



# Congressional Health Insurance Rates

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# 2024

For Members of Congress and designated Congressional Staff

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**Because your well-being is our  
priority, we're doing more to  
protect your health.**

*With Care,*

CareFirst  

## Happy with your CareFirst plan?

If you previously selected a CareFirst BlueCross BlueShield plan on the DC Health Link, and you would like to keep the same plan without making any changes, you do not have to re-enroll to receive your 2024 benefits.

# Welcome

Inside, you'll find information to help you select a Congressional plan best suited to your needs. We hope this simplified booklet provides information that makes choosing the right CareFirst plan easy.

## When you're ready to enroll

Once you've decided on the best CareFirst plan for you and your family, go to **DCHealthLink.com**. Your payroll and benefits office will provide more specific information about how to enroll.

## Still have questions?

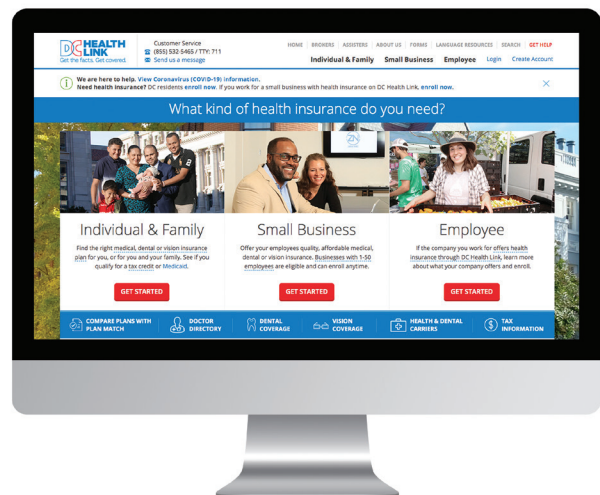
- Visit our dedicated website for Congress:  
**carefirst.com/congress**
  - Compare plans
  - View premiums for all plans
  - Access additional plan information
- Go to the Office of Personnel Management (OPM) website: **opm.gov/healthcare-insurance**
  - Select *Insurance*
  - Select *Changes in Health Coverage*
  - Select *Eligibility & Enrollment*
  - Select *Members of Congress/Staff* tab
- Call our dedicated support line for Members of Congress and designated Congressional Staff at **855-541-3985**, Monday–Friday, 8 a.m. to 6 p.m. ET
- Attend a Virtual Open Season Health Fair

*The below information was last verified on **October 12, 2023** (the date this book went to press). Please check with your Health Benefits Officer or **carefirst.com/congress** for the latest information on Open Season.*

  - **House of Representatives**

Virtual Health Fair  
November 16, 2023  
2 p.m. to 5 p.m. ET  
December 7, 2023  
11 a.m. to 2 p.m. ET
  - **Senate**

In-Person Open Season Health Fair  
November 29, 2023  
10 a.m. to 3 p.m.  
Room SH-902, Hart Senate Office Building



## Members of Congress and designated Congressional Staff

Your open enrollment is



Ready to explore your 2024 rates and plans? Let's get started.

# What's New, What's Changed

Here's what CareFirst is introducing and updating in the new plan year, 2024.

## Your Congressional Benefits Book

We know health coverage is one of the most important decisions you make. To help simplify the process, we created two smaller guides focused on specific aspects of your healthcare journey.

- 1. **Choosing a Plan**—your new **Health Insurance Rates Guide** is designed to help you focus on selecting and enrolling in a plan that best meets your health and budget needs.
- 2. **Using Your Plan**—the **Health Plan Guide** is designed to help you better understand what's included in your plan and how to get the most out of it.

## CareFirst Plans

CareFirst reviews each Congress plan annually, and certain changes may be made to your coverage. These changes could involve plan benefits or adjustments to deductibles and other limits. Not all changes will necessarily apply to your CareFirst plan.

In addition, we optimized our options and removed three Gold plans from our offerings. Notification of this change was sent to impacted subscribers in September 2023.

- If this change affects you, you may choose any CareFirst plan that best suits your needs. However, we have provided the following recommendations in the chart below for your convenience.

If you had this NATIONAL plan ...	... you might like this plan.
BluePreferred PPO Gold 1100 90%/70%	BluePreferred PPO Gold 1000 Ded
BlueChoice Advantage HSA/HRA Gold 1500 90	BlueChoice Advantage HSA/HRA Gold 1600 Ded
If you had this REGIONAL plan ...	... you might like this plan.
BlueChoice HMO HSA/HRA Gold 1500 90	BlueChoice HMO HSA/HRA Gold 1600 Ded

**Please note:** If you have one of the three plans that are no longer available and do not re-enroll in a new CareFirst plan, you will be automatically enrolled in the recommended plan.

Eat Right Now is administered by Sharecare, Inc. and Noom is administered by Noom, Inc., independent companies that provide health improvement management services to CareFirst members. Sharecare, Inc. and Noom do not provide CareFirst BlueCross BlueShield products or services and are solely responsible for the health improvement management services they provide.

CloseKnit is a registered trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross and/or Blue Shield products or services and is providing telehealth services to CareFirst BlueCross BlueShield members.

## CareFirst WellBeing<sup>SM</sup>

CareFirst has recently introduced two new weight management programs to our well-being collection:

- **Noom**—join the millions of Americans already using the Noom app to achieve and maintain a healthy weight. Noom's psychology-based techniques can help you better understand your relationship with food.
- **Eat Right Now**—adopt new healthy habits using proven techniques and science-based tools to identify eating triggers and ride out cravings to change eating patterns.

## CloseKnit & Video Visit

To better meet your needs, CareFirst is simplifying its virtual care offerings. **Please note: CareFirst Video Visit will no longer be available after December 31, 2023.**

Starting January 1, 2024:

- Primary care will be available to CloseKnit members and dependents ages 18+.
- Urgent care will be available to members and dependents ages 2+. You do not need to be a CloseKnit primary care patient to access urgent care services.
- If you're enrolled in a CareFirst Virtual Connect Plan, you're eligible for the \$0 copay benefit for primary care and mental health visits. Even if your CareFirst plan does not include "Virtual Connect," you may still choose CloseKnit as your primary care practice.

# National and Regional Plans

We have created comparison charts to make it easier for you to review the plans. Remember that with most CareFirst plans you:

- **See who you want to see, where you want to see them**

As a BlueCross BlueShield plan, we provide plans with network access beyond Washington, D.C., Maryland and Northern Virginia. Nationwide, you have coverage available from more than 95% of providers.

- **Know you are covered with great benefits**

With 18 plans to choose from, you can find a plan to meet your needs—wherever you live or work.

- **Receive hassle-free care**

Whether you are visiting a provider or simply calling our dedicated Customer Service representatives, you can be assured you are receiving quality care and service.

## National versus Regional plans

Please review the benefit summaries on pages 15–32 carefully. The tab at the top of each summary will identify whether the plan is one of our National or Regional options. Both National and Regional plans offer you choices of different cost-sharing arrangements, premiums and networks.

- National plans have access to a large network of providers throughout the country (see the General Information row in each summary for specifics). These plans are the best option if you or your family members live outside Washington, D.C., Maryland or Northern Virginia.
- Regional plans use the BlueChoice network of participating doctors, specialists and hospitals only available in Washington, D.C., Maryland and Northern Virginia for in-network coverage. These plans are not recommended if you or your family members live outside this area.



### Want to find out which plans your doctor accepts?

Visit [carefirst.com/doctor](https://carefirst.com/doctor) and search by your plan or by your doctor's name.

### Getting care

Remember that CareFirst BlueCross BlueShield National plans are recognized by doctors all across the United States. It's important to let your provider know that you are a member of CareFirst BlueCross BlueShield.

# Compare Plans—National Plans

This chart shows the features used most often to compare National plans. **These plans are best suited for individuals and families who live and work outside the Washington, D.C., Maryland and Northern Virginia area.** For a more detailed description of each plan, please turn to the Benefit Summary section of this brochure (for a comprehensive summary of benefits visit [carefirst.com/congress](https://carefirst.com/congress)).

## National Plans Comparison Chart

All National CareFirst plans include Blue Rewards, in-network benefits for out-of-area access, and BlueCross BlueShield Global Core. See your contract for more information.

