# Maryland/Virginia Consumer Health Benefits 2016

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ElueChoice HMO         /isit www.carefirst.com/bluerew         Individual: \$6,550         Family: \$13,100         Individual: \$6,550         Family: \$13,100         No charge, no deductible         No charge after deductible	BlueChoice HMO HSA Silver \$1,350 HMO <sup>7</sup> BlueChoice HMO BlueChoice HMO Individual: \$1,350 Family: \$2,700 Individual: \$1,350 Family: \$2,700 Individual: \$6,550 Family: \$13,100 No charge, no deductible \$30 copay after deductible \$40 copay after deductible	BluePreferred PPO         PPO'         BluePreferred         BluePreferred         In-Network         Individual: \$1,600         Family: \$3,200         Individual: \$1,600         Family: \$3,200         Individual: \$6,550         Family: \$13,100         V         Individual: \$1,600         \$300 copay after deductible         \$40 copay after deductible         \$300 copay after deductible         \$40 copay after deductible         \$40 copay after deductible         \$40 copay after deductible	No charge, no deductible \$60 copay, no deductible	BlueChoice Plus         FOSP         BlueChoice Plus         BlueChoice Plus         BlueChoice Plus         Individual: \$2,500         Family: \$5,000         Individual: \$2,500         Family: \$5,000         Individual: \$2,500         Family: \$5,000         Individual: \$6,850         Family: \$13,700         V         No charge, no deductible         \$30 copay, no deductible         \$40 copay after deductible         \$100 copay after deductible         \$30 copay, no deductible         \$30 copay, no deductible	HealthyBlue HMO         Gold \$250         HMO'         HealthyBlue HMO         HealthyBlue HMO         In-Network         Individual: \$250         Family: \$500         Individual: \$250         Family: \$500         Individual: \$6,850         Family: \$13,700         No charge, no deductible         \$30 copay, no deductible         \$75 copay after deductible         No charge, no deductible         \$50 copay, no deductible         \$50 copay, no deductible	HealthyBlue PPO         Gold \$500         PPO'         HealthyBlue PPO         HealthyBlue PPO         Individual: \$500         Family: \$1,000         Individual: \$6,850         Family: \$13,700         No charge, no deductible         \$30 copay, no deductible         \$75 copay after deductible         No charge, no deductible         \$75 copay, no deductible         \$50 copay, no deductible	HealthyBlue Plus Gold \$750         POS <sup>3</sup> HealthyBlue Plus         Individual: \$750 Family: \$1,500         Individual: \$750 Family: \$1,500         Individual: \$4,000 Family: \$8,000         No charge, no deductible         Individual: \$4,000 Family: \$8,000         No charge, no deductible         \$30 copay, no deductible         \$75 copay after deductible         No charge, no deductible         \$50 copay, no deductible	HealthyBlue HMO         Gold \$1,000         HMO'         HealthyBlue HMO         HealthyBlue HMO         Individual: \$1,000         Family: \$2,000         Individual: \$1,000         Family: \$2,000         Individual: \$4,500         Family: \$9,000         No charge, no deductible         \$30 copay, no deductible         \$75 copay after deductible         No charge, no deductible         \$75 copay after deductible         \$50 copay, no deductible	BlueChoice F Young Adu \$6,850 HMO <sup>3</sup> BlueChoice Young In-Network Individual: \$6,8 Family: \$13,70 Individual: \$6,8 Family: \$13,70 Individual: \$6,8 Family: \$13,70 No charge, no dedu Visits 1–3: No char no deductible Visits 1–3: No char ge after ded No charge after ded No charge after ded No charge after ded
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Patient First, ExpressCare) ergency Room spital charge—copays are waived ou are admitted) XGNOSTIC SERVICES ays <sup>6</sup> Office/Non-Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital	Earn \$150 per adult and up to a         In-Network         Individual: \$4,500         Family: \$13,100         Individual: \$6,550         Family: \$13,100         Family: \$13,100         No charge, no deductible         \$25 copay after deductible         \$100 copay after deductible         \$25 copay after deductible         \$20 copay after deductible         \$2100 copay after deductible         \$2100 copay after deductible <td>a \$400 maximum per family to Individual: \$5,500 Family: \$11,000 Individual: \$6,850 Family: \$13,700 No charge, no deductible Visits 1–24: \$25 copay, no deductible Visits 3+: \$25 copay after deductible \$100 copay after deductible Visits 1–2: \$25 copay, no deductible \$100 copay after deductible \$100 copay after deductible \$100 copay after deductible \$300 copay after deductible \$300 copay after deductible \$100 copay after deductible \$100 copay after deductible \$100 copay after deductible</td> <td>In-Network         Individual: \$6,000         Family: \$12,000         Individual: \$6,000         Family: \$12,000         No charge, no deductible         No charge after deductible</td> <td>/isit www.carefirst.com/bluerew In-Network Individual: \$6,550 Family: \$13,100 Individual: \$6,550 Family: \$13,100 No charge, no deductible No charge after deductible</td> <td>ards for more information. 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<ul> <li>PCP visits: The lowest copays and the best option for consistent, quality care.</li> <li>Caution: Services on a hospital campus may incur a separate hospital charge.</li> <li>Retail health clinics: Low copays and after-hours care for minor health concerns.</li> <li>Caution - Emergency room: Highest out-of-pocket costs; explore other options for non-emergency care.</li> <li>Labs/X-rays/Imaging: Use non-hospital facilities for the lowest copays.