173	$205	
73					$230	$178	$211	
74					$237	$184	$218	
75	$278	$295	$334	$79	$241	$187	$221	$194
76					$249	$193	$229	
77					$258	$200	$237	
78					$267	$207	$245	
79					$276	$214	$254	
80	$335	$356	$403	$96	$283	$220	$260	$234
81					$290	$225	$267	
82					$297	$231	$273	
83					$305	$237	$280	
84					$312	$243	$287	
85	$359	$382	$431	$103	$320	$249	$294	$251
86					$324	$252	$298	
87					$328	$255	$302	
88					$332	$258	$305	
89					$336	$261	$309	
90 & Older					$340	$264	$313	

Competitive Rates

Take advantage of CareFirst BlueCross BlueShield's competitive rates

If you are applying more than six months past your Medicare Part B effective date, and are NOT applying during a Guaranteed Issue Period, your medical history will be reviewed (medical underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 Rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco use.

You can receive a discount of $2 off your monthly rate if you elect automated payment via bank withdrawal. See Section 6 of your application.

MediGap-65 Maryland: Level 2, Tobacco Female Rate

Monthly Premium Rates Effective January 1, 2016

	Plan A	Plan B	Plan F	High-Ded F	Plan G	Plan L	Plan M	Plan N
Under 65	$243	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$243	$258	$291	$69	$217	$168	$199	$169
66					$223	$173	$205	
67					$228	$177	$209	
68					$232	$180	$213	
69					$238	$184	$218	
70	$274	$292	$329	$78	$245	$190	$225	$191
71					$251	$195	$231	
72					$257	$200	$237	
73					$264	$205	$242	
74					$270	$209	$248	
75	$310	$329	$372	$88	$272	$211	$250	$216
76					$280	$217	$257	
77					$287	$223	$264	
78					$295	$229	$271	
79					$303	$236	$279	
80	$365	$388	$439	$104	$309	$240	$284	$255
81					$314	$244	$289	
82					$319	$248	$294	
83					$325	$252	$299	
84					$331	$257	$304	
85	$420	$447	$504	$120	$336	$261	$309	$293
86					$340	$264	$313	
87					$344	$267	$317	
88					$349	$271	$320	
89					$353	$274	$324	
90 & Older					$357	$277	$328	

Competitive Rates

Take advantage of CareFirst BlueCross BlueShield's competitive rates

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You can receive a discount of $2 off your monthly rate if you elect automated payment via bank withdrawal. See Section 6 of your application.

MediGap-65 Maryland: Level 2, Tobacco Male Rate

Monthly Premium Rates Effective January 1, 2016

	Plan A	Plan B	Plan F	High-Ded F	Plan G	Plan L	Plan M	Plan N
Under 65	$251	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$250	$266	$300	$71	$228	$177	$209	$174
66					$234	$182	$215	
67					$241	$187	$221	
68					$247	$192	$227	
69					$254	$197	$234	
70	$297	$316	$357	$85	$262	$203	$241	$207
71					$270	$210	$248	
72					$278	$216	$256	
73					$287	$223	$264	
74					$296	$230	$272	
75	$347	$369	$417	$99	$301	$234	$277	$242
76					$311	$242	$286	
77					$322	$250	$296	
78					$333	$259	$307	
79					$345	$268	$317	
80	$419	$446	$503	$120	$354	$275	$325	$292
81					$363	$282	$333	
82					$372	$289	$342	
83					$381	$296	$350	
84					$391	$303	$359	
85	$449	$477	$539	$128	$400	$311	$368	$313
86					$405	$315	$372	
87					$410	$318	$377	
88					$415	$322	$381	
89					$420	$326	$386	
90 & Older					$425	$330	$391	

Competitive Rates

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You can receive a discount of $2 off your monthly rate if you elect automated payment via bank withdrawal. See Section 6 of your application.

MediGap-65 Maryland: Level 3, Non-Tobacco Female Rate

Monthly Premium Rates Effective January 1, 2016

	Plan A	Plan B	Plan F	High-Ded F	Plan G	Plan L	Plan M	Plan N
Under 65	$282	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$314	$334	$377	$90	$278	$216	$255	$219
66					$287	$223	$264	
67					$294	$228	$270	
68					$296	$230	$272	
69					$301	$233	$276	
70	$325	$345	$389	$93	$304	$236	$279	$226
71					$306	$238	$281	
72					$307	$239	$282	
73					$308	$239	$283	
74					$312	$242	$287	
75	$360	$383	$433	$103	$317	$246	$291	$251
76					$326	$253	$299	
77					$335	$260	$307	
78					$344	$267	$316	
79					$353	$274	$325	
80	$425	$452	$510	$122	$359	$279	$330	$297
81					$366	$284	$336	
82					$372	$289	$342	
83					$378	$294	$348	
84					$385	$299	$354	
85	$489	$520	$587	$140	$391	$304	$360	$341
86					$396	$308	$364	
87					$401	$311	$368	
88					$406	$315	$373	
89					$411	$319	$377	
90 & Older					$415	$323	$382	

Competitive Rates

Take advantage of CareFirst BlueCross BlueShield's competitive rates

If you are applying more than six months past your Medicare Part B effective date, and are NOT applying during a Guaranteed Issue Period, your medical history will be reviewed (medical underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 Rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco use.

You can receive a discount of $2 off your monthly rate if you elect automated payment via bank withdrawal. See Section 6 of your application.

MediGap-65 Maryland: Level 3, Non-Tobacco Male Rate

Monthly Premium Rates Effective January 1, 2016

	Plan A	Plan B	Plan F	High-Ded F	Plan G	Plan L	Plan M	Plan N
Under 65	$292	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$323	$344	$388	$92	$291	$226	$268	$225
66					$301	$234	$277	
67					$310	$241	$285	
68					$316	$245	$290	
69					$321	$250	$295	
70	$352	$374	$422	$100	$325	$253	$299	$245
71					$329	$255	$302	
72					$332	$258	$305	
73					$335	$260	$308	
74					$342	$266	$315	
75	$404	$430	$485	$116	$350	$272	$322	$282
76					$362	$281	$333	
77					$375	$291	$345	
78					$388	$301	$357	
79					$402	$312	$369	
80	$488	$519	$585	$139	$412	$320	$379	$340
81					$422	$328	$388	
82					$433	$336	$398	
83					$443	$344	$408	
84					$455	$353	$418	
85	$523	$556	$627	$149	$466	$362	$428	$364
86					$471	$366	$433	
87					$477	$370	$439	
88					$483	$375	$444	
89					$489	$379	$449	
90 & Older					$495	$384	$455	

Competitive Rates

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If you are applying more than six months past your Medicare Part B effective date, and are NOT applying during a Guaranteed Issue Period, your medical history will be reviewed (medical underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 Rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco use.

You can receive a discount of $2 off your monthly rate if you elect automated payment via bank withdrawal. See Section 6 of your application.

MediGap-65 Maryland: Level 3, Tobacco Female Rate								
Monthly Premium Rates Effective January 1, 2016								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$353	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$392	$417	$471	$112	$347	$269	$319	$273
66					$359	$279	$330	
67					$367	$285	$337	
68					$370	$287	$340	
69					$376	$292	$345	
70	$406	$431	$487	$116	$379	$295	$349	$283
71					$383	$297	$352	
72					$384	$298	$353	
73					$385	$299	$354	
74					$390	$303	$359	
75	$450	$479	$541	$129	$396	$307	$364	$314
76					$407	$316	$374	
77					$418	$325	$384	
78					$430	$333	$395	
79					$441	$343	$406	
80	$532	$565	$638	$152	$449	$349	$413	$371
81					$457	$355	$420	
82					$465	$361	$427	
83					$473	$367	$435	
84					$481	$373	$442	
85	$611	$650	$734	$175	$489	$380	$450	$426
86					$495	$384	$455	
87					$501	$389	$460	
88					$507	$394	$466	
89					$513	$398	$472	
90 & Older					$519	$403	$477	

Competitive Rates

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You can receive a discount of $2 off your monthly rate if you elect automated payment via bank withdrawal. See Section 6 of your application.

MediGap-65 Maryland: Level 3, Tobacco Male Rate

Monthly Premium Rates Effective January 1, 2016

	Plan A	Plan B	Plan F	High-Ded F	Plan G	Plan L	Plan M	Plan N
Under 65	$365	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$404	$429	$485	$115	$364	$283	$335	$282
66					$377	$293	$346	
67					$388	$301	$356	
68					$395	$307	$363	
69					$402	$312	$369	
70	$439	$467	$527	$126	$407	$316	$374	$306
71					$411	$319	$378	
72					$415	$322	$382	
73					$419	$325	$385	
74					$428	$332	$393	
75	$505	$537	$606	$144	$438	$340	$402	$352
76					$453	$352	$416	
77					$469	$364	$431	
78					$485	$377	$446	
79					$502	$390	$462	
80	$610	$648	$732	$174	$515	$400	$473	$425
81					$527	$410	$485	
82					$541	$420	$497	
83					$554	$430	$509	
84					$568	$441	$522	
85	$653	$694	$784	$187	$582	$452	$535	$455
86					$589	$457	$542	
87					$596	$463	$548	
88					$603	$469	$555	
89					$611	$474	$561	
90 & Older					$618	$480	$568	

CareFirst BlueCross BlueShield

Outline of Medicare Supplement coverage

Premium information

CareFirst BlueCross BlueShield can only raise your premiums if we raise the premiums for all policies like yours in the state.