### TOP 3

Plan Name	BluePreferred PPO Standard Gold 500	BluePreferred PPO Gold 800 Ded	BluePreferred PPO Gold 1000 Ded	BluePreferred PPO Gold 1500 Ded
YOU PAY (IN-NETWORK)				
Individual Medical Deductible	\$500	\$800	\$1,000	\$1,500
Family Medical Deductible	\$1,000	\$1,600	\$2,000	\$3,000
Separate Family Deductible	✓	✓	✓	✓
Aggregate Family Deductible				
Individual Out-of-Pocket Maximum	\$5,800	\$8,850	\$7,500	\$6,200
Family Out-of-Pocket Maximum	\$11,600	\$17,700	\$15,000	\$12,400
PCP/Specialist	\$25/\$50	\$15/\$40	\$15/\$40	\$15/\$40
PLAN FEATURES (IN-NETWORK)				
HSA-Compatible				
PCP and Specialist office visits are not subject to deductible requirement	✓	✓	✓	✓
Pay no deductible for non-hospital labs, X-rays and imaging	✓	✓	✓	✓
Pay no deductible for urgent care or non-hospital outpatient surgery	✓	✓	✓	✓
Non-Integrated Prescription Drug Deductible Amount	\$0	\$250*	\$250*	\$250*

\* Per person



## Compare Plans—National Plans



### TOP 3

### TOP 3

BlueChoice Advantage Gold 0 Ded	BlueChoice Advantage Gold 800 Ded	BlueChoice Advantage Gold 1000 Ded	BlueChoice Advantage HSA/ HRA Gold 1600 Ded	BlueChoice Advantage Gold 3000 Ded Virtual Connect
\$0	\$800	\$1,000	\$1,600	\$3,000
\$0	\$1,600	\$2,000	\$3,200	\$6,000
✓	✓	✓		✓
			✓	
\$8,900	\$8,850	\$7,500	\$4,200	\$7,300
\$17,800	\$17,700	\$15,000	\$8,400	\$14,600
\$30/\$60	\$15/\$40	\$15/\$40	\$10**/\$30**	\$15***/\$40
			✓	
✓	✓	✓		✓
✓	✓	✓		✓
✓	✓	✓		✓
\$0	\$250*	\$250*	Integrated	\$250*

\* Per person

\*\* Copay/coinsurance applies once deductible is met

\*\*\* Virtual Connect Program Provider PCP (No charge)

# Compare Plans—Regional Plans

This chart shows the features used most often to compare Regional plans. **These plans are best suited for individuals and families who live and work in Washington, D.C., Maryland and Northern Virginia.** For a more detailed description of each plan, please turn to the Benefit Summary section of this brochure (for a comprehensive summary of benefits visit [carefirst.com/congress](http://carefirst.com/congress)).

## Regional Plans Comparison Chart

All Regional CareFirst plans include Blue Rewards and in-network benefits for emergency care. See your contract for more information.

Plan Name	BlueChoice Plus Gold 800 Ded	BlueChoice Plus Gold 1000 Ded	BlueChoice HMO Standard Gold 500	BlueChoice HMO Gold 800 Ded
<b>YOU PAY (IN-NETWORK)</b>				
Individual Medical Deductible	\$800	\$1,000	\$500	\$800
Family Medical Deductible	\$1,600	\$2,000	\$1,000	\$1,600
Separate Family Deductible	✓	✓	✓	✓
Aggregate Family Deductible				
Individual Out-of-Pocket Maximum	\$8,850	\$7,500	\$5,800	\$8,850
Family Out-of-Pocket Maximum	\$17,700	\$15,000	\$11,600	\$17,700
PCP/Specialist	\$15/\$40	\$15/\$40	\$25/\$50	\$15/\$40
<b>PLAN FEATURES (IN-NETWORK)</b>				
HSA-Compatible				
PCP and Specialist office visits are not subject to deductible requirement	✓	✓	✓	✓
Pay no deductible for non-hospital labs, X-rays and imaging	✓	✓	✓	✓
Pay no deductible for urgent care or non-hospital outpatient surgery	✓	✓	✓	✓
Non-Integrated Prescription Drug Deductible Amount	\$250*	\$250*	\$0	\$250*

\* Per person



## Compare Plans—Regional Plans



BlueChoice HMO Gold 1500 Ded	BlueChoice HMO HSA/HRA Gold 1600 Ded	BlueChoice HMO Gold 3000 Ded Virtual Connect	BlueChoice HMO Referral Gold 0 Ded	BlueChoice HMO Referral Gold 800 Ded
\$1,500	\$1,600	\$3,000	\$0	\$800
\$3,000	\$3,200	\$6,000	\$0	\$1,600
✓		✓	✓	✓
	✓			
\$6,200	\$4,200	\$7,300	\$8,900	\$8,850
\$12,400	\$8,400	\$14,600	\$17,800	\$17,700
\$15/\$40	\$10**/\$30**	\$15***/\$40	\$30/\$60	\$15/\$40
	✓			
✓		✓	✓	✓
✓		✓	✓	✓
✓		✓	✓	✓
\$250*	Integrated	\$250*	\$0	\$250*

\* Per person

\*\* Copay/coinsurance applies once deductible is met

\*\*\* Virtual Connect Program Provider PCP (No charge)

# Estimate Your Share of the Premium

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Premiums for plans on the DC Health Link, and all Exchanges, are based on the number and ages of each family member covered by the plan.

The Office of Personnel Management (OPM) Premium Contribution Calculator will provide the most accurate estimate of your contribution as well as your employer's contribution. To get to the calculator, visit [opm.gov/healthcare-insurance](https://opm.gov/healthcare-insurance) and select *Insurance* from the main menu and click *Changes in Health Coverage* in the drop-down. Next, click *Eligibility & Enrollment*, in the navigation on the left then choose the tab for *Members of Congress/Staff*.



# Insurance Rates and Benefit Summaries

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# National Plan Rates

## TOP 3

## TOP 3

	BluePreferred PPO Standard Gold 500	BluePreferred PPO Gold 800 Ded	BluePreferred PPO Gold 1000 Ded	BluePreferred PPO Gold 1500 Ded	BlueChoice Advantage Gold 0 Ded	BlueChoice Advantage Gold 800 Ded
Age	Monthly Premium (before employer contribution)*					
<=20	\$516.97	\$498.09	\$494.70	\$487.58	\$447.21	\$428.89
21	\$574.68	\$553.68	\$549.92	\$542.00	\$497.12	\$476.77
22	\$574.68	\$553.68	\$549.92	\$542.00	\$497.12	\$476.77
23	\$574.68	\$553.68	\$549.92	\$542.00	\$497.12	\$476.77
24	\$574.68	\$553.68	\$549.92	\$542.00	\$497.12	\$476.77
25	\$574.68	\$553.68	\$549.92	\$542.00	\$497.12	\$476.77
26	\$574.68	\$553.68	\$549.92	\$542.00	\$497.12	\$476.77
27	\$574.68	\$553.68	\$549.92	\$542.00	\$497.12	\$476.77
28	\$588.12	\$566.63	\$562.78	\$554.67	\$508.75	\$487.92
29	\$600.76	\$578.82	\$574.88	\$566.60	\$519.69	\$498.41
30	\$615.78	\$593.29	\$589.25	\$580.77	\$532.68	\$510.87
31	\$631.59	\$608.52	\$604.38	\$595.68	\$546.36	\$523.98
32	\$645.82	\$622.23	\$618.00	\$609.10	\$558.66	\$535.79
33	\$660.84	\$636.70	\$632.37	\$623.26	\$571.66	\$548.25
34	\$676.65	\$651.93	\$647.50	\$638.17	\$585.33	\$561.36
35	\$692.46	\$667.16	\$662.62	\$653.08	\$599.01	\$574.48
36	\$708.27	\$682.39	\$677.75	\$667.99	\$612.68	\$587.60
37	\$724.08	\$697.63	\$692.88	\$682.91	\$626.36	\$600.71
38	\$732.77	\$706.00	\$701.20	\$691.11	\$633.88	\$607.93
39	\$741.47	\$714.38	\$709.52	\$699.31	\$641.40	\$615.14
40	\$770.72	\$742.56	\$737.51	\$726.89	\$666.71	\$639.41
41	\$800.76	\$771.50	\$766.25	\$755.22	\$692.69	\$664.33
42	\$832.38	\$801.96	\$796.51	\$785.04	\$720.04	\$690.56
43	\$864.79	\$833.19	\$827.52	\$815.61	\$748.08	\$717.45
44	\$898.78	\$865.94	\$860.05	\$847.67	\$777.48	\$745.64
45	\$933.56	\$899.45	\$893.33	\$880.47	\$807.57	\$774.50
46	\$969.92	\$934.48	\$928.13	\$914.77	\$839.02	\$804.67
47	\$1,007.86	\$971.04	\$964.44	\$950.55	\$871.85	\$836.15
48	\$1,047.39	\$1,009.12	\$1,002.26	\$987.83	\$906.04	\$868.94
49	\$1,088.49	\$1,048.72	\$1,041.59	\$1,026.59	\$941.59	\$903.04
50	\$1,131.18	\$1,089.85	\$1,082.44	\$1,066.85	\$978.52	\$938.45
51	\$1,175.44	\$1,132.50	\$1,124.80	\$1,108.60	\$1,016.81	\$975.17
52	\$1,221.29	\$1,176.67	\$1,168.67	\$1,151.84	\$1,056.47	\$1,013.21
53	\$1,268.72	\$1,222.37	\$1,214.05	\$1,196.58	\$1,097.50	\$1,052.56
54	\$1,318.52	\$1,270.35	\$1,261.71	\$1,243.54	\$1,140.58	\$1,093.87
55	\$1,369.90	\$1,319.85	\$1,310.88	\$1,292.00	\$1,185.03	\$1,136.50
56	\$1,423.65	\$1,371.64	\$1,362.31	\$1,342.70	\$1,231.52	\$1,181.10
57	\$1,478.99	\$1,424.95	\$1,415.26	\$1,394.89	\$1,279.39	\$1,227.00
58	\$1,536.69	\$1,480.55	\$1,470.48	\$1,449.31	\$1,329.31	\$1,274.88
59	\$1,596.77	\$1,538.43	\$1,527.97	\$1,505.97	\$1,381.28	\$1,324.72
60	\$1,659.22	\$1,598.60	\$1,587.73	\$1,564.87	\$1,435.30	\$1,376.52
61	\$1,724.00	\$1,661.01	\$1,649.71	\$1,625.96	\$1,491.33	\$1,430.27
62	\$1,724.00	\$1,661.01	\$1,649.71	\$1,625.96	\$1,491.33	\$1,430.27
63	\$1,724.00	\$1,661.01	\$1,649.71	\$1,625.96	\$1,491.33	\$1,430.27
64 and over	\$1,724.00	\$1,661.01	\$1,649.71	\$1,625.96	\$1,491.33	\$1,430.27