</li> <li>Labs/X-rays/Imaging: 11</li> <li>Labs/X-rays/Imaging: 13</li> <li>Labs/X-rays/Imaging: 14</li> <li>Labs/X-rays/Imaging: 14</li> <li>Labs/X-rays/Imaging: 14</li> <li>Labs/X-rays/Imaging: 15</li> <li>Caution: These services will cost more if performed in a hospital.</li> <li>14</li> <li>15</li> <li>14</li> <li>14</li> <li>14</li> <li>15</li> <li>14</li> <li>15</li> </ul>	ductible* t-of-Pocket Maximum7 EVENTIVE SERVICES eventive Care (e.g. adult physical, ll-child care, cancer screenings) IMARY CARE AND SPECIALIST SERVICES IMARY CARE AND SPECIALIST SERVICES mary Care Provider (PCP) Visits— ice/Non-Hospital (non-preventive) ecialist Visits—Office/Non-Hospital SPITAL CHARGE—Add this charge if your mary care or specialist visit takes place in a spital setting TAIL CLINICS, URGENT AND IERGENCY SERVICES nvenience Care/Retail Health Clinics g. CVS MinuteClinic, Rite Aid RediClinic) gent Care Center g. Patient First, ExpressCare) ergency Room spital charge—copays are waived ou are admitted) XGNOSTIC SERVICES ays <sup>6</sup> Office/Non-Hospital Office/Non-Hospit	Individual: \$4,500 Family: \$9,000Individual: \$6,550 Family: \$13,100Individual: \$6,550 Family: \$13,100INo charge, no deductibleI\$25 copay after deductibleI\$50 copay after deductibleI\$100 copay after deductibleI\$25 copay after deductibleI\$300 copay after deductibleI\$25 copay after deductibleI\$25 copay after deductibleI\$25 copay after deductibleI\$100	Individual: \$5,500 Family: \$11,000 Individual: \$6,850 Family: \$13,700 No charge, no deductible Visits 1–24: \$25 copay, no deductible Visits 3+: \$25 copay after deductible \$50 copay after deductible \$100 copay after deductible Visits 1–2: \$25 copay, no deductible Visits 3+: \$25 copay after deductible \$300 copay after deductible \$300 copay after deductible \$25 copay, no deductible (LabCorp only)	Individual: \$6,000 Family: \$12,000 Individual: \$6,000 Family: \$12,000 No charge, no deductible No charge after deductible	Individual: \$6,550 Family: \$13,100 Individual: \$6,550 Family: \$13,100 No charge, no deductible No charge after deductible	Individual: \$1,350 Family: \$2,700 Individual: \$6,550 Family: \$13,100 No charge, no deductible \$30 copay after deductible \$40 copay after deductible \$100 copay after deductible \$30 copay after deductible	Individual: \$1,600         Family: \$3,200         Individual: \$6,550         Family: \$13,100         No charge, no deductible         \$30 copay after deductible         \$40 copay after deductible         30% coinsurance after deductible         \$30 copay after deductible	Individual: \$2,000 Family: \$4,000 Individual: \$6,850 Family: \$13,700 No charge, no deductible \$50 copay, no deductible \$100 copay after deductible No charge, no deductible \$100 copay, no deductible	Individual: \$2,500 Family: \$5,000 Individual: \$6,850 Family: \$13,700 No charge, no deductible \$30 copay, no deductible \$40 copay, no deductible \$40 copay after deductible \$30 copay, no deductible \$30 copay, no deductible	Individual: \$250 Family: \$500 Individual: \$6,850 Family: \$13,700 No charge, no deductible %30 copay, no deductible \$30 copay, no deductible %75 copay after deductible	Individual: \$500 Family: \$1,000 Individual: \$6,850 Family: \$13,700 No charge, no deductible \$30 copay, no deductible \$75 copay after deductible No charge, no deductible	Individual: \$750 Family: \$1,500 Individual: \$4,000 Family: \$8,000 No charge, no deductible \$30 copay, no deductible \$75 copay after deductible No charge, no deductible	Individual: \$1,000 Family: \$2,000 Individual: \$4,500 Family: \$9,000 No charge, no deductible \$30 copay, no deductible \$30 copay, no deductible \$75 copay after deductible	Individual: \$6 Family: \$13, Individual: \$6 Family: \$13, No charge, no de Visits 1–3: No c no deductib Visits 4+: No cha deductibl No charge after de No charge after de
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Patient First, ExpressCare) ergency Room spital charge—copays are waived ou are admitted)  AGNOSTIC SERVICES  ps <sup>8</sup> Office/Non-Hospital	\$25 copay after deductible       I         \$50 copay after deductible       I         \$50 copay after deductible       I         \$100 copay after deductible       I         \$25 copay after deductible       I         \$25 copay after deductible       I         \$300 copay after deductible       I         \$25 copay after deductible       I         \$25 copay after deductible       I         \$100 copay after deductible       I <td>Visits 1–24: \$25 copay, no deductible Visits 3+: \$25 copay after deductible \$50 copay after deductible \$100 copay after deductible Visits 1–2: \$25 copay, no deductible Visits 3+: \$25 copay after deductible \$75 copay, no deductible \$300 copay after deductible \$25 copay, no deductible \$100 copay after deductible</td> <td>No charge after deductible No charge after deductible</td> <td>No charge after deductible         No charge after deductible</td> <td>\$30 copay after deductible \$40 copay after deductible \$100 copay after deductible \$30 copay after deductible \$60 copay after deductible</td> <td><ul> <li>\$30 copay after deductible</li> <li>\$40 copay after deductible</li> <li>30% coinsurance after deductible</li> <li>\$30 copay after deductible</li> <li>\$30 copay after deductible</li> <li>\$60 copay after deductible</li> <li>30% coinsurance after</li> </ul></td> <td>No charge, no deductible \$50 copay, no deductible \$100 copay after deductible No charge, no deductible \$60 copay, no deductible</td> <td>\$30 copay, no deductible \$40 copay, no deductible \$100 copay after deductible \$30 copay, no deductible \$60 copay, no deductible</td> <td>No charge, no deductible \$30 copay, no deductible \$75 copay after deductible No charge, no deductible</td> <td>No charge, no deductible \$30 copay, no deductible \$75 copay after deductible No charge, no deductible</td> <td>No charge, no deductible \$30 copay, no deductible \$75 copay after deductible