There may be a rate increase when approved by the Maryland Insurance Administration or (if you have enrolled in Plans A, B, F, High-Deductible F or N) when you change from one age group to another, as shown below:

1) age 65 through 69
2) age 70 through 74
3) age 75 through 79
4) age 80 through 84
5) age 85 or older

Under Medicare supplement policies **G, L and M**, which use attained age rating, premiums automatically increase as you get older. You can expect your premiums to increase each year due to changes in age. We reserve the right to adjust premiums on your renewal.

The rate increase will be effective on the first of the policy renewal month. The policy renewal month means the month in which the policy becomes effective and each subsequent anniversary of that month. If the change from one age group to another occurs prior to the policy renewal month, the rate increase will not be effective until the first of the policy renewal month. You will be notified of any rate increase at least 45 days prior to the date that a premium increase becomes effective.

Disclosures

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after January 1, 2016. Policies sold for effective dates prior to January 1, 2016 have different benefits.

Read your policy very carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to return policy

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

CareFirst of Maryland, Inc.
d/b/a CareFirst BlueCross BlueShield
Individual Market Division
10800 Red Run Boulevard, RRE-375
Owings Mills, MD 21117

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

Policy replacement

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

Notice

This policy may not fully cover all of your medical costs. Neither CareFirst BlueCross BlueShield nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

Complete answers are very important

When you fill out the application for your new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

MediGap-65: **Plan A**

Medicare Part A hospital services per benefit period[1]

Services	Medicare Pays	Plan A Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$0	$1,288 (Part A Deductible)
61ST thru 90TH day	All but $322 a day	$322 a day	$0
91ST day and after:			
■ While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare-eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21ST thru 100TH day	All but $161 a day	$0	Up to $161 a day
101ST day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

MediGap-65: **Plan A**

Medicare Part B medical services per calendar year

Services	Medicare Pays	Plan A Pays	You Pay
Medical Expenses—In or Out of Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
Home Health Care Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
■ First $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	20%	$0

[1] Once you have been billed $166 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B deductible will have been met for the calendar year.

MediGap-65: **Plan B**

Medicare Part A hospital services per benefit period[1]

Services	Medicare Pays	Plan B Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0
61ST thru 90TH day	All but $322 a day	$322 a day	$0
91ST day and after:			
■ While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare-eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21ST thru 100TH day	All but $161 a day	$0	Up to $161 a day
101ST day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

MediGap-65: **Plan B**

Medicare Part B medical services per calendar year

Services	Medicare Pays	Plan B Pays	You Pay
Medical Expenses—In or Out of Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
Home Health Care Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
■ First $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	20%	$0

[1] Once you have been billed $166 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B deductible will have been met for the calendar year.

MediGap-65: **Plan F**

Medicare Part A hospital services per benefit period[1]

Services	Medicare Pays	Plan F Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0
61ST thru 90TH day	All but $322 a day	$322 a day	$0
91ST day and after:			
■ While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare-eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21ST thru 100TH day	All but $161 a day	Up to $161 a day	$0
101ST day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

MediGap-65: **Plan F**

Medicare Part B medical services per calendar year

Services	Medicare Pays	Plan F Pays	You Pay
Medical Expenses—In or Out of Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $166 of Medicare-approved amounts[1]	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-approved amounts[1]	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
Home Health Care Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
■ First $166 of Medicare-approved amounts[1]	$0	$166 (Part B Deductible)	$0
■ Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits Not Covered by Medicare			
Foreign Travel—Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

[1] Once you have been billed $166 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B deductible will have been met for the calendar year.

MediGap-65: **High-Deductible Plan F**

Medicare Part A hospital services per benefit period[1]

Services	Medicare Pays	High-Deductible Plan F Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies		**After you pay $2,180 deductible[2], High-Deductible Plan F pays**	**In addition to $2,180 deductible[2], you pay**
First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0
61ST thru 90TH day	All but $322 a day	$322 a day	$0
91ST day and after:			
■ While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare-eligible Expenses	$0[3]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21ST thru 100TH day	All but $161 a day	Up to $161 a day	$0
101ST day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

[2] *This High-Deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,180 deductible. Benefits from the High-Deductible Plan F will not begin until out-of-pocket expenses are $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.*

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

MediGap-65: **High-Deductible Plan F**

Medicare Part B medical services per calendar year

Services	Medicare Pays	High-Deductible Plan F Pays	You Pay
Medical Expenses—In or Out of Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:		**After you pay $2,180 deductible[2], High-Deductible Plan F pays**	**In addition to $2,180 deductible[2], you pay**
First $166 of Medicare-approved amounts[1]	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-approved amounts[1]	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
Home Health Care Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
■ First $166 of Medicare-approved amounts[1]	$0	$166 (Part B Deductible)	$0
■ Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits Not Covered by Medicare			
Foreign Travel—Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

[1] *Once you have been billed $166 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B deductible will have been met for the calendar year.*

[2] *This High-Deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,180 deductible. Benefits from the High-Deductible Plan F will not begin until out-of-pocket expenses are $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.*

MediGap-65: **Plan G**

Medicare Part A hospital services per benefit period[1]

Services	Medicare Pays	Plan G Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0
61ST thru 90TH day	All but $322 a day	$322 a day	$0
91ST day and after:			
■ While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare-eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21ST thru 100TH day	All but $161 a day	Up to $161 a day	$0
101ST day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

MediGap-65: **Plan G**

Medicare Part B medical services per calendar year

Services	Medicare Pays	Plan G Pays	You Pay
Medical Expenses—In or Out of Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
Home Health Care Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
■ First $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits Not Covered by Medicare			
Foreign Travel—Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

[1] Once you have been billed $166 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B deductible will have been met for the calendar year.

MediGap-65: **Plan L**

Medicare Part A hospital services per benefit period[2]

Services	Medicare Pays	Plan L Pays	You Pay[1]
Hospitalization[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$966 (75% of Part A Deductible)	$322♦ (25% of Part A Deductible)
61ST thru 90TH day	All but $322 a day	$322 a day	$0
91ST day and after:			
■ While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare-eligible Expenses	$0[3]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[2] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21ST thru 100TH day	All but $161 a day	Up to $120.75 a day (75% of Part A Coinsurance)♦	Up to $40.25 a day (25% of Part A Coinsurance)♦
101ST day and after	$0	$0	All costs
Blood			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance♦

[1] *You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,480 each calendar year. The amounts that count toward your annual limit are noted with diamonds "♦" in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year.* ***However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.***

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

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

MediGap-65: **Plan L**

Medicare Part B medical services per calendar year

Services	Medicare Pays	Plan L Pays	You Pay[1]
Medical Expenses—In or Out of Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $166 of Medicare-approved amounts[2]	$0	$0	$166[2] (Part B Deductible)♦
Preventive benefits for Medicare-covered services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket[3] limit of $2,480[1])
Blood			
First 3 pints	$0	75%	25%♦
Next $166 of Medicare-approved amounts[2]	$0	$0	$166♦ (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
Home Health Care Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
■ First $166 of Medicare-approved amounts[3]	$0	$0	$166♦ (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	15%	5%♦

[1] *This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,480 per year.* ***However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.***

[2] *Once you have been billed $166 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B Deductible will have been met for the calendar year.*

[3] *Medicare Benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.*

MediGap-65: **Plan M**

Medicare Part A hospital services per benefit period[1]

Services	Medicare Pays	Plan M Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$644 (50% of Part A Deductible)	$644 (50% of Part A Deductible)
61ST thru 90TH day	All but $322 a day	$322 a day	$0
91ST day and after:			
■ While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare-eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21ST thru 100TH day	All but $161 a day	Up to $161 a day	$0
101ST day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

MediGap-65: **Plan M**

Medicare Part B medical services per calendar year

Services	Medicare Pays	Plan M Pays	You Pay
Medical Expenses—In or Out of Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
Home Health Care Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
■ First $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits Not Covered by Medicare			
Foreign Travel—Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

[1] Once you have been billed $166 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B deductible will have been met for the calendar year.

MediGap-65: **Plan N**

Medicare Part A hospital services per benefit period[1]

Services	Medicare Pays	Plan N Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0
61ST thru 90TH day	All but $322 a day	$322 a day	$0
91ST day and after:			
■ While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare-eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21ST thru 100TH day	All but $161 a day	Up to $161 a day	$0
101ST day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

MediGap-65: **Plan N**

Medicare Part B medical services per calendar year

Services	Medicare Pays	Plan N Pays	You Pay
Medical Expenses—In or Out of Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
Home Health Care Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
■ First $166 of Medicare-approved amounts[1]	$0	$0	$166 (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	20%	$0

[1] Once you have been billed $166 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B deductible will have been met for the calendar year.

MediGap-65: **Plan N**

Medicare Part B medical services per calendar year

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

These benefits described are issued under Policy
Form Numbers:
CFMI/MG PLAN A (6/10)
CFMI/MG PLAN B (6/10)
CFMI/MG PLAN F (6/10)
CFMI/MG PLAN G (2/12)
CFMI/MG PLAN L (2/12)
CFMI/MG PLAN M (2/12)
CFMI/MG PLAN N (6/10)
CFMI/MG PLAN HI DED F (6/10)
CFMI/2010 PLAN HI F SOB (6/10)
as amended

MD/CF/MG PLAN A (6/10)
MD/CF/MG PLAN B (6/10)
MD/CF/MG PLAN F (6/10)
MD/CF/MG PLAN G (2/12)
MD/CF/MG PLAN L (2/12)
MD/CF/MG PLAN M (2/12)
MD/CF/MG PLAN N (6/10)
MD/CF/MG PLAN HI DED F (6/10)
MD/CF/2010 PLAN HI F SOB (6/10)
as amended

CareFirst of Maryland, Inc.
10455 Mill Run Circle
Owings Mills, Maryland 21117

A not-for-profit health service plan incorporated under the laws of the State of Maryland.