\* Visit [opm.gov/healthcare-insurance](https://opm.gov/healthcare-insurance) and enter your total from the above chart into the Premium Contribution Calculator for the most accurate estimate of your contribution as well as your employer's contribution.

## National Plan Rates



### Family plan? Use the same rate table.

- Find the age rows in the plan column and circle the rates for:
  - ☐ You
  - ☐ Your spouse
  - ☐ Your 3 oldest children under age 21 (all are covered, but only the oldest 3 count toward overall rate)
  - ☐ All children ages 21–25
- Add up everyone's rate.
- Circle that total premium.
- Repeat for each plan you want to consider.

### TOP 3

	BlueChoice Advantage Gold 1000 Ded	BlueChoice Advantage HSA/ HRA Gold 1600 Ded	BlueChoice Advantage Gold 3000 Ded Virtual Connect
Age	Monthly Premium (before employer contribution)*		
<=20	\$425.70	\$411.24	\$404.42
21	\$473.21	\$457.14	\$449.56
22	\$473.21	\$457.14	\$449.56
23	\$473.21	\$457.14	\$449.56
24	\$473.21	\$457.14	\$449.56
25	\$473.21	\$457.14	\$449.56
26	\$473.21	\$457.14	\$449.56
27	\$473.21	\$457.14	\$449.56
28	\$484.28	\$467.83	\$460.07
29	\$494.69	\$477.90	\$469.97
30	\$507.06	\$489.84	\$481.72
31	\$520.08	\$502.42	\$494.09
32	\$531.79	\$513.74	\$505.22
33	\$544.16	\$525.69	\$516.97
34	\$557.18	\$538.26	\$529.33
35	\$570.20	\$550.84	\$541.70
36	\$583.22	\$563.41	\$554.07
37	\$596.23	\$575.99	\$566.44
38	\$603.39	\$582.91	\$573.24
39	\$610.55	\$589.82	\$580.04
40	\$634.64	\$613.09	\$602.92
41	\$659.37	\$636.98	\$626.42
42	\$685.41	\$662.14	\$651.15
43	\$712.10	\$687.92	\$676.51
44	\$740.08	\$714.96	\$703.10
45	\$768.72	\$742.62	\$730.31
46	\$798.67	\$771.55	\$758.75
47	\$829.91	\$801.73	\$788.43
48	\$862.46	\$833.17	\$819.35
49	\$896.30	\$865.87	\$851.51
50	\$931.45	\$899.83	\$884.90
51	\$967.90	\$935.04	\$919.53
52	\$1,005.66	\$971.51	\$955.40
53	\$1,044.71	\$1,009.24	\$992.50
54	\$1,085.72	\$1,048.86	\$1,031.46
55	\$1,128.03	\$1,089.73	\$1,071.65
56	\$1,172.29	\$1,132.49	\$1,113.70
57	\$1,217.85	\$1,176.50	\$1,156.99
58	\$1,265.37	\$1,222.41	\$1,202.13
59	\$1,314.84	\$1,270.20	\$1,249.13
60	\$1,366.26	\$1,319.87	\$1,297.98
61	\$1,419.60	\$1,371.40	\$1,348.66
62	\$1,419.60	\$1,371.40	\$1,348.66
63	\$1,419.60	\$1,371.40	\$1,348.66
64 and over	\$1,419.60	\$1,371.40	\$1,348.66

\* Visit [opm.gov/healthcare-insurance](https://opm.gov/healthcare-insurance) and enter your total from the above chart into the Premium Contribution Calculator for the most accurate estimate of your contribution as well as your employer's contribution.

# Regional Plan Rates

	BlueChoice Plus Gold 800 Ded	BlueChoice Plus Gold 1000 Ded	BlueChoice HMO Standard Gold 500	BlueChoice HMO Gold 800 Ded	BlueChoice HMO Gold 1500 Ded
Age	Monthly Premium (before employer contribution)*				
<=20	\$385.42	\$382.22	\$393.18	\$375.51	\$366.00
21	\$428.44	\$424.89	\$437.07	\$417.43	\$406.86
22	\$428.44	\$424.89	\$437.07	\$417.43	\$406.86
23	\$428.44	\$424.89	\$437.07	\$417.43	\$406.86
24	\$428.44	\$424.89	\$437.07	\$417.43	\$406.86
25	\$428.44	\$424.89	\$437.07	\$417.43	\$406.86
26	\$428.44	\$424.89	\$437.07	\$417.43	\$406.86
27	\$428.44	\$424.89	\$437.07	\$417.43	\$406.86
28	\$438.46	\$434.82	\$447.29	\$427.19	\$416.37
29	\$447.89	\$444.17	\$456.91	\$436.38	\$425.33
30	\$459.09	\$455.28	\$468.33	\$447.29	\$435.96
31	\$470.87	\$466.97	\$480.36	\$458.77	\$447.15
32	\$481.48	\$477.49	\$491.18	\$469.11	\$457.23
33	\$492.68	\$488.59	\$502.60	\$480.01	\$467.86
34	\$504.47	\$500.28	\$514.63	\$491.50	\$479.05
35	\$516.25	\$511.97	\$526.65	\$502.98	\$490.24
36	\$528.04	\$523.66	\$538.68	\$514.47	\$501.44
37	\$539.83	\$535.35	\$550.70	\$525.95	\$512.63
38	\$546.31	\$541.78	\$557.31	\$532.26	\$518.79
39	\$552.79	\$548.20	\$563.93	\$538.58	\$524.94
40	\$574.60	\$569.83	\$586.17	\$559.83	\$545.65
41	\$596.99	\$592.04	\$609.02	\$581.64	\$566.92
42	\$620.56	\$615.42	\$633.06	\$604.61	\$589.30
43	\$644.73	\$639.38	\$657.71	\$628.15	\$612.25
44	\$670.07	\$664.51	\$683.56	\$652.84	\$636.31
45	\$696.00	\$690.22	\$710.02	\$678.11	\$660.93
46	\$723.11	\$717.11	\$737.67	\$704.52	\$686.68
47	\$751.40	\$745.16	\$766.53	\$732.08	\$713.54
48	\$780.86	\$774.38	\$796.59	\$760.79	\$741.52
49	\$811.51	\$804.77	\$827.85	\$790.65	\$770.62
50	\$843.33	\$836.33	\$860.32	\$821.65	\$800.84
51	\$876.33	\$869.06	\$893.98	\$853.81	\$832.18
52	\$910.51	\$902.96	\$928.85	\$887.11	\$864.64
53	\$945.87	\$938.03	\$964.93	\$921.56	\$898.22
54	\$983.00	\$974.85	\$1,002.80	\$957.73	\$933.48
55	\$1,021.31	\$1,012.83	\$1,041.88	\$995.05	\$969.86
56	\$1,061.38	\$1,052.58	\$1,082.76	\$1,034.10	\$1,007.91
57	\$1,102.64	\$1,093.49	\$1,124.85	\$1,074.29	\$1,047.09
58	\$1,145.66	\$1,136.15	\$1,168.73	\$1,116.21	\$1,087.94
59	\$1,190.45	\$1,180.57	\$1,214.42	\$1,159.84	\$1,130.47
60	\$1,237.00	\$1,226.74	\$1,261.92	\$1,205.20	\$1,174.68
61	\$1,285.30	\$1,274.63	\$1,311.19	\$1,252.26	\$1,220.55
62	\$1,285.30	\$1,274.63	\$1,311.19	\$1,252.26	\$1,220.55
63	\$1,285.30	\$1,274.63	\$1,311.19	\$1,252.26	\$1,220.55
64 and over	\$1,285.30	\$1,274.63	\$1,311.19	\$1,252.26	\$1,220.55