No charge, no deductible</td> <td>No charge, no deductible \$30 copay, no deductible \$75 copay after deductible No charge, no deductible</td> <td>Visits 1–3: No no deducti Visits 4+: No ch deductit No charge after o No charge after o No charge after o</td>	Visits 1–24: \$25 copay, no deductible Visits 3+: \$25 copay after deductible \$50 copay after deductible \$100 copay after deductible Visits 1–2: \$25 copay, no deductible Visits 3+: \$25 copay after deductible \$75 copay, no deductible \$300 copay after deductible \$25 copay, no deductible \$100 copay after deductible	No charge after deductible	No charge after deductible	\$30 copay after deductible \$40 copay after deductible \$100 copay after deductible \$30 copay after deductible \$60 copay after deductible	<ul> <li>\$30 copay after deductible</li> <li>\$40 copay after deductible</li> <li>30% coinsurance after deductible</li> <li>\$30 copay after deductible</li> <li>\$30 copay after deductible</li> <li>\$60 copay after deductible</li> <li>30% coinsurance after</li> </ul>	No charge, no deductible \$50 copay, no deductible \$100 copay after deductible No charge, no deductible \$60 copay, no deductible	\$30 copay, no deductible \$40 copay, no deductible \$100 copay after deductible \$30 copay, no deductible \$60 copay, no deductible	No charge, no deductible \$30 copay, no deductible \$75 copay after deductible No charge, no deductible	No charge, no deductible \$30 copay, no deductible \$75 copay after deductible No charge, no deductible	No charge, no deductible \$30 copay, no deductible \$75 copay after deductible No charge, no deductible	No charge, no deductible \$30 copay, no deductible \$75 copay after deductible No charge, no deductible	Visits 1–3: No no deducti Visits 4+: No ch deductit No charge after o No charge after o No charge after o
PCP visits: The lowest copays and the best option for consistent, quality care.4Primary Office/NCaution: Services on a hospital campus may incur a separate hospital charge.5Specialla HOSPITA Primary hospital GRetail health clinics: Low copays and after-hours care for minor health concerns.7Conventi (e.g. CVS)Retail health clinics: Low copays and after-hours care for minor health concerns.7Conventi (e.g. CVS)Bighest out-of-pocket costs; explore other options for non-emergency care.9Urgent Cl (e.g. Pat (mospital for the lowest copays.Labs/X-rays/Imaging: Use non-hospital facilities for the lowest copays.10Labs*Caution: These services will cost more if performed in a hospital.13X-rays*14Imaging (tal Scan14Imaging	mary Care Provider (PCP) Visits— fice/Non-Hospital (non-preventive) ecialist Visits—Office/Non-Hospital SPITAL CHARGE—Add this charge if your mary care or specialist visit takes place in a spital setting TAIL CLINICS, URGENT AND IERGENCY SERVICES nvenience Care/Retail Health Clinics g. CVS MinuteClinic, Rite Aid RediClinic) gent Care Center g. Patient First, ExpressCare) ergency Room ospital charge—copays are waived ou are admitted) AGNOSTIC SERVICES ps <sup>8</sup> Office/Non-Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital Office /Non-Hospital	\$50 copay after deductible       2         \$50 copay after deductible       2         \$100 copay after deductible       2         \$25 copay after deductible       2         \$300 copay after deductible       2         \$25 copay after deductible       2         \$300 copay after deductible       2         \$25 copay after deductible       2         \$25 copay after deductible       2         \$25 copay after deductible       2         \$100 copay after deductible       2         \$100 copay after deductible       2         \$100 copay after deductible       3         \$100 copay after deductible       3         \$100 copay after deductible       3	no deductible Visits 3+: \$25 copay after deductible \$50 copay after deductible \$100 copay after deductible Visits 1-2: \$25 copay, no deductible Visits 3+: \$25 copay after deductible \$75 copay, no deductible \$300 copay after deductible (LabCorp only) \$100 copay after deductible <sup>5</sup>	No charge after deductible	No charge after deductible	\$40 copay after deductible \$100 copay after deductible \$30 copay after deductible \$60 copay after deductible	\$40 copay after deductible 30% coinsurance after deductible \$30 copay after deductible \$60 copay after deductible 30% coinsurance after	\$50 copay, no deductible \$100 copay after deductible No charge, no deductible \$60 copay, no deductible	\$40 copay, no deductible \$100 copay after deductible \$30 copay, no deductible \$60 copay, no deductible	\$30 copay, no deductible \$75 copay after deductible No charge, no deductible	\$30 copay, no deductible \$75 copay after deductible No charge, no deductible	\$30 copay, no deductible \$75 copay after deductible No charge, no deductible	\$30 copay, no deductible \$75 copay after deductible No charge, no deductible	no deduct Visits 4+: No ch deductil No charge after No charge after
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<ul> <li>separate hospital charge.</li> <li>formary hospital RETAIL C EMERGE</li> <li>Retail health clinics: Low copays and after-hours care for minor health concerns.</li> <li>Caution – Emergency room: Highest out-of-pocket costs; explore other options for non-emergency care.</li> <li>g</li> <li>Labs/X-rays/Imaging: Use non-hospital facilities for the lowest copays.</li> <li>Caution: These services will cost more if performed in a hospital.