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

www.carefirst.com

If you reside in either Prince George's or Montgomery County, then a Group Hospitalization and Medical Services, Inc. policy will be issued. For Baltimore City and all other counties in the state of Maryland, a CareFirst of Maryland, Inc. policy will be issued.

MDSUPPOOC (6/15) CDS1125-1P (6/15)

Apply Today

Apply Today

Three Ways to Apply!

Applying for a MediGap-65 plan is easy. Select one of the three ways to apply from the list below.

1. Apply online and be approved in as little as 24 hours at **www.carefirst.com/individual**. Click on the *Medicare* tab at the top. To see where you can apply online – take a look at the picture of our website at the bottom of this page.
2. Fill out and mail the enclosed application. Send no money when you apply. We'll begin processing your application right away.
3. Apply through your broker.

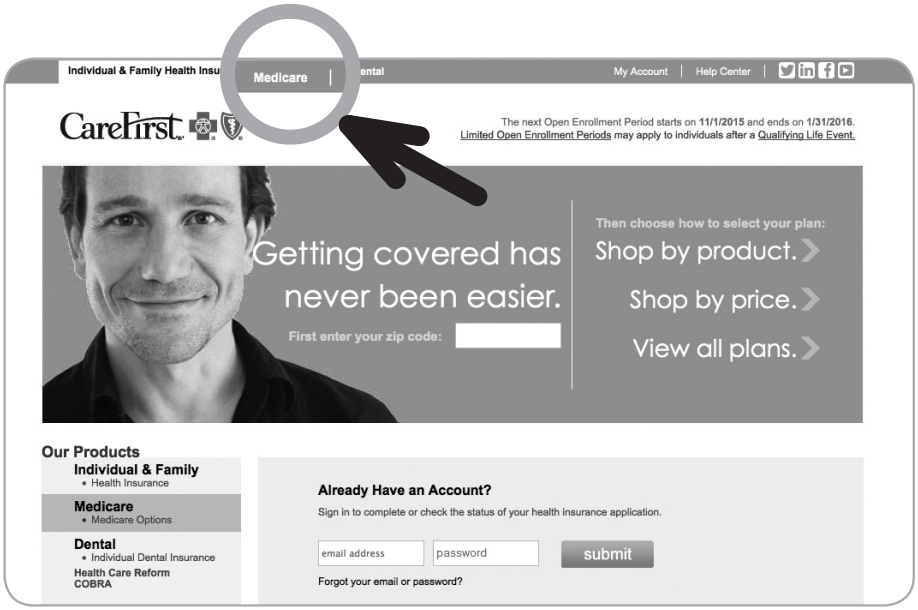
Steps to apply:

- Review the plan options and premiums in the Outline of Coverage.
- Complete your application. Don't forget to:
  - Indicate the MediGap-65 plan of your choice.
  - Read Section 3 of your application to see if you automatically qualify for Guaranteed Acceptance and our lowest rates.
  - Sign your application.
- Mail your application in the enclosed, postage-paid envelope.

Please Note: We recommend folding the application into thirds before placing it into the enclosed envelope.

Once you have submitted your application, you can call the Application Status Hotline at 877-746-7515 with questions. Your coverage will become effective the first of the month following the month in which we approve your application.

If you have questions, please call our product consultants at 410-356-8123 or toll-free at 800-275-3802, Monday–Friday 8 a.m.–6 p.m., Saturday 8 a.m.–12 noon. Or, visit the CareFirst website at **www.carefirst.com**.



Apply Today

Pay your premium online and save!

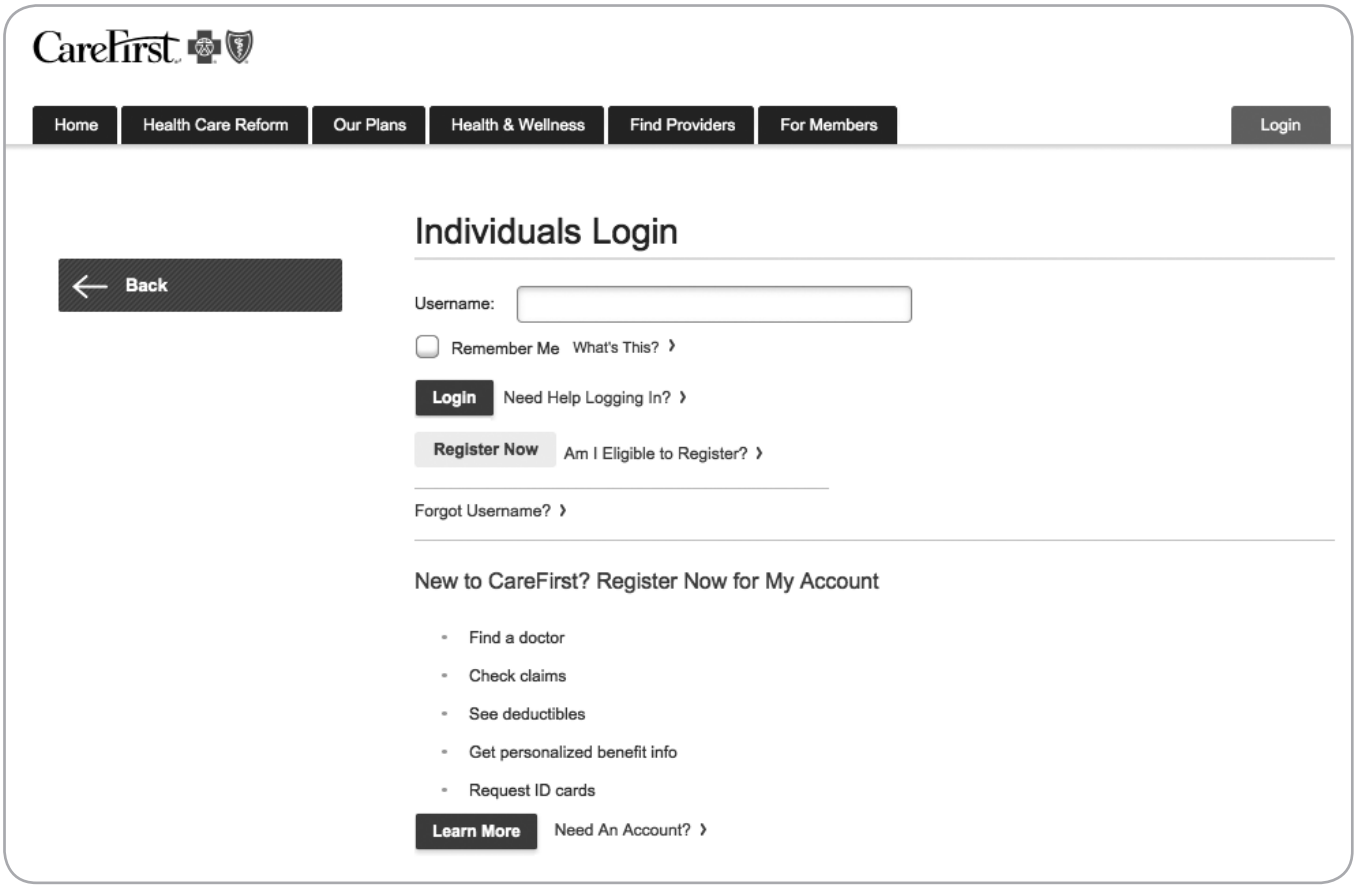
As a member, you can save time and money when you take advantage of our online billing system called e-Billing.

With e-Billing you can:

- Set up recurring monthly payments in two ways:
  1. Fill out Section 6 on the enclosed application with your checking account information. If you sign up for automated payments via bank withdrawal, you'll receive a $2 discount off your monthly rate for a savings of $24 a year.

     OR

  2. You can also sign up for e-Billing once you are a member. Either through *My Account*, which can be found at **www.carefirst.com/myaccount**, or call the customer service number on the back of your membership card.
- View and pay your monthly bill online 24 hours a day, seven days a week.
- Check the status of your payment and any outstanding balances.
- End the hassle of buying stamps and the worry of getting your payment in the mail on time.



MediGap-65 Application

Maryland Residents

For assistance completing this application, call 800-275-3802. Note: Please consider retaining your existing plan coverage until it is determined that you have passed Medical Underwriting.

☐ CareFirst of Maryland, Inc.
10455 Mill Run Circle, Owings Mills, MD 21117
☐ Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Sign this application on page 13 and return it in the postage-paid envelope, if provided. Or mail to:
   Mailroom Administrator
   P.O. Box 14651
   Lexington, KY 40512
3. **Send no money with this application.** You will be notified by mail of the amount due if this application is accepted.

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

PLEASE READ AND CHECK APPLICABLE BOX ABOVE

If you live in Baltimore City or any other county in the State of Maryland, besides Prince George's or Montgomery County, please check the CareFirst of Maryland, Inc. box above. If you live in Prince George's or Montgomery County, please check the Group Hospitalization and Medical Services, Inc. box above. Please check only one box.