\* Visit [opm.gov/healthcare-insurance](https://opm.gov/healthcare-insurance) and enter your total from the above chart into the Premium Contribution Calculator for the most accurate estimate of your contribution as well as your employer's contribution.



## Regional Plan Rates



### Family plan? Use the same rate table.

- Find the age rows in the plan column and circle the rates for:
  - ☐ You
  - ☐ Your spouse
  - ☐ Your 3 oldest children under age 21 (all are covered, but only the oldest 3 count toward overall rate)
  - ☐ All children ages 21–25
- Add up everyone's rate.
- Circle that total premium.
- Repeat for each plan you want to consider.

	BlueChoice HMO HSA/HRA Gold 1600 Ded	BlueChoice HMO Gold 3000 Ded Virtual Connect	BlueChoice HMO Referral Gold 0 Ded	BlueChoice HMO Referral Gold 800 Ded
Age	Monthly Premium (before employer contribution)*			
<=20	\$357.03	\$352.38	\$374.93	\$356.27
21	\$396.88	\$391.71	\$416.77	\$396.04
22	\$396.88	\$391.71	\$416.77	\$396.04
23	\$396.88	\$391.71	\$416.77	\$396.04
24	\$396.88	\$391.71	\$416.77	\$396.04
25	\$396.88	\$391.71	\$416.77	\$396.04
26	\$396.88	\$391.71	\$416.77	\$396.04
27	\$396.88	\$391.71	\$416.77	\$396.04
28	\$406.16	\$400.87	\$426.52	\$405.30
29	\$414.90	\$409.50	\$435.69	\$414.02
30	\$425.27	\$419.73	\$446.59	\$424.37
31	\$436.19	\$430.51	\$458.05	\$435.26
32	\$446.02	\$440.21	\$468.37	\$445.07
33	\$456.39	\$450.45	\$479.26	\$455.42
34	\$467.31	\$461.22	\$490.73	\$466.31
35	\$478.23	\$472.00	\$502.19	\$477.21
36	\$489.14	\$482.77	\$513.66	\$488.10
37	\$500.06	\$493.55	\$525.12	\$499.00
38	\$506.07	\$499.48	\$531.43	\$504.99
39	\$512.07	\$505.40	\$537.74	\$510.98
40	\$532.27	\$525.34	\$558.95	\$531.14
41	\$553.02	\$545.81	\$580.73	\$551.84
42	\$574.85	\$567.37	\$603.66	\$573.63
43	\$597.24	\$589.46	\$627.17	\$595.97
44	\$620.71	\$612.63	\$651.82	\$619.39
45	\$644.73	\$636.33	\$677.04	\$643.36
46	\$669.84	\$661.12	\$703.41	\$668.42
47	\$696.05	\$686.98	\$730.93	\$694.57
48	\$723.34	\$713.92	\$759.60	\$721.81
49	\$751.73	\$741.94	\$789.41	\$750.13
50	\$781.21	\$771.04	\$820.36	\$779.55
51	\$811.78	\$801.21	\$852.47	\$810.06
52	\$843.45	\$832.46	\$885.72	\$841.65
53	\$876.20	\$864.79	\$920.11	\$874.34
54	\$910.59	\$898.74	\$956.23	\$908.66
55	\$946.08	\$933.76	\$993.49	\$944.07
56	\$983.20	\$970.40	\$1,032.48	\$981.11
57	\$1,021.42	\$1,008.11	\$1,072.61	\$1,019.25
58	\$1,061.27	\$1,047.45	\$1,114.46	\$1,059.01
59	\$1,102.76	\$1,088.40	\$1,158.03	\$1,100.42
60	\$1,145.89	\$1,130.96	\$1,203.31	\$1,143.45
61	\$1,190.62	\$1,175.12	\$1,250.30	\$1,188.09
62	\$1,190.62	\$1,175.12	\$1,250.30	\$1,188.09
63	\$1,190.62	\$1,175.12	\$1,250.30	\$1,188.09
64 and over	\$1,190.62	\$1,175.12	\$1,250.30	\$1,188.09

\* Visit [opm.gov/healthcare-insurance](https://opm.gov/healthcare-insurance) and enter your total from the above chart into the Premium Contribution Calculator for the most accurate estimate of your contribution as well as your employer's contribution.

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### Standard Plans

Our national BluePreferred PPO Standard Gold 500 plan (pg. 15) and regional BlueChoice HMO Standard Gold 500 plan (pg. 26) cover many in-network medical services without you having to meet the deductible first. Services include primary care and specialist visits, mental health services, generic prescription drugs, and urgent care.

For more details visit [www.dchealthlink.com/individuals/standard-plans](http://www.dchealthlink.com/individuals/standard-plans).

### Virtual Connect—Expanding Access and Affordability

Two plans include Virtual Connect—an embedded virtual care benefit that provides more \$0 care options. Members can access \$0 PCP and urgent care visits, as well as \$0 mental health visits, through CloseKnit, a virtual care practice.

# BluePreferred PPO Standard Gold 500

General Information	In-Network BlueCard PPO	Out-of-Network Non-Participating Providers
Deductible (Ind/Fam)—Separate	\$500/\$1,000	\$1,000/\$2,000
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$5,800/\$11,600	\$11,600/\$23,200
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	\$25 PCP/\$50 Specialist per visit	Deductible, then 30% of allowed benefit
Convenience Care (Retail Health Clinic)	\$25 per visit	Deductible, then 30% of allowed benefit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$30 per visit	Deductible, then 30% of allowed benefit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	\$60 per visit	Deductible, then 30% of allowed benefit
Hospital Emergency Room	\$300 per visit (waived if admitted)	\$300 per visit (waived if admitted)
Emergency Room—Physician Services	No charge after deductible	In-network deductible, then 30% of allowed benefit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	\$30 per visit	Deductible, then 30% of allowed benefit
Lab Hospital	\$30 per visit	Deductible, then 30% of allowed benefit
X-ray Non-Hospital	\$50 per visit	Deductible, then 30% of allowed benefit
X-ray Hospital	\$50 per visit	Deductible, then 30% of allowed benefit
Imaging Non-Hospital	\$250 per visit	Deductible, then 30% of allowed benefit
Imaging Hospital	\$250 per visit	Deductible, then 30% of allowed benefit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	\$375 per visit	Deductible, then 30% of allowed benefit
Outpatient Hospital Facility Surgical	\$375 per visit	Deductible, then 30% of allowed benefit
Outpatient Non-Hospital Physician Surgical	\$125 per visit	Deductible, then 30% of allowed benefit
Outpatient Hospital Physician Surgical	\$125 per visit	Deductible, then 30% of allowed benefit
Inpatient Facility Services	Deductible, then \$600 per day (5 day maximum payment per admission)	Deductible, then 30% of allowed benefit
Inpatient Physician Services	No charge after deductible	Deductible, then 30% of allowed benefit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then 30% of allowed benefit
Delivery and Facility Services	No charge after deductible	Deductible, then 30% of allowed benefit
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	\$25 per visit	Deductible, then 30% of allowed benefit
Outpatient Facility Services	\$25 per visit	Deductible, then 30% of allowed benefit
Inpatient Facility Services	Deductible, then \$600 per day (5 day maximum payment per admission)	Deductible, then 30% of allowed benefit
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$0 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	\$15 (30-day supply)/\$30 (90-day supply) <sup>2</sup>	
Preferred Brand Name Drugs	\$50 (30-day supply)/\$100 (90-day supply) <sup>2</sup>	
Non-Preferred Brand Name Drugs	\$70 (30-day supply)/\$140 (90-day supply) <sup>2</sup>	
Preferred Specialty Drugs	\$150 (30-day supply) /\$300 (90-day supply) <sup>2</sup>	
Non-Preferred Specialty Drugs	\$150 (30-day supply) /\$300 (90-day supply) <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BluePreferred PPO Gold 800 Ded TOP 3