</li> <li>14</li> <li>Imaging (5)</li> </ul>	mary care or specialist visit takes place in a spital setting TAIL CLINICS, URGENT AND IERGENCY SERVICES  nvenience Care/Retail Health Clinics g, CVS MinuteClinic, Rite Aid RediClinic)  gent Care Center g, Patient First, ExpressCare) ergency Room ospital charge—copays are waived ou are admitted)  NGNOSTIC SERVICES  SS <sup>8</sup> Office/Non-Hospital Outpatient Hospital Outpatient Hospital Office /Non-Hospital Office /Non-Hospital Office /Non-Hospital Office /Non-Hospital Office /Non-Hospital Office /Non-Hospital	\$25 copay after deductible \$75 copay after deductible \$300 copay after deductible \$25 copay after deductible \$25 copay after deductible \$100 copay after deductible	Visits 1–2: \$25 copay, no deductible Visits 3+: \$25 copay after deductible \$75 copay, no deductible \$300 copay after deductible \$25 copay, no deductible (LabCorp only) \$100 copay after deductible <sup>5</sup>	No charge after deductible No charge after deductible No charge after deductible No charge after deductible LabCorp only	No charge after deductible No charge after deductible No charge after deductible No charge after deductible	\$30 copay after deductible \$60 copay after deductible	deductible       \$30 copay after deductible       \$60 copay after deductible       30% coinsurance after	No charge, no deductible \$60 copay, no deductible	\$30 copay, no deductible \$60 copay, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge after
Retail health clinics: Low copays and after-hours care for minor health concerns.       7       Convenie (e.g. CVS)         Caution – Emergency room: Highest out-of-pocket costs; explore other options for non-emergency care.       9       Urgent O (e.g. Pat Emergen (hospital for the lowest copays).         Labs/X-rays/Imaging: Use non-hospital facilities for the lowest copays.       10       Labs*         Caution: These services will cost more if performed in a hospital.       12       X-rays*	TAIL CLINICS, URGENT AND LERGENCY SERVICES Invenience Care/Retail Health Clinics g. CVS MinuteClinic, Rite Aid RediClinic) gent Care Center g. Patient First, ExpressCare) ergency Room Ispital charge – copays are waived ou are admitted) AGNOSTIC SERVICES DS <sup>6</sup> Office/Non-Hospital Office/Non-Hospital Outpatient Hospital Office /Non-Hospital Office /Non-Hospital Office /Non-Hospital	\$75 copay after deductible \$300 copay after deductible \$25 copay after deductible \$100 copay after deductible \$100 copay after deductible	no deductible Visits 3+: \$25 copay after deductible \$75 copay, no deductible \$300 copay after deductible \$25 copay, no deductible (LabCorp only) \$100 copay after deductible <sup>5</sup>	No charge after deductible No charge after deductible No charge after deductible (LabCorp only)	No charge after deductible No charge after deductible No charge after deductible	\$60 copay after deductible	\$60 copay after deductible 30% coinsurance after	\$60 copay, no deductible	\$60 copay, no deductible					
Retail health clinics: Low copays and after-hours care for minor health concerns.       7       Convenie (e.g. CVS         Caution – Emergency room: Highest out-of-pocket costs; explore other options for non-emergency care.       8       Urgent Cl (e.g. Pat 9         9       9       DiAGNO         Labs/X-rays/Imaging: Use non-hospital facilities for the lowest copays.       10       Labs*         11       12       X-rays*         13       X-rays*       14         14       Imaging (15)       Imaging	ays <sup>8</sup> Orffice/Non-Hospital Office/Non-Hospital	\$75 copay after deductible \$300 copay after deductible \$25 copay after deductible \$100 copay after deductible \$100 copay after deductible	no deductible Visits 3+: \$25 copay after deductible \$75 copay, no deductible \$300 copay after deductible \$25 copay, no deductible (LabCorp only) \$100 copay after deductible <sup>5</sup>	No charge after deductible No charge after deductible No charge after deductible (LabCorp only)	No charge after deductible No charge after deductible No charge after deductible	\$60 copay after deductible	\$60 copay after deductible 30% coinsurance after	\$60 copay, no deductible	\$60 copay, no deductible					
for minor health concerns. Caution – Emergency room: Highest out-of-pocket costs; explore other options for non-emergency care. 9 Use non-hospital facilities for the lowest copays. Caution: These services will cost more if performed in a hospital. 14 Imaging 15 (*,g. Pat 8 Urgent C (*,g. Pat 10 Labs <sup>4</sup> 11 Labs <sup>4</sup> 12 X-rays <sup>4</sup> 13	g. CVS MinuteClinic, Rite Aid RediClinic)  gent Care Center g. Patient First, ExpressCare) ergency Room spital charge – copays are waived ou are admitted)  AGNOSTIC SERVICES  25 <sup>6</sup> ays <sup>6</sup> Grifice/Non-Hospital Office/Non-Hospital Outpatient Hospital Outpatient Hospital Office/Non-Hospital Office/Non-Hospital Office/Non-Hospital Office/Non-Hospital Office/Non-Hospital	\$75 copay after deductible \$300 copay after deductible \$25 copay after deductible \$100 copay after deductible \$100 copay after deductible	Visits 3+: \$25 copay after deductible \$75 copay, no deductible \$300 copay after deductible \$25 copay, no deductible (LabCorp only) \$100 copay after deductible <sup>5</sup>	No charge after deductible No charge after deductible No charge after deductible (LabCorp only)	No charge after deductible No charge after deductible No charge after deductible	\$60 copay after deductible	\$60 copay after deductible 30% coinsurance after	\$60 copay, no deductible	\$60 copay, no deductible					
Highest out-of-pocket costs; explore other options for non-emergency care.       8       digent deg. Pat         9       Imaging:       9         Labs/X-rays/Imaging:       10       DIAGNO         Use non-hospital facilities for the lowest copays.       10       Labs*         Caution: These services will cost more if performed in a hospital.       12       X-rays*         14       Imaging (15)       14	2. Patient First, ExpressCare) ergency Room spital charge – copays are waived ou are admitted) AGNOSTIC SERVICES DS <sup>6</sup> Office/Non-Hospital Office/Non-Hospital Outpatient Hospital Outpatient Hospital Office/Non-Hospital	\$300 copay after deductible \$25 copay after deductible \$100 copay after deductible \$100 copay after deductible	\$75 copay, no deductible \$300 copay after deductible \$25 copay, no deductible (LabCorp only) \$100 copay after deductible <sup>5</sup>	No charge after deductible No charge after deductible (LabCorp only)	No charge after deductible No charge after deductible		30% coinsurance after			\$50 copay, no deductible	\$50 copay, no deductible	\$50 copay, no deductible	\$50 copay, no deductible	No charge after