SECTION 1. APPLICANT INFORMATION

1A. PERSONAL INFORMATION

Last Name:	First Name:	Initial:
Residence Address (Number and Street, Apt #):		
City:	State:	Zip Code (9-digit, if known):
Billing Address, if different from Resident Address (Number and Street, Apt #):		
City:	State:	Zip Code (9-digit, if known):
Social Security (or Railroad Retirement) Number: _____ – _____ – _____	Date of Birth: _____ / _____ / _____ Month Day Year	
Home Phone: ( )	Sex: ☐ Male ☐ Female	

A private not for-profit health service plan incorporated under the laws of the state of Maryland. CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. which are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®´ Registered trademark of CareFirst of Maryland, Inc. If you reside in either Prince George's or Montgomery county, then a Group Hospitalization and Medical Services, Inc. policy will be issued. For Baltimore City and all other counties in the state of Maryland, a CareFirst of Maryland, Inc. policy will be issued.

SECTION 1. APPLICANT INFORMATION (continued)

1B. PLAN OPTIONS

Please check the MediGap-65 Plan for which you are applying (check only one plan):

☐ **PLAN A*** ☐ **PLAN B** ☐ **PLAN F** ☐ **High Deductible PLAN F**
☐ **PLAN G** ☐ **PLAN L** ☐ **PLAN M** ☐ **PLAN N**

If you are under age 65 and have Medicare, you may apply for* **PLAN A *only.*

1C. EFFECTIVE DATE

Your coverage becomes effective on the first day of the month following receipt and approval of this application. You will receive a Policy confirming the following effective date.

Requested Effective Date of Coverage: _____/_____/_____
Month Day Year

SECTION 2. MEDICARE COVERAGE INFORMATION

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

Health Insurance Claim Number:

Medicare Hospital (**PART A**) Effective Date:	Medicare Medical/Surgical (**PART B**) Effective Date:
_____/_____/_____ Month Day Year	_____/_____/_____ Month Day Year

SECTION 3. ELIGIBILITY INFORMATION

Please answer the following questions regarding your eligibility:

3A. Did you turn age 65 in the last 6 months?	☐ Yes ☐ No
3B. Are you age 65 or older and have you enrolled in Medicare Part B within the last 6 months?	☐ Yes ☐ No
3C. Are you under age 65, eligible for Medicare due to a disability, AND did you enroll in Medicare Part B within the last 6 months? OR, Are you under age 65, eligible for Medicare due to a disability, AND have you been terminated from the Maryland Health Insurance Plan as a result of enrollment in Medicare Part B within the last 6 months?	☐ Yes ☐ No
3D. At the time of this application, are you within 6 months from the first day of the month in which you first enrolled or will enroll in Medicare Part B?	☐ Yes ☐ No

NOTE:

- If you answered **YES** to **3A, 3B, 3C** or **3D,** your acceptance is guaranteed. If you are applying for Plans A, B, F, High-Deductible F or N, answer **3E**. If you are applying for Plans G, L, or M, skip **3E** and Section 4, and go directly to Section 5.
- If you answered **NO** to **3A, 3B, 3C AND 3D**, continue to question **3E**.

SECTION 3. ELIGIBILITY INFORMATION (continued)

3E. Please answer questions 1-7 in this section.

1. Were you enrolled under an employer group health plan or union coverage that pays after Medicare pays (Medicare Supplemental Plan) and that plan is ending or will no longer provide you with supplemental health benefits, and the applicable coverage was terminated or ceased within the past 63 days? **OR,** Did you receive a notice of termination or cessation of all supplemental health benefits within the past 63 days (if you did not receive the notice, did the date you received notice that a claim has been denied because of a termination or cessation of all supplemental health benefits occur within the past 63 days)?	☐ Yes ☐ No
WITHIN THE PAST 63-DAY PERIOD WERE YOU ENROLLED UNDER:	
2. A Medicare Health Plan* such as a Medicare Advantage Plan or you are 65 years of age or older and enrolled with a Program of All-Inclusive Care For the Elderly (PACE) and at least one of the following was met: a. The Plan was terminated, no longer provides or has discontinued the Plan in the service area where you live b. You were not able to continue coverage with the Plan because you moved out of the plan's service area or other change in circumstances specified by the Secretary of the Department of Health and Human Services. This does not include failure to pay premiums on a timely basis c. You are leaving because you can show that the Plan substantially violated a material provision of the policy including not providing medically necessary care on a timely basis or in accordance with medical standards d. You are leaving because you can show that the Plan or its agent misled you in marketing the policy e. The certification of the organization was terminated f. You meet any other exceptional condition as the Secretary may provide.	☐ Yes ☐ No
3. A Medicare Supplemental policy and your enrollment ended and at least one of the following was met: a. Through no fault of your own or because your insurance company has gone bankrupt and you lost coverage, or is going bankrupt and you will be losing your coverage b. You are leaving because you can show that the company substantially violated a material provision of the policy c. You are leaving because you can show that the company or its agent misled you in marketing the policy	☐ Yes ☐ No
4. A Medicare Health Plan* such as a Medicare Advantage or PACE plan that you joined when you first enrolled under Medicare Part B at age 65 or older, and within 12 months of enrolling you decided to switch to a Medicare Supplement policy.	☐ Yes ☐ No
5. A Medicare Supplemental plan that you dropped and subsequently enrolled for the first time with a Medicare Health Plan* such as Medicare Advantage or PACE plan; and you have been in the plan less than 12 months and want to return to a Medicare Supplemental plan.	☐ Yes ☐ No

* *Medicare Health Plan includes a Medicare Advantage Plan; a Medicare Cost plan (under 1876 of the federal Social Security Act); a similar organization operating under demonstration project authority effective for periods before April 1, 1999); a Health Care Prepayment Plan (under an agreement under 1833 (a)(1)(A) of the federal Social Security Act), a Medicare Select policy, HCFA certified provider sponsored organization, or a Program of All-Inclusive Care for the Elderly (PACE).*

SECTION 3. ELIGIBILITY INFORMATION (continued)

6. A Medicare Part D plan, and ALSO were enrolled under a Medicare Supplement plan that covers outpatient prescription drugs. When you enrolled in Medicare Part D, you terminated enrollment in the Medicare Supplement Plan that covered outpatient prescription drug coverage.	☐ Yes ☐ No
7. An employer group health plan or union coverage that provides health benefits and the plan terminated, and solely because of your Medicare eligibility, you are not eligible for the tax credit for health insurance costs (under 35 of the Internal Revenue Code) and enrollment in the Maryland Health Insurance Plan (under 14-501 (f) of the Insurance Articles).	☐ Yes ☐ No

NOTE:

- If you answered **YES** to questions **3A, 3B, 3C** or **3D**, your acceptance is guaranteed. Skip Section 4 and go directly to Section 5.
- If you answered **YES** to any question in Section **3E** you will **NOT** have to meet the pre-existing condition waiting period. You must submit evidence of the date of termination or disenrollment of the other plan **OR** evidence of enrollment in Medicare Part D along with this application. Skip Section 4 and go directly to Section 5.
- Pre-existing condition waiting periods only apply to Plans A, B, F, High-Deductible F and N. Pre-existing condition waiting periods do not apply to Plans G, L, or M.
- If you answered **NO** to ALL questions in Section 3 (**3A, 3B, 3C, 3D AND 3E**) continue to Section 4.

SECTION 4. HEALTH EVALUATION

Please complete Section 4A. If you answer "Yes" to any of the questions in Section 4A, you are not required to complete Sections 4B–4E.

Have you had a physical exam within the past 5 years?	☐ Yes ☐ No
Have you used tobacco products within the last 5 years?	☐ Yes ☐ No

4A. PLEASE ANSWER THE FOLLOWING HEALTH QUESTIONS TO HELP DETERMINE WHETHER OR NOT YOU ARE ELIGIBLE.

To the best of your knowledge and belief, in the last five years, have you consulted a physician, licensed medical provider, been diagnosed, treated, OR advised by a medical practitioner to have treatment for known symptoms or known indications of the following conditions:
NOTE: ALL QUESTIONS MUST BE CHECKED "YES" OR "NO" OR YOUR APPLICATION WILL BE RETURNED.

1. Cancer (except skin or thyroid)	☐ Yes ☐ No
2. Melanoma, Hodgkin's Disease, Leukemia, or Multiple Myeloma	☐ Yes ☐ No
3. Kidney Disease or Disorder: Including Kidney Failure, Kidney Dialysis	☐ Yes ☐ No
4. Amyotrophic Lateral Sclerosis or Anterior Horn Disease	☐ Yes ☐ No
5. Alzheimer's, Senile Dementia, or other organic brain disorders, including alcoholic psychosis	☐ Yes ☐ No
6. An Organ Transplant (kidney, liver, heart, lung, or bone marrow), or are on a waiting list for a transplant	☐ Yes ☐ No
7. Have you tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection, or other sickness or condition derived from such infection?	☐ Yes ☐ No

If you answered **YES** to any of the questions in Section 4A, you are **NOT** eligible for these plans at this time. If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time. For information regarding plans that may be available, contact your local state department on aging.

If you answered **NO** to **ALL** the questions in Section 4A, please continue to Section 4B.