General Information	In-Network BlueCard PPO	Out-of-Network Non-Participating Providers
Deductible (Ind/Fam)—Separate	\$800/\$1,600	\$1,600/\$3,200
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$8,850/\$17,700	\$17,700/\$35,400
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	\$15 PCP/\$40 Specialist per visit	Deductible, then \$50 per visit
Convenience Care (Retail Health Clinic)	\$15 per visit	Deductible, then \$50 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$40 per visit	Deductible, then \$50 per visit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	\$50 per visit	Deductible, then \$150 per visit
Hospital Emergency Room	Deductible, then \$350 per visit (waived if admitted)	In-network deductible, then \$350 per visit
Emergency Room—Physician Services	Deductible, then \$40 per visit	In-network deductible, then \$40 per visit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	\$15 per visit	Deductible, then \$65 per visit
Lab Hospital	Deductible, then \$30 per visit	Deductible, then \$110 per visit
X-ray Non-Hospital	\$30 per visit	Deductible, then \$80 per visit
X-ray Hospital	Deductible, then \$60 per visit	Deductible, then \$110 per visit
Imaging Non-Hospital	\$200 per visit	Deductible, then \$250 per visit
Imaging Hospital	Deductible, then \$400 per visit	Deductible, then \$450 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	\$200 per visit	Deductible, then \$300 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$300 per visit	Deductible, then \$400 per visit
Outpatient Non-Hospital Physician Surgical	\$40 per visit	Deductible, then \$50 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$40 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
Inpatient Physician Services	Deductible, then \$40 per visit	Deductible, then \$50 per visit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then \$50 per visit
Delivery and Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	\$15 per visit	Deductible, then \$50 per visit
Outpatient Facility Services	\$50 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	\$10 (30-day supply)/\$20 (90-day supply) <sup>2</sup>	
Preferred Brand Name Drugs	Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply) <sup>2</sup>	
Non-Preferred Brand Name Drugs	Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply) <sup>2</sup>	
Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200 <sup>2</sup>	
Non-Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300 <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BluePreferred PPO Gold 1000 Ded

General Information	In-Network BlueCard PPO	Out-of-Network Non-Participating Providers
Deductible (Ind/Fam)—Separate	\$1,000/\$2,000	\$2,000/\$4,000
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$7,500/\$15,000	\$15,000/\$30,000
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	\$15 PCP/\$40 Specialist per visit	Deductible, then \$50 per visit
Convenience Care (Retail Health Clinic)	\$15 per visit	Deductible, then \$50 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$40 per visit	Deductible, then \$50 per visit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	\$50 per visit	Deductible, then \$150 per visit
Hospital Emergency Room	Deductible, then \$350 per visit (waived if admitted)	In-network deductible, then \$350 per visit (waived if admitted)
Emergency Room—Physician Services	Deductible, then \$40 per visit	In-network deductible, then \$40 per visit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	\$15 per visit	Deductible, then \$65 per visit
Lab Hospital	Deductible, then \$30 per visit	Deductible, then \$110 per visit
X-ray Non-Hospital	\$30 per visit	Deductible, then \$80 per visit
X-ray Hospital	Deductible, then \$60 per visit	Deductible, then \$110 per visit
Imaging Non-Hospital	\$200 per visit	Deductible, then \$250 per visit
Imaging Hospital	Deductible, then \$400 per visit	Deductible, then \$450 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	\$200 per visit	Deductible, then \$300 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$300 per visit	Deductible, then \$400 per visit
Outpatient Non-Hospital Physician Surgical	\$40 per visit	Deductible, then \$50 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$40 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
Inpatient Physician Services	Deductible, then \$40 per visit	Deductible, then \$50 per visit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then \$50 per visit
Delivery and Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	\$15 per visit	Deductible, then \$50 per visit
Outpatient Facility Services	\$50 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	\$10 (30-day supply)/\$20 (90-day supply) <sup>2</sup>	
Preferred Brand Name Drugs	Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply) <sup>2</sup>	
Non-Preferred Brand Name Drugs	Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply) <sup>2</sup>	
Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200 <sup>2</sup>	
Non-Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300 <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BluePreferred PPO Gold 1500 Ded

General Information	In-Network BlueCard PPO	Out-of-Network Non-Participating Providers
Deductible (Ind/Fam)—Separate	\$1,500/\$3,000	\$3,000/\$6,000
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$6,200/\$12,400	\$12,400/24,800
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	\$15 per visit PCP/\$40 Specialist per visit	Deductible, then \$50 per visit
Convenience Care (Retail Health Clinic)	\$15 per visit	Deductible, then \$50 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$40 per visit	Deductible, then \$50 per visit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	\$50 per visit	Deductible, then \$150 per visit
Hospital Emergency Room	Deductible, then \$350 per visit (waived if admitted)	In-network deductible, then \$350 per visit (waived if admitted)
Emergency Room—Physician Services	Deductible, then \$40 per visit	In-network deductible, then \$40 per visit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	\$15 per visit	Deductible, then \$65 per visit
Lab Hospital	Deductible, then \$30 per visit	Deductible, then \$110 per visit
X-ray Non-Hospital	\$30 per visit	Deductible, then \$80 per visit
X-ray Hospital	Deductible, then \$60 per visit	Deductible, then \$110 per visit
Imaging Non-Hospital	\$200 per visit	Deductible, then \$250 per visit
Imaging Hospital	Deductible, then \$400 per visit	Deductible, then \$450 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	\$200 per visit	Deductible, then \$300 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$300 per visit	Deductible, then \$400 per visit
Outpatient Non-Hospital Physician Surgical	\$40 per visit	Deductible, then \$50 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$40 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
Inpatient Physician Services	Deductible then \$40 per visit	Deductible, then \$50 per visit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then \$50 per visit
Delivery and Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	No charge	Deductible, then \$50 per visit
Outpatient Facility Services	No charge	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	\$10 (30-day supply)/\$20 (90-day supply) <sup>2</sup>	
Preferred Brand Name Drugs	Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply) <sup>2</sup>	
Non-Preferred Brand Name Drugs	Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply) <sup>2</sup>	
Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200 <sup>2</sup>	
Non-Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300 <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.



# BlueChoice Advantage Gold 0 Ded

General Information	In-Network BlueChoice (in MD, DC and Northern VA) BlueCard PPO (out of MD, DC and Northern VA)	Out-of-Network PPO/BlueCard PPO Non-Participating Providers
Deductible (Ind/Fam)—Separate	\$0/\$0	\$1,000/\$2,000
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$8,900/\$17,800	\$17,800/\$35,600
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	\$30 PCP/\$60 Specialist per visit	Deductible, then \$50 per visit
Convenience Care (Retail Health Clinic)	\$30 per visit	Deductible, then \$50 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$60 per visit	Deductible, then \$50 per visit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	\$50 per visit	Deductible, then \$150 per visit
Hospital Emergency Room	\$350 per visit (waived if admitted)	\$350 per visit (waived if admitted)
Emergency Room—Physician Services	\$60 per visit	\$60 per visit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	\$30 per visit	Deductible, then \$65 per visit
Lab Hospital	\$80 per visit	Deductible, then \$110 per visit
X-ray Non-Hospital	\$40 per visit	Deductible, then \$80 per visit
X-ray Hospital	\$100 per visit	Deductible, then \$110 per visit
Imaging Non-Hospital	\$200 per visit	Deductible, then \$250 per visit
Imaging Hospital	\$400 per visit	Deductible, then \$450 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	\$200 per visit	Deductible, then \$300 per visit
Outpatient Hospital Facility Surgical	\$300 per visit	Deductible, then \$400 per visit
Outpatient Non-Hospital Physician Surgical	\$60 per visit	Deductible, then \$50 per visit
Outpatient Hospital Physician Surgical	\$60 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	\$500 per admission	Deductible, then \$600 per admission
Inpatient Physician Services	\$60 per visit	Deductible, then \$50 per visit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then \$50 per visit
Delivery and Facility Services	\$500 per admission	Deductible, then \$600 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	\$30 per visit	Deductible, then \$50 per visit
Outpatient Facility Services	\$50 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	\$500 per admission	Deductible, then \$600 per admission
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$0 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	\$10 (30-day supply)/\$20 (90-day supply) <sup>2</sup>	
Preferred Brand Name Drugs	\$45 (30-day supply)/\$90 (90-day supply) <sup>2</sup>	
Non-Preferred Brand Name Drugs	\$65 (30-day supply)/\$130 (90-day supply) <sup>2</sup>	
Preferred Specialty Drugs	\$100 (30-day supply)/\$200 (90-day supply) <sup>2</sup>	
Non-Preferred Specialty Drugs	\$150 (30-day supply)/\$300 (90-day supply) <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