explore other options for non-emergency care. 9 Labs/X-rays/Imaging: Use non-hospital facilities for the lowest copays. Caution: These services will cost more if performed in a hospital. 14 Imaging 15 Labs <sup>a</sup> 14 Imaging 15	ergency Room opital charge copays are waived ou are admitted) AGNOSTIC SERVICES Office/Non-Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital	\$300 copay after deductible \$25 copay after deductible \$100 copay after deductible \$100 copay after deductible	\$300 copay after deductible \$25 copay, no deductible (LabCorp only) \$100 copay after deductible <sup>5</sup>	No charge after deductible No charge after deductible (LabCorp only)	No charge after deductible No charge after deductible		30% coinsurance after			\$50 copuy, no deddetible	\$90 copay, no acquetiste	\$50 copuy, no acquetible	\$90 copay, no acqueible	no charge after
Labs/X-rays/Imaging: Use non-hospital facilities for the lowest copays. Caution: These services will cost more if performed in a hospital. (1) (10) (10) (10) (12) (12) (13) (13) (14) (14) (15) (14) (15) (15) (14) (15) (15) (16) (16) (16) (16) (16) (16) (16) (16	ou are admitted) AGNOSTIC SERVICES DS <sup>6</sup> Office/Non-Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital	\$25 copay after deductible \$100 copay after deductible \$100 copay after deductible	\$25 copay, no deductible (LabCorp only) \$100 copay after deductible <sup>5</sup>	No charge after deductible (LabCorp only)	No charge after deductible	\$300 copay after deductible		\$200 consulation doductible						
Labs/X-rays/Imaging:       10         Use non-hospital facilities for the lowest copays.       11         Caution: These services will cost more if performed in a hospital.       12         13       X-rays <sup>8</sup> 14       Imaging Cat Scan         15       Cat Scan	os <sup>e</sup> Office/Non-Hospital Outpatient Hospital Office/Non-Hospital Outpatient Hospital	\$100 copay after deductible \$100 copay after deductible	(LabCorp only) \$100 copay after deductible <sup>5</sup>	(LabCorp only)				\$500 copay after deductible	\$300 copay after deductible	\$300 copay after deductible	\$300 copay after deductible	\$300 copay after deductible	\$300 copay after deductible	No charge after
Luse non-hospital facilities for the lowest copays.       11       Labs*         Caution: These services will cost more if performed in a hospital.       12       X-rays*         14       Imaging Cat Scan	os <sup>a</sup> Outpatient Hospital Office/Non-Hospital Outpatient Hospital Office/Non-Hospital	\$100 copay after deductible \$100 copay after deductible	(LabCorp only) \$100 copay after deductible <sup>5</sup>	(LabCorp only)										
for the lowest copays. Caution: These services will cost more if performed in a hospital. 11 12 13 X-rays <sup>8</sup> 13 14 Imaging 15	ays <sup>e</sup> Office/Non-Hospital Outpatient Hospital Office/Non-Hospital	\$100 copay after deductible		No charge after deductible <sup>5</sup>	(Labcorp only)	\$25 copay after deductible (LabCorp only)	\$25 copay after deductible	\$25 copay, no deductible (LabCorp only)	\$25 copay, no deductible (LabCorp only)	\$15 copay, no deductible (LabCorp only)	\$15 copay, no deductible	No charge, no deductible (LabCorp only)	\$15 copay, no deductible (LabCorp only)	No charge after (LabCorp
cost more if performed in a hospital. 13 14 14 15 X-rays <sup>b</sup> Imaging Cat Scan	ays <sup>a</sup> Outpatient Hospital Office /Non-Hospital		\$100 copay, no deductible		No charge after deductible⁵	\$90 copay after deductible <sup>5</sup>	30% coinsurance after deductible	\$90 copay after deductible⁵	\$90 copay after deductible⁵	\$60 copay after deductible⁵	\$60 copay after deductible	\$60 copay after deductible⁵	\$60 copay after deductible⁵	No charge after
hospital. (13) A logs (14) (14) (14) (15) Cat Scar	Office /Non-Hospital	\$150 copay after deductible		No charge after deductible	No charge after deductible	\$55 copay after deductible	\$55 copay after deductible	\$55 copay, no deductible	\$55 copay, no deductible	\$65 copay, no deductible	\$65 copay, no deductible	No charge, no deductible	\$65 copay, no deductible	No charge after
15 Cat Scan	Office/Non-Hospital		\$150 copay after deductible⁵	No charge after deductible⁵	No charge after deductible⁵	\$130 copay after deductible <sup>5</sup>	30% coinsurance after deductible	\$130 copay after deductible <sup>5</sup>	\$130 copay after deductible <sup>5</sup>	\$100 copay after deductible <sup>5</sup>	\$100 copay after deductible	\$100 copay after deductible <sup>5</sup>	\$100 copay after deductible <sup>5</sup>	No charge after o
	aging (e.g. MRI,	\$500 copay after deductible	\$500 copay after deductible	No charge after deductible	No charge after deductible	\$250 copay after deductible	\$250 copay after deductible	\$250 copay, no deductible	\$250 copay, no deductible	\$250 copay, no deductible	\$250 copay, no deductible	\$250 copay, no deductible	\$250 copay, no deductible	No charge after o
	TRATIENT CURCERY (In a long of the formation of the forma	\$750 copay after deductible	\$750 copay after deductible⁵	No charge after deductible <sup>5</sup>	No charge after deductible <sup>5</sup>	\$500 copay after deductible⁵	; 30% coinsurance after deductible	\$500 copay after deductible⁵	\$500 copay after deductible⁵	\$350 copay after deductible <sup>5</sup>	\$350 copay after deductible	\$350 copay after deductible <sup>5</sup>	\$350 copay after deductible <sup>5</sup>	No charge after d
	TPATIENT SURGERY (Members are responsible for h facility and physician charges)													