SECTION 4. HEALTH EVALUATION (continued)

4B. MEDICATIONS

If you are presently using or have used medication or prescription drugs in the past 12 months (1 year), please provide details below. If more space is needed, attach a separate sheet of paper.

Illness or Condition:	Medication:	Dosage:	How Often Taken:
Date of Last Treatment: _____/_____/_____	Attending Physician Name and Address:		
Illness or Condition:	Medication:	Dosage:	How Often Taken:
Date of Last Treatment: _____/_____/_____	Attending Physician Name and Address:		
Illness or Condition:	Medication:	Dosage:	How Often Taken:
Date of Last Treatment: _____/_____/_____	Attending Physician Name and Address:		

4C. HEALTH QUESTIONNAIRE

To the best of your knowledge and belief, in the last five years, have you consulted a physician, licensed medical provider, been diagnosed, treated, OR advised by a medical practitioner to have treatment for known symptoms or known indications of the following conditions:

NOTE: ALL QUESTIONS MUST BE CHECKED "YES" OR "NO" OR YOUR APPLICATION WILL BE RETURNED.

1. Insulin Dependent Diabetes Mellitus (Diabetes for which you take Insulin)	☐ Yes ☐ No
2. Liver Disease or Disorder: including Cirrhosis of Liver, Hepatitis C	☐ Yes ☐ No
3. Lung Disease or Disorder: including Chronic Obstructive Pulmonary Disease, Emphysema or required use of oxygen therapy to assist in breathing	☐ Yes ☐ No
4. Heart or circulatory surgery of any type, including angioplasty, bypass, stent placement or replacement, valve placement or replacement	☐ Yes ☐ No
5. Heart conditions including congestive heart failure, heart attack, cardiomyopathy, heart rhythm disorders including pacemakers or defibrillator	☐ Yes ☐ No
6. Coronary Artery Disease (CAD) including hypertension or elevated or high cholesterol	☐ Yes ☐ No
7. Stroke (CVA)	☐ Yes ☐ No
8. Transient Ischemic Attack (TIA)	☐ Yes ☐ No
9. Multiple Sclerosis, Parkinson's Disease, Muscular Dystrophy or paralysis of any type	☐ Yes ☐ No
10. Auto Immune conditions including Systemic Lupus, Scleroderma, other connective tissue conditions	☐ Yes ☐ No
11. Nervous or Mental Disorder requiring psychiatric care or hospitalization, including substance or alcohol abuse	☐ Yes ☐ No
12. Thyroid cancer	☐ Yes ☐ No

SECTION 4. HEALTH EVALUATION (continued)

4D. ADDITIONAL HEALTH QUESTIONS

Please answer the following questions regarding your most recent medical history, to the best of your knowledge and belief.
NOTE: ALL QUESTIONS MUST BE CHECKED "YES" OR "NO" OR YOUR APPLICATION WILL BE RETURNED.

1. Are you currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, or received home health care in the last 90 days?	☐ Yes ☐ No
2. Have you been advised by a medical practitioner that you will need to be hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, or receive home health care within the next six months?	☐ Yes ☐ No
3. Have you been advised by a medical practitioner to have surgery within the next six months?	☐ Yes ☐ No
4. Have you had medical tests in the last year for which you have not yet received results?	☐ Yes ☐ No
5. Have you ever been hospitalized or had a condition that required hospitalization that occurred during the past seven years immediately before the date of this application? **Duration Dates:** From: _____/_____/_____ To: _____/_____/_____ **Condition:** _____	☐ Yes ☐ No

6. What is your current height and weight?	Height: ____ ft. ____ in.	Weight: _____ lbs.

4E. EXPLANATION OF DIAGNOSIS AND TREATMENTS

If you have checked "Yes" to any part of SECTION 4C or 4D, for each box checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgeries and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

Question Number	Diagnosis or Condition	Duration Dates	**Explain treatment** (including all medications, hospitalizations, surgery and diagnostic test results and physician/hospital name)	Recovery (check one box)
		From: **To:**		☐ **Full** ☐ **Partial**
		From: **To:**		☐ **Full** ☐ **Partial**
		From: **To:**		☐ **Full** ☐ **Partial**
		From: **To:**		☐ **Full** ☐ **Partial**
		From: **To:**		☐ **Full** ☐ **Partial**
		From: **To:**		☐ **Full** ☐ **Partial**
		From: **To:**		☐ **Full** ☐ **Partial**
		From: **To:**		☐ **Full** ☐ **Partial**

SECTION 5. PAST AND CURRENT COVERAGE

Please review the statements below, then answer all questions to the best of your knowledge.

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

For your protection, you are required to answer all of the questions below (5A through 5M).
You are only required to answer questions 5N and 5O if you are applying for Plans A, B, F, High-Deductible F or N. Please Note: If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your enrollment form.

5A. Did you turn age 65 in the last 6 months?	☐ Yes ☐ No
5B. Did you enroll in Medicare Part B in the last 6 months?	☐ Yes ☐ No
5C. If Yes, what is the effective date? _____/_____/_____	
5D. Are you covered for medical assistance through the State Medicaid program? (Medicaid is not the same as Federal Medicare. Medicaid is a program run by the state to assist with medical costs for lower or limited-income people.) **NOTE TO APPLICANT:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer "NO" to this question. If **NO**, skip to question **5G**. If **YES**, continue to **5E**.	☐ Yes ☐ No
5E. Will Medicaid pay your premiums for this Medicare supplement policy?	☐ Yes ☐ No

SECTION 5. PAST AND CURRENT COVERAGE (continued)

5F. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ Yes ☐ No
5G. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage Plan, or a Medicare HMO or PPO)? If **NO**, skip to question **5K**. **If YES, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.** START _____/_____/_____ END _____/_____/_____	☐ Yes ☐ No
5H. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	☐ Yes ☐ No
5I. Was this your first time in this type of Medicare plan?	☐ Yes ☐ No
5J. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ Yes ☐ No
5K. Do you have another Medicare supplement policy in force? If **NO**, skip to question **5M**. If **YES**, indicate the company and plan name (i.e. Medigap Plan A, B, etc.) and then continue to **5L**. Company Name _____ Plan Name _____	☐ Yes ☐ No
5L. Since you have another Medicare supplement policy in force, do you intend to replace your current Medicare supplement policy with this policy?	☐ Yes ☐ No
5M. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) If **YES**: What company and what kind of policy? **Company Name** _____ **Membership number IF a CareFirst BlueCross BlueShield Policy** _____ **Policy Type:** (Please select only **ONE** box) ☐ HMO/PPO ☐ Major Medical ☐ Employer Plan ☐ Union Plan ☐ Other What are your dates of coverage under the policy listed in 5M? (If you are still covered under the other policy, leave "END" blank.) START _____/_____/_____ END _____/_____/_____	☐ Yes ☐ No

SECTION 5. PAST AND CURRENT COVERAGE (continued)

Please ONLY answer Questions 5N and 5O if you are applying for Plans A, B, F, High-Deductible F or N. If you are applying for Plans G, L or M, skip ahead to Section 6.

5N. At the time of this application, have you had continuous creditable coverage* of at least 90 days, without a break in this coverage of more than 63 consecutive days? If **NO**, please continue to question 5O. If you answered **YES** and are applying for **Plans A, B, F, High-Deductible F** or **N,** you **must** submit evidence of Creditable Coverage along with this application. However, you will **NOT** have to meet the pre-existing condition waiting period. Please skip ahead to Section 6.	☐ Yes ☐ No
5O. At the time of this application, have you had continuous creditable coverage* of less than 90 days, without a break in this coverage of more than 63 consecutive days? If you answered **YES** and applied for **Plans A, B, F, High-Deductible F** or **N,** you **MUST** submit evidence of Creditable Coverage along with this application and the 90-day pre-existing condition waiting period will be reduced by the number of days you had creditable coverage. **However, there is one exception.** If you answered **YES** to any question in **Section 3E**, you will **NOT** have to meet the pre-existing condition waiting period.	☐ Yes ☐ No

***Creditable coverage** means coverage under any of the following plans: 1) a group health plan; 2) health insurance coverage; 3) Medicare Part A or Part B; 4) Medicaid 5) CHAMPUS; 6) a medical care program of the Indian Health Service or of a tribal organization; 7) a State health benefit risk pool; 8) the Federal Employees Health Benefit Plan; 9) a public health plan as defined in federal regulations; or 10) a health benefit plan defined under the Peace Corp Act.*

Documents that may be used as evidence of "creditable coverage," include:

- *a certificate of "creditable coverage;"*
- *paystubs showing a payroll deduction for health coverage;*
- *a health insurance identification card;*
- *third-party statements verifying periods of coverage;*
- *and any other relevant documents that evidence periods of health coverage.*

SECTION 6. PREMIUM PAYMENT

☐ **Please check this box if you DO NOT wish to set up an automated payment account and intend to pay by submitting paper checks or by credit card. (Discounted rates are NOT available with this payment method.)**

CareFirst BlueCross BlueShield wants to help you save time and money! We offer discounted rates to members who elect our standard payment method of automated payment via bank withdrawal.