BlueChoice Advantage Gold 800 Ded **TOP 3**

General Information	In-Network BlueChoice (in MD, DC and Northern VA) BlueCard PPO (out of MD, DC and Northern VA)	Out-of-Network PPO/BlueCard PPO Non-Participating Providers
Deductible (Ind/Fam)—Separate	\$800/\$1,600	\$1,600/\$3,200
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$8,850/\$17,700	\$17,700/\$35,400
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	\$15 PCP/\$40 Specialist per visit	Deductible, then \$50 per visit
Convenience Care (Retail Health Clinic)	\$15 per visit	Deductible, then \$50 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$40 per visit	Deductible, then \$50 per visit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	\$50 per visit	Deductible, then \$150 per visit
Hospital Emergency Room	Deductible, then \$350 per visit (waived if admitted)	In-network deductible, then \$350 per visit (waived if admitted)
Emergency Room—Physician Services	Deductible, then \$40 per visit	In-network deductible, then \$40 per visit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	\$15 per visit	Deductible, then \$65 per visit
Lab Hospital	Deductible, then \$30 per visit	Deductible, then \$110 per visit
X-ray Non-Hospital	\$30 per visit	Deductible, then \$80 per visit
X-ray Hospital	Deductible, then \$60 per visit	Deductible, then \$110 per visit
Imaging Non-Hospital	\$200 per visit	Deductible, then \$250 per visit
Imaging Hospital	Deductible, then \$400 per visit	Deductible, then \$450 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	\$200 per visit	Deductible, then \$300 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$300 per visit	Deductible, then \$400 per visit
Outpatient Non-Hospital Physician Surgical	\$40 per visit	Deductible, then \$50 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$40 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
Inpatient Physician Services	Deductible, then \$40 per visit	Deductible, then \$50 per visit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then \$50 per visit
Delivery and Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	\$15 per visit	Deductible, then \$50 per visit
Outpatient Facility Services	\$50 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	\$10 (30-day supply)/\$20 (90-day supply) <sup>2</sup>	
Preferred Brand Name Drugs	Deductible, then \$45 (30-day supply)/\$90 (90-day supply) <sup>2</sup>	
Non-Preferred Brand Name Drugs	Deductible, then \$65 (30-day supply)/\$130 (90-day supply) <sup>2</sup>	
Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200 <sup>2</sup>	
Non-Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300 <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BlueChoice Advantage Gold 1000 Ded TOP 3

General Information	In-Network BlueChoice (in MD, DC and Northern VA) BlueCard PPO (out of MD, DC and Northern VA)	Out-of-Network PPO/BlueCard PPO Non-Participating Providers
Deductible (Ind/Fam)—Separate	\$1,000/\$2,000	\$2,000/\$4,000
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$7,500/\$15,000	\$15,000/\$30,000
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	\$15 PCP/\$40 Specialist per visit	Deductible, then \$50 per visit
Convenience Care (Retail Health Clinic)	\$15 per visit	Deductible, then \$50 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$40 per visit	Deductible, then \$50 per visit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	\$50 per visit	Deductible, then \$150 per visit
Hospital Emergency Room	Deductible, then \$350 per visit (waived if admitted)	In-network deductible, then \$350 per visit (waived if admitted)
Emergency Room—Physician Services	Deductible, then \$40 per visit	In-network deductible, then \$40 per visit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	\$15 per visit	Deductible, then \$65 per visit
Lab Hospital	Deductible, then \$30 per visit	Deductible, then \$110 per visit
X-ray Non-Hospital	\$30 per visit	Deductible, then \$80 per visit
X-ray Hospital	Deductible, then \$60 per visit	Deductible, then \$110 per visit
Imaging Non-Hospital	\$200 per visit	Deductible, then \$250 per visit
Imaging Hospital	Deductible, then \$400 per visit	Deductible, then \$450 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	\$200 per visit	Deductible, then \$300 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$300 per visit	Deductible, then \$400 per visit
Outpatient Non-Hospital Physician Surgical	\$40 per visit	Deductible, then \$50 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$40 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
Inpatient Physician Services	Deductible then \$40 per visit	Deductible, then \$50 per visit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then \$50 per visit
Delivery and Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	\$15 per visit	Deductible, then \$50 per visit
Outpatient Facility Services	\$50 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	\$10 (30-day supply)/\$20 (90-day supply <sup>2</sup> )	
Preferred Brand Name Drugs	Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply <sup>2</sup> )	
Non-Preferred Brand Name Drugs	Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply <sup>2</sup> )	
Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200 <sup>2</sup>	
Non-Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300 <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.



# BlueChoice Advantage HSA/HRA Gold 1600 Ded

General Information	In-Network BlueChoice (in MD, DC and Northern VA) BlueCard PPO (out of MD, DC and Northern VA)	Out-of-Network PPO/BlueCard PPO Non-Participating Providers
Deductible (Ind/Fam)—Aggregate	\$1,600/\$3,200	\$3,200/\$6,400
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$4,200/\$8,400	\$8,400/\$16,800
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	Deductible, then \$10 per visit PCP/ Deductible, then \$30 per visit Specialist	Deductible, then \$40 per visit
Convenience Care (Retail Health Clinic)	Deductible, then \$10 per visit	Deductible, then \$40 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	Deductible, then \$30 per visit	Deductible, then \$40 per visit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	Deductible, then \$50 per visit	Deductible, then \$150 per visit
Hospital Emergency Room	Deductible, then \$250 per visit (waived if admitted)	In-network deductible, then \$250 per visit (waived if admitted)
Emergency Room—Physician Services	Deductible, then \$30 per visit	In-network deductible, then \$30 per visit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	Deductible, then \$10 per visit	Deductible, then \$40 per visit
Lab Hospital	Deductible, then \$20 per visit	Deductible, then \$80 per visit
X-ray Non-Hospital	Deductible, then \$20 per visit	Deductible, then \$40 per visit
X-ray Hospital	Deductible, then \$40 per visit	Deductible, then \$80 per visit
Imaging Non-Hospital	Deductible, then \$50 per visit	Deductible, then \$150 per visit
Imaging Hospital	Deductible, then \$100 per visit	Deductible, then \$200 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	Deductible, then \$50 per visit	Deductible, then \$150 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$100 per visit	Deductible, then \$200 per visit
Outpatient Non-Hospital Physician Surgical	Deductible, then \$30 per visit	Deductible, then \$40 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$30 per visit	Deductible, then \$40 per visit
Inpatient Facility Services	Deductible, then \$200 per admission	Deductible, then \$300 per admission
Inpatient Physician Services	Deductible, then \$30 per visit	Deductible, then \$40 per visit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then \$40 per visit
Delivery and Facility Services	Deductible, then \$200 per admission	Deductible, then \$300 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	Deductible, then \$10 per visit	Deductible, then \$40 per visit
Outpatient Facility Services	Deductible, then \$20 per visit	Deductible, then \$40 per visit
Inpatient Facility Services	Deductible, then \$200 per admission	Deductible, then \$300 per admission
<b>PRESCRIPTION DRUGS—INTEGRATED (COMBINED MEDICAL AND PRESCRIPTION DRUG DEDUCTIBLE)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	Deductible, then \$10 (30-day supply)/Deductible, then \$20 (90-day supply <sup>2</sup> )	
Preferred Brand Name Drugs	Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply <sup>2</sup> )	
Non-Preferred Brand Name Drugs	Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply <sup>2</sup> )	
Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200 <sup>2</sup>	
Non-Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300 <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BlueChoice Advantage Gold 3000 Ded Virtual Connect