(allibulatory) surgery centers	tpatient Surgery Surgical Center	\$50 copay after deductible	\$50 copay after deductible	No charge after deductible	No charge after deductible	\$40 copay after deductible	\$40 copay after deductible	\$50 copay, no deductible	\$40 copay, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	No charge after o
many outpatient surgeries.	Hospital Non-Hospital			No charge after deductible <sup>5</sup>		\$40 copay after deductible <sup>5</sup>	\$40 copay after deductible	\$50 copay after deductible⁵		\$30 copay after deductible <sup>5</sup>	\$30 copay after deductible	\$30 copay after deductible <sup>5</sup>	\$30 copay after deductible <sup>5</sup>	No charge after d
	tpatient Surgery Surgical Center cility charge)	\$300 copay after deductible	\$300 copay after deductible	No charge after deductible	No charge after deductible	\$300 copay after deductible		\$300 copay, no deductible	\$300 copay, no deductible	\$300 copay, no deductible	\$300 copay, no deductible	\$300 copay, no deductible	\$300 copay, no deductible	No charge after o
	Hospital	\$450 copay after deductible	\$450 copay after deductible <sup>5</sup>	No charge after deductible <sup>5</sup>	No charge after deductible <sup>5</sup>	\$450 copay after deductible⁵	after deductible	\$450 copay after deductible⁵	\$450 copay after deductible⁵	\$400 copay after deductible <sup>5</sup>	\$400 copay after deductible	\$400 copay after deductible⁵	\$400 copay after deductible <sup>5</sup>	No charge after o
including	PATIENT HOSPITAL SERVICES uding all inpatient surgery, labor & delivery, mental													
	Ith related visits (Members are responsible for both spital and physician charges)													
[20] Inpatien	atient Services (physician charge)	\$50 copay after deductible	\$50 copay after deductible	No charge after deductible	No charge after deductible	\$40 copay after deductible \$500 copay/day after	\$40 copay after deductible	\$50 copay after deductible \$500 copay/day after	\$40 copay after deductible \$500 copay/day after	\$30 copay after deductible \$450 copay/day after	\$30 copay after deductible \$450 copay/day after	\$30 copay after deductible \$450 copay/day after	\$30 copay after deductible \$450 copay/day after	No charge after
21 Inpatien	atient Services (hospital charge)	\$500 copay/day after deductible	\$500 copay/day after deductible⁵	No charge after deductible <sup>5</sup>	No charge after deductible <sup>5</sup>	deductible (up to a copay maximum of \$2,500) <sup>5</sup>	30% coinsurance after deductible	deductible (up to a copay maximum of \$2,500) <sup>5</sup>	deductible (up to a copay maximum of \$2,500) <sup>5</sup>	deductible (up to a copay maximum of \$2,250) <sup>5</sup>	deductible (up to a copay maximum of \$2,250)	deductible (up to a copay maximum of \$2,250) <sup>5</sup>	deductible (up to a copay maximum of \$2,250) <sup>5</sup>	No charge after d
MATER	TERNITY OFFICE VISITS								maximum of \$2,500)		maximum or \$2,230)	maximum of \$2,290)		
22 Preventi	eventive Prenatal & Postnatal Office Visits <sup>13</sup>	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no d
MENTAL	NTAL HEALTH & SUBSTANCE ABUSE <sup>9</sup>													
[23] Office Vi	ice Visits	\$25 copay after deductible	Visits 1–24: \$25 copay, no deductible	No charge after deductible	No charge after deductible	\$30 copay after deductible	\$30 copay after deductible	No charge, no deductible	\$30 copay, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	Visits 1–3: No no deducti
			Visits 3+: \$25 copay after deductible				,							Visits 4+: No cha deductib
PRESCR	ESCRIPTION DRUGS <sup>10</sup>	No concepto dura		No concerto dura	No concepto dura	No concerto duvo	Necessaria							Nersenerste
Generic drugs: Always your lowest cost option;	scription Drug Deductible		\$150 per person (Tiers 2–4)		No separate drug deductible; Must meet	No separate drug deductible; Must meet	No separate drug deductible; Must meet	\$150 per person (Tiers 2-4)	\$250 per person (Tiers 2-4)	\$150 per person (Tiers 2–4)	\$150 per person (Tiers 2-4)	\$250 per person (Tier 2-4)	\$150 per person (Tiers 2–4)	No separate deductible; Mu
some are no charge and	neric Drugs (Tier 1)	medical deductible first \$10 copay after deductible	\$10 copay, no deductible	medical deductible first	medical deductible first	medical deductible first \$10 copay after deductible	medical deductible first \$10 copay after deductible	\$10 copay, no deductible	\$10 copay, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	medical deduct
	eferred Brand Drugs (Tier 2) <sup>11</sup>		\$75 copay after deductible			\$75 copay after deductible	\$50 copay after deductible	\$50 copay after deductible	\$50 copay after deductible	\$50 copay after deductible	\$50 copay after deductible	\$50 copay after deductible		
	n-Preferred Brand Drugs (Tier 3) <sup>12</sup>		\$150 copay after deductible	No charge after deductible	No charge after deductible	\$150 copay after deductible	\$70 copay after deductible	\$70 copay after deductible		\$70 copay after deductible	\$70 copay after deductible	\$70 copay after deductible	\$70 copay after deductible	No charge after d
28 Specialt	ecialty Drugs (Tier 4)	\$150 copay after deductible	\$150 copay after deductible			\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible	
OUT-OF	T-OF-NETWORK	Out-of-Network	Out-of-Network				Out-of-Network		Out-of-Network		Out-of-Network	Out-of-Network		
cost, always visit doctors	ductible	Individual: \$8,000 Family: \$16,000	Individual: \$8,000 Family: \$16,000	N/A	N/A	N/A	Individual: \$3,200 Family: \$6,400	N/A	Individual: \$5,000 Family: \$10,000	N/A	Individual: \$1,000 Family: \$2,000	Individual: \$1,500 Family: \$3,000	N/A	N/A
such a sub-transfer sub-transfer ( )	t-of-Pocket Maximum	Individual: \$10,000 Family: \$20,000	Individual: \$10,000 Family: \$20,000	N/A	N/A	N/A	Individual: \$9,000 Family: \$18,000	N/A	Individual: \$9,000 Family: \$18,000	N/A	Individual: \$9,000 Family: \$18,000	Individual: \$8,000 Family: \$16,000	N/A	N/A