To take advantage of this time and money saving option, please fill out the information below.
Choose either:

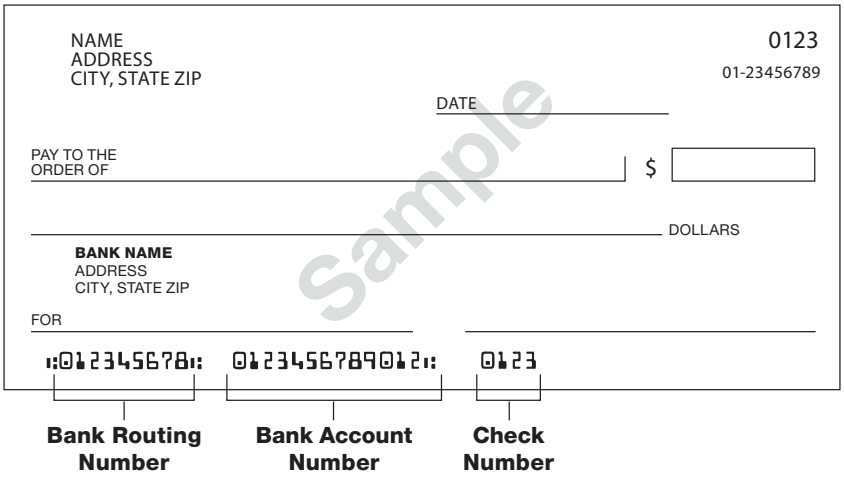
☐ Checking Account ☐ Savings Account

Bank Name:

Bank Routing Number:

Bank Account Number:

Name that appears on the Account:



I hereby authorize CareFirst BlueCross BlueShield to charge my account for the payment of premiums due for an unpaid invoice. If any check draft is dishonored for any reason, or drawn after the depositor's authorization has been withdrawn, CareFirst agrees that the financial institution will not be held liable. I understand that non-payment of premiums due to dishonored auto-draft payment attempts may result in termination of coverage. I also understand that if the Policyholder elects to pay premium through an electronic payment, CareFirst BlueCross BlueShield may not debit or charge the amount of the premium due prior to the premium due date, except as authorized by the Policyholder. My recurring payments will be processed on the 6th of each month (including holidays), with the payment due date the first of the month. Members registered for recurring payment will not receive a paper bill in the mail. However, you may view and print your invoice during the recurring payment period from the invoice history online at **www.carefirst.com/myaccount**.

Signature of Account Holder: X_____ Date:_____/_____/_____

SECTION 7. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield (CareFirst) wants to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst health care coverage through email and/or text messaging by providing your email address and/or cell phone number and consent below.

Electronic notices regarding your CareFirst health care coverage include, but are not limited to:

- Explanation of Benefits alerts
- Reminders
- Notice of HIPAA Privacy Practices
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please Note: *you may change your email and consent information* ***anytime*** *by logging into* ***www.carefirst.com/myaccount*** *or by calling the customer service phone number on your ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.*

I understand that to access the information provided electronically through email, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

I understand that to receive notices through text messaging:

- A text messaging plan with my cell phone provider is required; and
- Standard text messaging rates will apply.

By checking below, I hereby agree to electronic delivery of notices, instead of paper delivery by:

- ☐ Email only
- ☐ Cell phone text messaging only
- ☐ Email and cell phone text messaging

Applicant Name	
Email Address	Cell Phone Number

CareFirst BlueCross BlueShield will not sell your email or phone number to any third party and we do not share it with third parties except for CareFirst business associates that perform functions on our behalf or to comply with the law.

SECTION 8. CONDITIONS OF ENROLLMENT (Please Read This Section Carefully)

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Policyholder (or to a person authorized to act on his/her behalf), from CareFirst BlueCross BlueShield (CareFirst).

This information is subject to verification. To do so I authorize any physician, hospital, pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company including MIB, Inc. to release my "Medical Information" to CareFirst's business associates or representatives. I further authorize any business associate who receives "Medical Information" from any physician, hospital pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company including MIB, Inc. to release my "Medical Information" to CareFirst. I understand that my Medical Information consists of any diagnoses, treatment, prescriptions from a pharmacy, or any other medically related information about me. I authorize CareFirst to use my Medical Information for underwriting and to determine my eligibility for insurance benefits. I authorize CareFirst to make a brief report of my protected health information to MIB.

This authorization shall include and apply to any and all protected health information related to treatments where I have requested a restriction to a health care provider to release information and/or for any health care item or service for which I have paid the health care provider in full. I understand this authorization will remain in effect for 30 months from the date signed.

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

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

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for a CareFirst policy. I understand that a medically underwritten policy is only issued under the conditions that the health of the applicant named on the application remains as represented above. This provision is based on the date the policy was issued, and not any time period following the date of issuance. Applicants who are permitted to skip Section 4 of this application are not issued a medically underwritten policy. I also understand that failure to enter accurate, complete and updated medical information may result in the denial of all benefits or cancellation of my policy. (This statement does not apply to applicants who are permitted to skip Section 4 of this application and are issued a policy under the Guaranteed Issue provisions.) CareFirst may rescind or void my coverage only if (1) I have performed an act, practice, or omission that constitutes fraud; or (2) I have made an intentional misrepresentation of material fact. CareFirst will provide 30-days advance written notice of any rescission of coverage and refund any premiums to the Policyholder. The Member is responsible for repayment of any claim payment made by CareFirst on the Member's behalf.

I will update CareFirst if there have been any changes in health concerning the applicant listed in this application that occur prior to acceptance of this application by CareFirst. (This statement does not apply to applicants who are permitted to skip Section 4 of this application and are issued a policy under the Guaranteed Issue provisions.)

If you have any questions concerning the benefits and services that are provided by or excluded under this Policy, please contact a membership services representative before signing this application.

SECTION 8. CONDITIONS OF ENROLLMENT (continued)

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

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

Information regarding your insurability will be treated as confidential. CareFirst or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Regarding MIB: Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in the MIB file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. CareFirst or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

X_____ Date _____/_____/_____

Applicant's Signature (PLEASE DO NOT PRINT)

SECTION 9. RACE, ETHNICITY, LANGUAGE (This information is voluntary)

As required by Maryland law, CareFirst is asking its members to voluntarily provide their race, ethnicity and language attributes. The information provided, while voluntary, will assist the State of Maryland and CareFirst of Maryland to improve quality of care and access to care thereby reducing health care disparities and promote better health outcomes. The information you provide will not have a negative impact on any services we provide you. The information is kept strictly confidential and will not be shared unless required by law to disclose it.

Race
White/Caucasian
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Other – (To include Multi-Racial)
Decline to answer
Unknown – Could not be determined

Ethnicity
Hispanic/Latino/Spanish origin

Preferred Spoken Language*

01 English
02 Albanian
03 Amharic
04 Arabic
05 Burmese
06 Cantonese
07 Chinese (simplified & traditional)
08 Creole (Haitian)
09 Farsi
10 French (European)
11 Greek
12 Gujarati
13 Hindi
14 Italian
15 Korean
16 Mandarin
17 Portuguese (Brazilian)
18 Russian
19 Serbian
20 Somali
21 Spanish (Latin America)
22 Tagalog (Filipino)
23 Urdu
24 Vietnamese
98 Other and unspecified languages
99 Unknown

Race	Ethnicity	Country of Origin

Preferred Spoken Language (*specify number from above):

FOR OFFICE USE ONLY:

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

Signature of Applicant: X_____ Date _____/_____/_____

FOR BROKER USE ONLY:

	Name:	NPN#:	Tax ID #:	CareFirst-Assigned ID#:
Contracted Broker:		[redacted]		
Sub-Agent/ Sub-Agency:				[redacted]
Writing Agent:				

Additional Information

Open Enrollment/Guaranteed Issue Guidelines

I. During an Open Enrollment period, acceptance is guaranteed if the individual:

- Is age 65 or older and enrolled in Medicare Part B within the last six months;
- Turned age 65 in the last six months (member must have Medicare Parts A and B);
- Is under age 65, eligible for Medicare due to a disability, and enrolled in Medicare Part B within the last six months;
- Is under age 65, eligible for Medicare due to a disability, AND has been terminated from the Maryland Health Insurance Plan as a result of enrollment in Medicare Part B within the last six months; or
- At the time of application is within six months from the first day of the month in which he or she first enrolled or will enroll in Medicare Part B.

II. Acceptance may also be guaranteed through other special Guaranteed Issue Enrollment Provisions. If health insurance coverage is lost, the individual may be considered an "Eligible Person" entitled to guaranteed acceptance and may have a guaranteed right to enroll in CareFirst Medicare Supplement Plans under the following circumstances:

A. Supplemental Plan Termination, meaning:

- The individual was enrolled under an employer group health plan or union coverage that pays after Medicare pays (Medicare Supplemental Plan) and the plan is ending or will no longer provide the individual with supplemental health benefits and the coverage was terminated or ceased within the last 63 days;

***A Medicare Health Plan is defined as:**

a) Any Medicare Advantage plan;

b) Any eligible organization under a contract under Section 1876 (Medicare cost);

c) Any similar organization operating under demonstration pro authority;

d) Any PACE provider, under section 1894 of the Social Security Act;

e) Any organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

f) A Medicare Select policy

- The individual got a notice that supplemental health benefits were terminated or ceased within the past 63 days; or
- The individual did NOT get a notice that supplemental health benefits terminated or ceased, BUT within the past 63 days received a notice that a claim was denied because supplemental benefits terminated or ceased.