General Information	In-Network BlueChoice (in MD, DC and Northern VA) BlueCard PPO (out of MD, DC and Northern VA)	Out-of-Network PPO/BlueCard PPO Non-Participating Providers
Deductible (Ind/Fam)—Separate	\$3,000/\$6,000	\$6,000/\$12,000
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$7,300/\$14,600	\$14,600/\$29,200
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	Virtual Connect through CloseKnit—No charge/All other providers: \$15 per visit/ \$40 Specialist per visit	Deductible, then \$50 per visit
Convenience Care (Retail Health Clinic)	\$15 per visit	Deductible, then \$50 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$40 per visit	Deductible, then \$50 per visit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	\$50 per visit	Deductible, then \$150 per visit
Hospital Emergency Room	Deductible, then \$250 per visit (waived if admitted)	In-network deductible, then \$250 per visit (waived if admitted)
Emergency Room—Physician Services	Deductible, then \$40 per visit	In-network deductible, then \$40 per visit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	\$15 per visit	Deductible, then \$65 per visit
Lab Hospital	Deductible, then \$30 per visit	Deductible, then \$110 per visit
X-ray Non-Hospital	\$30 per visit	Deductible, then \$80 per visit
X-ray Hospital	Deductible, then \$60 per visit	Deductible, then \$110 per visit
Imaging Non-Hospital	\$100 per visit	Deductible, then \$150 per visit
Imaging Hospital	Deductible, then \$200 per visit	Deductible, then \$250 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	\$100 per visit	Deductible, then \$150 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$200 per visit	Deductible, then \$250 per visit
Outpatient Non-Hospital Physician Surgical	\$40 per visit	Deductible, then \$50 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$40 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$200 per admission	Deductible, then \$300 per admission
Inpatient Physician Services	Deductible, then \$40 per visit	Deductible, then \$50 per visit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then \$50 per visit
Delivery and Facility Services	Deductible, then \$200 per admission	Deductible, then \$300 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	Virtual Connect through CloseKnit—No charge/All other providers: No Charge	Deductible, then \$50 per visit
Outpatient Facility Services	No charge	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$200 per admission	Deductible, then \$300 per admission
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	\$10 (30-day supply)/\$20 (90-day supply <sup>2</sup> )	
Preferred Brand Name Drugs	Deductible, then \$40 (30-day supply)/Deductible, then \$80 (90-day supply <sup>2</sup> )	
Non-Preferred Brand Name Drugs	Deductible, then \$70 (30-day supply)/Deductible, then \$140 (90-day supply <sup>2</sup> )	
Preferred Specialty Drugs	Deductible, then \$100 (30-day supply)/Deductible, then \$200 (90-day supply <sup>2</sup> )	
Non-Preferred Specialty Drugs	Deductible, then \$150 (30-day supply)/Deductible, then \$300 (90-day supply <sup>2</sup> )	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BlueChoice Plus Gold 800 Ded

General Information	In-Network BlueChoice HMO (in MD, DC and Northern VA only)	Out-of-Network PPO/BlueCard PPO Non-Participating Provider
Deductible (Ind/Fam)—Separate	\$800/\$1,600	\$1,600/\$3,200
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$8,850/\$17,700	\$17,700/\$35,400
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	\$15 PCP/\$40 Specialist per visit	Deductible, then \$50 per visit
Convenience Care (Retail Health Clinic)	\$15 per visit	Deductible, then \$50 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$40 per visit	Deductible, then \$50 per visit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	\$50 per visit	Deductible, then \$150 per visit
Hospital Emergency Room	Deductible, then \$350 per visit (waived if admitted)	In-network deductible, then \$350 per visit (waived if admitted)
Emergency Room—Physician Services	Deductible, then \$40 per visit	In-network deductible, then \$40 per visit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	\$15 per visit	Deductible, then \$65 per visit
Lab Hospital	Deductible, then \$30 per visit	Deductible, then \$110 per visit
X-ray Non-Hospital	\$30 per visit	Deductible, then \$80 per visit
X-ray Hospital	Deductible, then \$60 per visit	Deductible, then \$110 per visit
Imaging Non-Hospital	\$200 per visit	Deductible, then \$250 per visit
Imaging Hospital	Deductible, then \$400 per visit	Deductible, then \$450 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	\$200 per visit	Deductible, then \$300 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$300 per visit	Deductible, then \$400 per visit
Outpatient Non-Hospital Physician Surgical	\$40 per visit	Deductible, then \$50 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$40 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
Inpatient Physician Services	Deductible, then \$40 per visit	Deductible, then \$50 per visit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then \$50 per visit
Delivery and Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	\$15 per visit	Deductible, then \$50 per visit
Outpatient Facility Services	\$50 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	\$10 (30-day supply)/\$20 (90-day supply) <sup>2</sup>	
Preferred Brand Name Drugs	Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply) <sup>2</sup>	
Non-Preferred Brand Name Drugs	Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply) <sup>2</sup>	
Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200 <sup>2</sup>	
Non-Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300 <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.



# BlueChoice Plus Gold 1000 Ded

General Information	In-Network BlueChoice (in MD, DC and Northern VA only)	Out-of-Network PPO/BlueCard PPO Non-Participating Provider
Deductible (Ind/Fam)—Separate	\$1,000/\$2,000	\$2,000/\$4,000
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$7,500/\$15,000	\$15,000/\$30,000
<b>24-HOUR NURSE ADVICE LINE</b>		
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.		
<b>Services</b>		
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>		
Well-Child Care	No charge	No charge
Adult Physical Exam	No charge	No charge after deductible
Breast Cancer Screening/PAP Test	No charge	No charge
Colorectal Screening	No charge	No charge after deductible
Prostate Screening	No charge	No charge
Office Visits <sup>1</sup>	\$15 PCP/\$40 Specialist per visit	Deductible, then \$50 per visit
Convenience Care (Retail Health Clinic)	\$15 per visit	Deductible, then \$50 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$40 per visit	Deductible, then \$50 per visit
<b>URGENT AND EMERGENCY CARE</b>		
Urgent Care Center	\$50 per visit	Deductible, then \$150 per visit
Hospital Emergency Room	Deductible, then \$350 per visit (waived if admitted)	In-network deductible, then \$350 per visit (waived if admitted)
Emergency Room—Physician Services	Deductible, then \$40 per visit	In-network deductible, then \$40 per visit
<b>DIAGNOSTIC SERVICES</b>		
Lab Non-Hospital	\$15 per visit	Deductible, then \$65 per visit
Lab Hospital	Deductible, then \$30 per visit	Deductible, then \$110 per visit
X-ray Non-Hospital	\$30 per visit	Deductible, then \$80 per visit
X-ray Hospital	Deductible, then \$60 per visit	Deductible, then \$110 per visit
Imaging Non-Hospital	\$200 per visit	Deductible, then \$250 per visit
Imaging Hospital	Deductible, then \$400 per visit	Deductible, then \$450 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>		
Outpatient Non-Hospital Facility Surgical	\$200 per visit	Deductible, then \$300 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$300 per visit	Deductible, then \$400 per visit
Outpatient Non-Hospital Physician Surgical	\$40 per visit	Deductible, then \$50 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$40 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
Inpatient Physician Services	Deductible, then \$40 per visit	Deductible, then \$50 per visit
<b>MATERNITY</b>		
Preventive Pre/Postnatal Office Visits	No charge	Deductible, then \$50 per visit
Delivery and Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>		
Office Visits <sup>1</sup>	\$15 per visit	Deductible, then \$50 per visit
Outpatient Facility Services	\$50 per visit	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission	Deductible, then \$500 per admission
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>		
Preferred Insulin	No charge	
Preventive Drugs	No charge	
Generic Drugs	\$10 (30-day supply)/\$20 (90-day supply <sup>2</sup> )	
Preferred Brand Name Drugs	Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply <sup>2</sup> )	
Non-Preferred Brand Name Drugs	Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply <sup>2</sup> )	
Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200 <sup>2</sup>	
Non-Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300 <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BlueChoice HMO Standard Gold 500