<sup>6</sup> For family coverage only – For BlueChoice HMO HSA Silver \$1,350 and BluePreferred PPO HSA Silver \$1,600: The family deductible must be met before full benefits will be available to any member on the policy. Once the family deductible has been met, full benefits will become available to everyone covered. All other plans: If one member on the policy meets the individual deductible, full benefits will begin for that member. That member will not be able to contribute more than the individual deductible amount towards the family deductible. Once the family deductible has been met, full benefits will be available to all members on the policy.

<sup>7</sup> For family coverage only – When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the allowed benefit. Each family member cannot contribute more than the individual out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the allowed benefit.
 <sup>8</sup> For HMO and POS plans: For in-network benefits, members must use LabCorp for laboratory services and freestanding facilities for diagnostic services and X-rays. Other providers/facilities may be used in POS plans but will be considered out-of-network.

<sup>9</sup> For HMO and POS plans. To receive in-network coverage, mental health and substance abuse coverage must be performed by Magellan behavioral health providers. Other providers may be used for out-of-network coverage for POS plans. <sup>10</sup> All out-of-pocket drug costs contribute to the in-network out-of-pocket maximum.

 <sup>11</sup> If a generic drug becomes available for a preferred brand drug, the preferred brand drug moves to the non-preferred brand drug tier.
 <sup>12</sup> If a provider prescribes a non-preferred brand drug and the member selects the non-preferred brand drug when a generic drug is available, the member shall pay the applicable copayment as stated above plus the difference between the price of the non-preferred brand drug when a generic drug is available, the member shall pay the applicable copayment as stated above plus the difference between the price of the non-preferred brand drug when a generic drug and the generic drug up to the cost of the drug. This amount will not contribute to the in-network out-of-pocket maximum. <sup>13</sup> For non-routine obstetrical care or complications of pregnancy, cost-sharing may apply.

The CareFirst BlueCross BlueShield family of health care plans

See a summary of any plan and a glossary of common health insurance terms by visiting www.carefirst.com/individual. Just enter your zip code, gender and date of birth to view and compare plans. Look for the Summary of Benefits & Coverage and Uniform Glossary of Coverage & Medical Terms links for each plan by clicking on the plan name and scrolling to the bottom of the box. **Questions?** Ask your broker or call one of our product specialists at 410-356-8000 or toll-free at 800-544-8703 Monday–Friday, 8 a.m.– 6 p.m. and Saturday, 8 a.m.– noon.

# 2016 MARYLAND POLICY FORM NUMBERS:

#### BluePreferred HSA Bronze \$4,500

MD/CF/BP/IEA (1/14); MD/GHMSI/DOL APPEAL (R. 9/11); MD/CF/EXC/BP/DOCS (1/14); MD/CF/EXC/BP HSA/BRZ 4500 (1/16); MD/CF/DB/PPO HSA/INCENT (1/16); CFMI/BP/IEA (1/14); CFMI/DOL APPEAL (R. 9/11); CFMI/EXC/BP/DOCS (1/14); CFMI/EXC/BP HSA/BRZ 4500 (1/16); CFMI/DB/PPO HSA/INCENT (1/16) and any amendments

#### BlueChoice Plus Bronze \$5,500

MD/CFBC/BC+ IN/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/BC+ IN/DOCS (1/14); MD/ CFBC/EXC/BC+ IN/BRZ 5500 (1/16); MD/CFBC/ DB/POS/INCENT (R. 1/16); MD/CF/BC+ OON/IEA (1/14); MD/GHMSI/DOL APPEAL (R. 9/11); MD/ CF/BC+ OON/DOCS (1/14); MD/CF/EXC/BC+ OON/ BRZ 5500 (1/16); CFMI/BC+ OON/IEA (1/14); CFMI/ DOL APPEAL (R. 9/11); CFMI/EXC/BC+ OON/DOCS (1/14); CFMI/EXC/BC+ OON/BRZ 5500 (1/16) and any amendments

#### BlueChoice HMO HSA Bronze \$6,000

MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/ CFBC/EXC/HMO HSA/BRZ 6000 (1/16); MD/CFBC/ DB/HMO HSA/INCENT (1/16) and any amendments

#### BlueChoice HMO Bronze \$6,550

MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/ CFBC/EXC/HMO/BRZ 6550 (1/16); MD/CFBC/DB/

HMO/INCENT (R. 1/16) and any amendments

## BlueChoice HMO HSA Silver \$1,350

MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/ CFBC/EXC/HMO HSA/SIL 1350 (1/16); MD/CFBC/DB/ HMO HSA/INCENT (1/16) and any amendments

## BluePreferred HSA Silver \$1,600

MD/CF/BP/IEA (1/14); MD/GHMSI/DOL APPEAL (R. 9/11); MD/CF/EXC/BP/DOCS (1/14); MD/CF/EXC/BP HSA/SIL 1600 (1/16); MD/CF/DB/PPO HSA/INCENT (1/16); CFMI/BP/IEA (1/14); CFMI/DOL APPEAL (R. 9/11); CFMI/EXC/BP/DOCS (1/14); CFMI/EXC/BP HSA/SIL 1600 (1/16); CFMI/DB/PPO HSA/INCENT (1/16) and any amendments

#### BlueChoice HMO Silver \$2,000

MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/ CFBC/EXC/HMO/SIL 2000 (1/16); MD/CFBC/DB/ HMO/INCENT (R. 1/16) and any amendments

# BlueChoice Plus Silver \$2,500

MD/CFBC/BC+ IN/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/BC+ IN/DOCS (1/14); MD/ CFBC/EXC/BC+ IN/SIL 2500 (1/16); MD/CFBC/DB/ POS/INCENT (R. 1/16); MD/CF/BC+ OON/IEA (1/14); MD/GHMSI/DOL APPEAL (R. 9/11); MD/CF/EXC/ BC+ OON/DOCS (1/14); MD/CF/EXC/BC+ OON/ SIL 2500 (1/16); CFMI/BC+ OON/IEA (1/14); CFMI/ DOL APPEAL (R.9/11); CFMI/EXC/BC+ OON/DOCS (1/14); CFMI/EXC/BC+ OON/SIL 2500 (1/16) and any amendments

## HealthyBlue HMO Gold \$250

MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/ CFBC/EXC/HB HMO/GOLD 250 (1/16); MD/CFBC/DB/ HMO/INCENT (R. 1/16) and any amendments

#### BluePreferred Gold \$500

MD/CF/BP/IEA (1/14); MD/GHMSI/DOL APPEAL (R. 9/11); MD/CF/EXC/BP/DOCS (1/14); MD/CF/EXC/ HB PPO/GOLD 500 (1/16); MD/CF/DB/PPO/INCENT (R. 1/16); CFMI/BP/IEA (1/14); CFMI/DOL APPEAL (R. 9/11); CFMI/EXC/BP/DOCS (1/14); CFMI/EXC/ HB PPO/GOLD 500 (1/16); CFMI/DB/PPO/INCENT (R. 1/16) and any amendments