B. Medicare Health Plan* termination, movement out of service area, violation of contract terms or marketing violations, meaning:

Within the past 63-day period the individual was enrolled under: A Medicare Health Plan* (such as a Medicare Advantage Plan), or was 65 years of age or older and enrolled with a

PACE provider (Program of All Inclusive Care for the Elderly), and one of the following occurs:

i. The plan was terminated, no longer provides or has discontinued to offer coverage in the service area where the individual lives;

ii. The individual lost coverage because of a move out of the plan's service area or experienced other change in circumstances specified by Health and Human Services (NOTE: This does not include failure to pay premiums on a timely basis.);

iii. The individual terminated because he or she can show that the Plan violated the terms of the Plan's contract such as failing to provide timely medically necessary care or in accordance with medical standards;

iv. The individual can show that the Plan or its agent misled them in marketing the Plan; or

v. The certificate of the organization was terminated.

C. Medicare Supplemental Plan involuntary termination, or termination due to a violation of contract terms, or marketing violations, meaning:

Within the past 63-day period the individual was enrolled under a Medicare supplemental policy and the individual's enrollment ended because:

i. Of any involuntary termination of coverage or enrollment under the policy, including plan bankruptcy;

ii. The plan violated the terms of the plan's contract; or

iii. The individual can show that the company or its agent misled them in marketing the plan.

D. Enrollment change from a Medicare Health Plan* to Medicare Supplemental Plan (enrolled in MA less than 12 months), meaning:

- Within the past 63-day period the individual was enrolled under: A Medicare Health Plan* (such as Medicare Advantage or PACE plan), when the individual first enrolled under Medicare Part B at age 65 or older, and within 12 months of enrollment in the Medicare Health Plan* decided to switch back to a Medicare Supplement policy; or
- Within the past 63-day period the individual was enrolled under: A Medicare Supplemental plan that the individual dropped and subsequently enrolled for the first time with a Medicare Health Plan* (such as Medicare Advantage or PACE); and was with the plan less than 12 months and wants to return to a Medicare Supplemental plan.

E. Enrollment termination from Medicare Supplemental plan WITH drug (like Plan I or Plan J) when Part D purchased, meaning:

- Within the past 63-day period the individual was enrolled under: A Medicare Part D plan, and ALSO enrolled under a Medicare Supplement policy that covers outpatient prescription drugs. When the individual enrolled in Medicare Part D, he or she terminated enrollment in the Medicare supplement policy that covered outpatient prescription drug coverage (NOTE: Evidence of enrollment in Medicare Part D must be submitted with this application).

Open Enrollment/Guaranteed Issue Guidelines

F. Loss of employer group or union coverage due to termination of employer group or union plan, and ineligibility for insurance tax credits solely because of Medicare eligibility, meaning:

- Within the past 63-day period the individual was enrolled under: An employer group health plan or union coverage that provides health benefits and the plan terminated; and solely because of your Medicare eligibility, the individual is not eligible for the tax credit for health insurance costs.

IMPORTANT NOTES

- Individuals are required to:
  - Apply within the required time period following the termination of prior health insurance plan.
  - Provide a copy of the termination notice received from the prior insurer with the application. This notice must verify the circumstance of the Plan's termination and describe the individual's right to guaranteed issue of Medicare Supplement Insurance.
- Questions on the guaranteed right to insurance should be directed to the Administrator of the individual's prior health insurance plan or to the local state Department on Aging.

CareFirst's Privacy Practices

Our commitment to our members

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

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

Categories of personal information we may collect

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

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

How your information is used

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

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

Disclosure of your information

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

CareFirst's Privacy Practices

Our commitment to our members

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

Changes in our privacy policy

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

We're here to answer your questions.

If you have any questions about the plans described in this book, or if you'd like assistance, just call 800-275-3802 (in the Baltimore area call 410-356-8123). You'll receive courteous, knowledgeable assistance from one of our dedicated product consultants.

Rights and Responsibilities

Notice of privacy practices

CareFirst BlueCross BlueShield (CareFirst) 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. The notice outlines the uses and disclosures of protected health information, the individual's rights and CareFirst's responsibility for protecting the member's health information.

To obtain an additional copy of our Notice of Privacy Practices, visit **www.carefirst.com** and go to the bottom of the page under Legal & Mandates. Click on *Members Privacy Policy*. Or call the Member Services telephone number on your member ID card.

Member satisfaction

CareFirst wants to hear your concerns and/or complaints so that 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 you can do:

- If your comment or concern is regarding the quality of service received from a CareFirst representative or related to administrative problems (e.g., enrollment, claims, bills, etc.) you should contact Member Services. If you send your comments to us in writing, please include your member ID number and provide us with as much detail as possible regarding any events. Please include your daytime telephone number so that we may contact you directly if we need additional information.
- If your concern or complaint is about the quality of care or quality of service received from a specific provider, contact Member Services. A representative will record your concerns and may request a written summary of the issues. To write to us directly with a quality of care or service concern, you can:
  - Send an email to: **quality.care.complaints@carefirst.com**
  - Fax a written complaint to: 301-470-5866
  - 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 identification number and provide us with as much detail as possible regarding the event or incident. Please include your daytime telephone number so that we may contact you directly if we need additional information. Our Quality of Care Department will investigate your concerns, share those issues with the provider involved and request a response. We will then provide you with a summary of our findings. CareFirst member complaints are retained in our provider files and are reviewed when providers are considered for continuing participation with CareFirst.

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

Maryland

Maryland Insurance Administration
Inquiry and Investigation, Life and Health
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 800-492-6116 or 410-468-2244

Office of Health Care Quality
Spring Grove Center, Bland-Bryant Building
55 Wade Avenue
Catonsville, MD 21228
Phone: 410-402-8016 or 877-402-8218

Rights and Responsibilities

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:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or 877-261-8807
Fax: 410-576-6571
www.oag.state.md.us

Hearing impaired

To contact a Member Services representative, please choose the appropriate hearing impaired assistance number below, based on the region in which your coverage originates.

Maryland Relay Program: 800-735-2258
National Capital Area TTY: 202-479-3546.
Please have your Member Services number ready.

Language assistance

Interpreter services are available through Member Services. When calling Member Services, inform the representative that you need language assistance.

Note: CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

Confidentiality of subscriber/ member information

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 or your health plan, and from your providers as well, when you visit their office.

CareFirst has policies and procedures in place to protect the confidentiality of member information. Your confidential information includes Protected Health Information (PHI), whether oral, written or electronic, 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 for these purposes. 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 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 treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We may disclose your protected health information to the plan sponsor/employer to perform plan administration function. The Notice is sent to all policy holders upon enrollment.

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 some reasons other than treatment, payment, or health care operations.
- Give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice.

Inquiries and complaints

If you have a privacy-related inquiry, please contact the CareFirst Privacy Office at 800-853-9236 or send an email to: **privacy.office@carefirst.com**.

Members' rights and responsibilities statement

Members have the 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.

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.
- Decline participation or disenroll from wellness and health promotion services offered by the organization.
- Be treated courteously and respectfully by the organization's staff.
- 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.

Compensation and Premium Disclosure Statement

Our compensation to providers who offer health care services and behavioral health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your physician, please call our Member Services Department at the number listed on your identification card, or write to:

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559
Attention: Member Services

A. Methods of paying physicians

The following definitions explain how insurance carriers may pay physicians (or other providers) for your health care services.

The examples show how Dr. Jones, an obstetrician/gynecologist, would be compensated under each method of payment.

Salary: A physician (or other provider) is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services.

Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing prenatal care to Mrs. Smith, who is a member of the HMO, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have an effect upon Dr. Jones' salary.

Capitation: A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires.

Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.

Fee-for-service: A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder.

Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.

Compensation and Premium Disclosure Statement

Discounted fee-for-service: Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician (or other provider), who usually gets an increased volume of patients.

Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or HMO.

Bonus: A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.

An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.

Case rate: The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care.

This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.

B. Percentage of provider payment methods

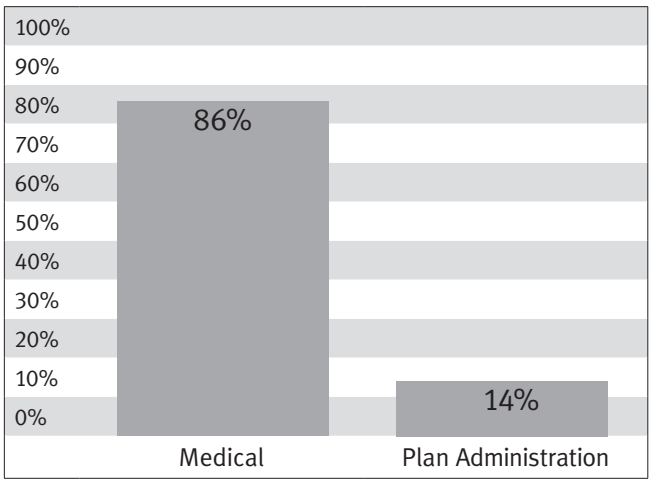
For its Indemnity and Preferred Provider Organization (PPO) products, CareFirst of Maryland, Inc. contracts directly with physicians. All physicians are reimbursed on a discounted fee-for-service basis.

C. Distribution of premium dollars

The bar graph below illustrates the proportion of every $100 in premium used by CareFirst of Maryland, Inc. to pay physicians (or other providers) for medical care expenses, and the proportion used to pay for plan administration.

These numbers represent an average for all HMO accounts based on our annual statement. The ratio of direct medical care expenses to plan administration will vary by account.