# HealthyBlue Plus Gold \$750

MD/CFBC/HB IN/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HB IN/DOCS (1/14); MD/ CFBC/EXC/HB IN/GOLD 750 (1/16); MD/CFBC/DB/ POS/INCENT (R. 1/16); MD/CF/HB OON/IEA (1/14); MD/GHMSI/DOL APPEAL (R. 9/11); MD/CF/EXC/HB OON/DOCS (1/14); MD/CF/EXC/HB OON/GOLD 750 (1/16); CFMI/HB OON/IEA (1/14); CFMI/DOL APPEAL (R. 9/11); CFMI/EXC/HB OON/DOCS (1/14); CFMI/ EXC/HB OON/GOLD 750 (1/16) and any amendments

# HealthyBlue HMO Gold \$1,000

MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/ CFBC/EXC/HB HMO/GOLD 1000 (1/16); MD/CFBC/ DB/HMO/INCENT (R. 1/16) and any amendments

# CAT

MD/CFBC/CAT/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/ CFBC/EXC/HMO/YA SOB (1/16); MD/CFBC/DB/HMO/ INCENT (R. 1/16) and any amendments

# BlueDental Preferred HIGH Option:

CFMI/DEN/IEA (1/14); CFMI/DB/PREF DENT DOCS-SOB (R. 1/15); CFMI/DB/2016 DENTAL AMEND (1/16) CFMI/DOL APPEAL (R. 9/11); and any amendments

BlueDental Preferred LOW Option: CFMI/DEN/IEA (1/14); CFMI/DB/PREF DENT DOCS-SOB LOW (1/15); CFMI/DB/2016 DENTAL AMEND LOW (1/16); CFMI/DOL APPEAL (R. 9/11); and any amendments

## 2016 VIRGINIA POLICY FORM NUMBERS:

# BluePreferred PPO HSA Bronze \$4,500

VA/CF/DB/BP (1/14)-HIX; VA/CF/EXC/BP HSA/BRZ 4500 (1/16)-HIX (Bronze Metal Level); VA/CF/EXC/ PPO/2016 AMEND (1/16)-HIX; VA/CF/DB/PPO HSA/ INCENT (1/16)-HIX

## BlueChoice Plus Bronze \$5,500

VA/CFBC/DB/BCOO/INN (1/14); VA/CFBC/EXC/BC+ IN/BRZ 5500 (1/16); VA/CFBC/DB/POS IN/2016 AMEND (1/16); VA/CFBC/DB/POS/INCENT (R. 1/16); MVAPP (4/15)

## BlueChoice HMO HSA Bronze \$6,000

VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO HSA/ BRZ 6000 (1/16) (Bronze Metal Level); VA/CFBC/DB/ HMO/2016 AMEND (1/16); VA/CFBC/ DB/HMO HSA/ INCENT (1/16); MVAPP (4/15)

# BlueChoice HMO HSA Bronze \$6,550

VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/HSA/ BRZ 6550 (1/16) (Bronze Metal Level); VA/CFBC/DB/ HMO/2016 AMEND (1/16); VA/CFBC/DB/HMO HSA/ INCENT (1/16) (HSA plans only)

# BlueChoice HMO HSA Silver \$1,350

VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/ SIL 2000 (1/16) (Silver Metal Level); VA/CFBC/DB/ HMO/2016 AMEND (1/16); VA/CFBC/DB/HMO HSA/ INCENT (R. 1/16); MVAPP (4/15)

## BluePreferred PPO HSA Silver \$1,600

VA/CF/DB/BP (1/14)-HIX; VA/CF/EXC/BP HSA/SIL 1600 (1/16)-HIX (Silver Metal Level); VA/CF/EXC/ PPO/2016 AMEND (1/16)-HIX; VA/CF/DB/PPO HSA/ INCENT (1/16)-HIX (HSA plans only)

# BlueChoice HMO Silver \$2,000

VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/ SIL 2000 (1/16); VA/CFBC/DB/HMO/2016 AMEND (1/16); VA/CFBC/DB/HMO/INENT (R. 1/16); MVAPP (4/15)

# BlueChoice Plus Silver \$2,500

VA/CFBC/DB/BCOO/INN (1/14); VA/CFBC/EXC/ BC+ IN/SIL 2500 (1/16); VA/CFBC/DB/POS IN/2016 AMEND (1/16); VA/CFBC/DB/POS/INCENT (R. 1/16); MVAPP (4/15)

# HealthyBlue HMO Gold \$250

VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HB HMO/ GOLD 250 (1/16) (Gold Metal Level); VA/CFBC/ DB/HMO/2016 AMEND (1/16); VA/CFBC/DB/HMO/ INCENT (R. 1/16); MVAPP (4/15)

# HealthyBlue PPO Gold \$500

VA/CF/DB/BP (1/14); VA/CF/EXC/HB PPO/GOLD 500 (1/16) (Gold Metal Level); VA/CF/EXC/PPO/2016 AMEND (1/16); VA/CF/DB/PPO/INCENT (R. 1/16); MVAPP (4/15)

### HealthyBlue Plus Gold \$750

VA/CFBC/DB/HB/INN (1/14); VA/CFBC/EXC/HB IN/ GOLD 750 (1/16); VA/CFBC/DB/POS IN/2016 AMEND (1/16); VA/CFBC/DB/POS/INCENT (R. 1/16); MVAPP (4/15)

# HealthyBlue HMO Gold \$1,000

VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HB HMO/ GOLD 1000 (1/16) (Gold Metal Level); VA/CFBC/DB/ HMO/2016 AMEND (1/16); VA/CFBC/HMO/INCENT (R.1/16); MVAPP (4/15)

## BlueChoice HMO Young Adult

VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/YA SOB (1/16); VA/CFB VA/CFBC/EXC/HMO/INCENT (R.1/16); C/DB/HMO/2016 AMEND (1/16); MVAPP (4/15)

#### BlueDental Preferred HIGH Option: VA/CF/DB/PREF DENT (R. 1/15); VA/CF/DB/2016 DENTAL AMD HIGH (1/16)

# BlueDental Preferred LOW Option:

VA/CF/DB/PREF DENT LOW (1/15); VA/CF/DB/2016 DENTAL AMD LOW (1/16)

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





CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both 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.