The composite distribution presented in this disclosure is presented pursuant to the requirements of Maryland law, and may differ from calculations of federal medical loss ratio for a carrier in a particular market under the requirements of the Patient Protection and Affordable Care Act, based on accounting differences in the formulae used.



Compensation and Premium Disclosure Statement

Our compensation to providers who offer health care services and behavioral health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your physician, please call our Member Services Department at the number listed on your identification card, or write to:

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
Attention: Member Services

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Capitation: A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires.

Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.

Fee-for-service: A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder.

Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.

Discounted fee-for-service: Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure,

or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician (or other provider), who usually gets an increased volume of patients.

Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or HMO.

Bonus: A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.

An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.

Case rate: The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care.

This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.

B. Percentage of provider payment methods

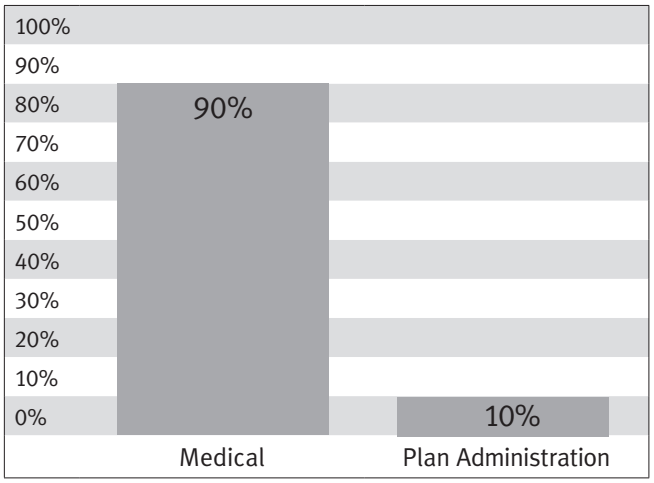
For its Indemnity and Preferred Provider Organization (PPO) products, CareFirst BlueCross BlueShield contracts directly with physicians. All physicians are reimbursed on a discounted fee-for-service basis.

C. Distribution of premium dollars

The bar graph below illustrates the proportion of every $100 in premium used by CareFirst BlueCross BlueShield to pay physicians (or other providers) for medical care expenses, and the proportion used to pay for plan administration.

These numbers represent an average for all indemnity accounts based on our annual statement. The ratio of direct medical care expenses to plan administration will vary by account.

The composite distribution presented in this disclosure is presented pursuant to the requirements of Maryland law, and may differ from calculations of federal medical loss ratio for a carrier in a particular market under the requirements of the Patient Protection and Affordable Care Act, based on accounting differences in the formulae used.



Compensation and Premium Disclosure Statement

Our compensation to providers who offer health care services and behavioral health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your physician, please call our Member Services Department at the number listed on your identification card, or write to:

The Dental Network, Inc.
10455 Mill Run Circle
Owings Mills, MD 21117
Attention: Member Services

A. Methods of paying physicians

The following definitions explain how insurance carriers may pay physicians (or other providers) for your health care services.

The examples show how Dr. Jones, an obstetrician/gynecologist, would be compensated under each method of payment.

Salary: A physician (or other provider) is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services.

Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing prenatal care to Mrs. Smith, who is a member of the HMO, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have an effect upon Dr. Jones' salary.

Capitation: A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires.

Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.

Fee-for-service: A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder.

Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.

Discounted fee-for-service: Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower

costs and the physician (or other provider), who usually gets an increased volume of patients.

Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or HMO.

Bonus: A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.

An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.

Case rate: The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care.

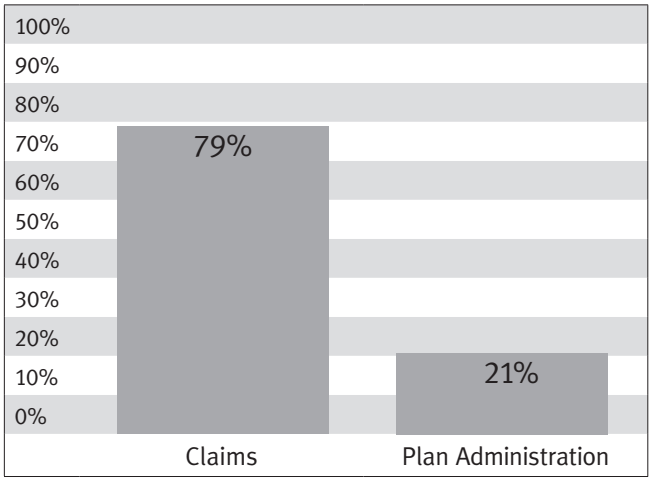
This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.

B. Percentage of provider payment methods

TDN utilizes the following methods of paying physicians (dentists) who render health care (dental) services to our enrollees: capitation, fee-for-service, and discounted fee-for-service.

C. Distribution of premium dollars

The bar graph below illustrates the proportion of every $100 in premium used by The Dental Network, Inc. to pay providers (dentists) for medical care (dental care) expenses, and the proportion used to pay for plan administration. The provider payment method percentages for TDN are approximately 47% discounted fee-for-service and approximately 53% capitated.



Policy Form Numbers

The benefits described are issued under policies:
CFMI/MG PLAN A (6/10) • CFMI/MG PLAN B (6/10) • CFMI/MG PLAN F (6/10) • CFMI/MG PLAN G (2/12) CFMI/MG PLAN L (2/12) • CFMI/MG PLAN M (2/12) • CFMI/MG PLAN N (6/10) • CFMI/MG PLAN HI DED F (6/10) MD/CF/MG PLAN G (2/12) • MD/CF/MG PLAN L (2/12) • MD/CF/MG PLAN M (2/12) • CFMI/2010 PLAN HI F SOB (6/10) • MDSUPPAPP (8/12) • MD/CF/MG PLAN A (6/10) • MD/CF/MG PLAN B (6/10) • MD/CF/MG PLAN F (6/10) • MD/CF/MG PLAN N (6/10) • MD/CF/MG PLAN HI DED F (6/10) • MD/CF/2010 PLAN HI F SOB (6/10) MDSUPPAPP (8/12) as amended

BlueVision Plan:
Legal entity CareFirst of Maryland, Inc.; policy #: CFMI/BLUEVISION (R. 1/06) and any amendments

Legal entity Group Hospitalization and Medical Services, Inc.; policy #: GHMSI BlueVision (R. 1/06) and any amendments

Individual Select Dental HMO:
FORM DN001C (R. 1/10) • FORM DN4001 (R. 1/10) • MD/TDN/DB/DEPENDENT AGE (9/10) TDN – DISCLOSURE 10/12 • MD/TDN/DOL APPEAL (R. 9/11) and any amendments

Individual Select Preferred Dental Plus:
MD GHMSI/DB/ISPP DOCS (10/11) • MD GHMSI/DB/ISPP IEA (10/11) • MD/GHMSI/DB/DENT/ES (10/11) MD/GHMSI/ISPP/AMEND (2/12) and any amendments

CFMI/DB/ISPP DOCS (10/11) • CFMI/DB/ISPP IEA (10/11) • MD/CFMI/DB/DENT/ES (2/12) MD/CFMI/ISPP/AMEND (2/12) and any amendments

Individual Select Preferred Dental:
MD/GHMSI/DB/IEA-DENTAL (2/08) • MD/GHMSI/DB/DOCS-DENTAL (2/08) • MD/GHMSI/DB/ES-DENTAL (2/08) MD/GHMSI/DOL APPEAL (R. 9/11) • MD/GHMSI/DB/PARTNER (12/08) • MD/CF/DB/DEPENDENT AGE (9/10) GHMSI-DISCLOSURE (10/12) • MD NCA – HEALTH GUARANTY (10/12) and any amendments

BlueDental Preferred:
Legal Entity CareFirst of Maryland, Inc.: CFMI/DEN/IEA (1/14) • CFMI/DB/PREF DENT DOCS-SOB (R. 1/15) CFMI/DB/2015 DENTAL AMEND (1/15) • CFMI/DEN/IEA (1/14) • CFMI/DB/PREF DENT DOCS-SOB LOW (1/15) CFMI/DB/2015 DENTAL AMEND (1/15) and any amendments

Legal Entity Group Hospitalization and Medical Services, Inc.: MD/CF/DEN/IEA (1/14) • MD/CF/DB/PREF DENT DOCS-SOB (R. 1/15) • MD/CF/DB/2015 DENTAL AMEND (1/15) • MD/CF/DEN/IEA (1/14) • MD/CF/DB/PREF DENT DOCS-SOB LOW (1/15) • MD/CF/DB/2015 DENTAL AMEND (1/15) and any amendments

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

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

Offered by CareFirst of Maryland, Inc.*, d/b/a CareFirst BlueCross BlueShield, 10455 Mill Run Circle, Owings Mills, Maryland 21117-5559. Offered by Group Hospitalization and Medical Services, Inc.*, d/b/a CareFirst BlueCross BlueShield, 840 First Street, NE, Washington, DC 20065. A not-for-profit health service plan.

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

CareFirst of Maryland, Inc.
10455 Mill Run Circle
Owings Mills, Maryland 21117

A not-for-profit health service plan incorporated under the laws of the State of Maryland.

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

www.carefirst.com

If you reside in either Prince George's or Montgomery County, then a Group Hospitalization and Medical Services, Inc. policy will be issued. For Baltimore City and all other counties in the state of Maryland, a CareFirst of Maryland, Inc. policy will be issued.

CDS1125-1P (6/15)