General Information	In-Network BlueChoice HMO (in MD, DC and Northern VA only)
Deductible (Ind/Fam)—Separate	\$500/\$1,000
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$5,800/\$11,600
<b>24-HOUR NURSE ADVICE LINE</b>	
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.	
<b>Services</b>	
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>	
Well-Child Care	No charge
Adult Physical Exam	No charge
Breast Cancer Screening/PAP Test	No charge
Prostate/Colorectal Screening	No charge
Office Visits <sup>1</sup>	\$25 per visit/\$50 Specialist per visit
Convenience Care (Retail Health Clinic)	\$25 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	\$30 per visit
<b>URGENT AND EMERGENCY CARE</b>	
Urgent Care Center	\$60 per visit
Hospital Emergency Room	\$300 per visit (waived if admitted)
Emergency Room—Physician Services	No charge
<b>DIAGNOSTIC SERVICES</b>	
LabCorp	\$30 per visit
Lab Hospital	\$30 per visit
X-ray Non-Hospital	\$50 per visit
X-ray Hospital	\$50 per visit
Imaging Non-Hospital	\$250 per visit
Imaging Hospital	\$250 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>	
Outpatient Non-Hospital Facility Surgical	\$375 per visit
Outpatient Hospital Facility Surgical	\$375 per visit
Outpatient Non-Hospital Physician Surgical	\$125 per visit
Outpatient Hospital Physician Surgical	\$125 per visit
Inpatient Facility Services	Deductible, then \$600 per day (5 day maximum payment per admission)
Inpatient Physician Services	No charge after deductible
<b>MATERNITY</b>	
Preventive Pre/Postnatal Office Visits	No charge
Delivery and Facility Services	Deductible, then \$600 per day (5 day maximum payment per admission)
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>	
Office Visits <sup>1</sup>	\$25 per visit
Outpatient Facility Services	\$25 per visit
Inpatient Facility Services	Deductible, then \$600 per day (5 day maximum payment per admission)
<b>PRESCRIPTION DRUGS—NON-INTEGRATED (\$0 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)</b>	
Preferred Insulin	No charge
Preventive Drugs	No charge
Generic Drugs	\$15 (30-day supply)/\$30 (90-day supply <sup>2</sup> )
Preferred Brand Name Drugs	\$50 (30-day supply)/\$100 (90-day supply <sup>2</sup> )
Non-Preferred Brand Name Drugs	\$70 (30-day supply)/\$140 (90-day supply <sup>2</sup> )
Preferred Specialty Drugs	\$150 (30-day supply)/\$300 (90-day supply <sup>2</sup> )
Non-Preferred Specialty Drugs	\$150 (30-day supply)/\$300 (90-day supply <sup>2</sup> )

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BlueChoice HMO Gold 800 Ded

General Information		In-Network BlueChoice HMO (in MD, DC and Northern VA only)	
Deductible (Ind/Fam)—Separate		\$800/\$1,600	
Out-of-Pocket Maximum (Ind/Fam)—Separate		\$8,850/\$17,700	
24-HOUR NURSE ADVICE LINE			
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.			
Services			
PREVENTIVE AND PHYSICIAN SERVICES			
Well-Child Care		No charge	
Adult Physical Exam		No charge	
Breast Cancer Screening/PAP Test		No charge	
Prostate/Colorectal Screening		No charge	
Office Visits <sup>1</sup>		\$15 per visit PCP/\$40 Specialist per visit	
Convenience Care (Retail Health Clinic)		\$15 per visit	
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>		\$40 per visit	
URGENT AND EMERGENCY CARE			
Urgent Care Center		\$50 per visit	
Hospital Emergency Room		Deductible, then \$350 per visit (waived if admitted)	
Emergency Room—Physician Services		Deductible, then \$40 per visit	
DIAGNOSTIC SERVICES			
LabCorp		\$15 per visit	
Lab Hospital		Deductible, then \$30 per visit	
X-ray Non-Hospital		\$30 per visit	
X-ray Hospital		Deductible, then \$60 per visit	
Imaging Non-Hospital		\$200 per visit	
Imaging Hospital		Deductible, then \$400 per visit	
HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)			
Outpatient Non-Hospital Facility Surgical		\$200 per visit	
Outpatient Hospital Facility Surgical		Deductible, then \$300 per visit	
Outpatient Non-Hospital Physician Surgical		\$40 per visit	
Outpatient Hospital Physician Surgical		Deductible, then \$40 per visit	
Inpatient Facility Services		Deductible, then \$400 per admission	
Inpatient Physician Services		Deductible, then \$40 per visit	
MATERNITY			
Preventive Pre/Postnatal Office Visits		No charge	
Delivery and Facility Services		Deductible, then \$400 per admission	
MENTAL HEALTH AND SUBSTANCE USE DISORDER			
Office Visits <sup>1</sup>		\$15 per visit	
Outpatient Facility Services		\$50 per visit	
Inpatient Facility Services		Deductible, then \$400 per admission	
PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)			
Preferred Insulin		No charge	
Preventive Drugs		No charge	
Generic Drugs		\$10 (30-day supply)/\$20 (90-day supply <sup>2</sup> )	
Preferred Brand Name Drugs		Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply <sup>2</sup> )	
Non-Preferred Brand Name Drugs		Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply <sup>2</sup> )	
Preferred Specialty Drugs		30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200 <sup>2</sup>	
Non-Preferred Specialty Drugs		30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300 <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BlueChoice HMO Gold 1500 Ded

General Information		In-Network BlueChoice HMO (in MD, DC and Northern VA only)	
Deductible (Ind/Fam)—Separate		\$1,500/\$3,000	
Out-of-Pocket Maximum (Ind/Fam)—Separate		\$6,200/\$12,400	
24-HOUR NURSE ADVICE LINE			
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.			
Services			
PREVENTIVE AND PHYSICIAN SERVICES			
Well-Child Care		No charge	
Adult Physical Exam		No charge	
Breast Cancer Screening/PAP Test		No charge	
Prostate/Colorectal Screening		No charge	
Office Visits¹		\$15 per visit PCP/\$40 Specialist per visit	
Convenience Care (Retail Health Clinic)		\$15 per visit	
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies¹		\$40 per visit	
URGENT AND EMERGENCY CARE			
Urgent Care Center		\$50 per visit	
Hospital Emergency Room		Deductible, then \$350 per visit (waived if admitted)	
Emergency Room—Physician Services		Deductible, then \$40 per visit	
DIAGNOSTIC SERVICES			
LabCorp		\$15 per visit	
Lab Hospital		Deductible, then \$30 per visit	
X-ray Non-Hospital		\$30 per visit	
X-ray Hospital		Deductible, then \$60 per visit	
Imaging Non-Hospital		\$200 per visit	
Imaging Hospital		Deductible, then \$400 per visit	
HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)			
Outpatient Non-Hospital Facility Surgical		\$200 per visit	
Outpatient Hospital Facility Surgical		Deductible, then \$300 per visit	
Outpatient Non-Hospital Physician Surgical		\$40 per visit	
Outpatient Hospital Physician Surgical		Deductible, then \$40 per visit	
Inpatient Facility Services		Deductible, then \$400 per admission	
Inpatient Physician Services		Deductible, then \$40 per visit	
MATERNITY			
Preventive Pre/Postnatal Office Visits		No charge	
Delivery and Facility Services		Deductible, then \$400 per admission	
MENTAL HEALTH AND SUBSTANCE USE DISORDER			
Office Visits¹		No charge	
Outpatient Facility Services		No charge	
Inpatient Facility Services		Deductible, then \$400 per admission	
PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)			
Preferred Insulin		No charge	
Preventive Drugs		No charge	
Generic Drugs		\$10 (30-day supply)/\$20 (90-day supply²)	
Preferred Brand Name Drugs		Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply²)	
Non-Preferred Brand Name Drugs		Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply²)	
Preferred Specialty Drugs		30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200²	
Non-Preferred Specialty Drugs		30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300²	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BlueChoice HMO HSA/HRA Gold 1600 Ded

General Information	In-Network BlueChoice HMO (in MD, DC and Northern VA only)
Deductible (Ind/Fam)—Aggregate	\$1,600/\$3,200
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$4,200/\$8,400
<b>24-HOUR NURSE ADVICE LINE</b>	
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.	
<b>Services</b>	
<b>PREVENTIVE AND PHYSICIAN SERVICES</b>	
Well-Child Care	No charge
Adult Physical Exam	No charge
Breast Cancer Screening/PAP Test	No charge
Prostate/Colorectal Screening	No charge
Office Visits <sup>1</sup>	Deductible, then \$10 per visit PCP/Deductible, then \$30 per visit Specialist
Convenience Care (Retail Health Clinic)	Deductible, then \$10 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>	Deductible, then \$30 per visit
<b>URGENT AND EMERGENCY CARE</b>	
Urgent Care Center	Deductible, then \$50 per visit
Hospital Emergency Room	Deductible, then \$250 per visit (waived if admitted)
Emergency Room—Physician Services	Deductible, then \$30 per visit
<b>DIAGNOSTIC SERVICES</b>	
LabCorp	Deductible, then \$10 per visit
Lab Hospital	Deductible, then \$20 per visit
X-ray Non-Hospital	Deductible, then \$20 per visit
X-ray Hospital	Deductible, then \$40 per visit
Imaging Non-Hospital	Deductible, then \$50 per visit
Imaging Hospital	Deductible, then \$100 per visit
<b>HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)</b>	
Outpatient Non-Hospital Facility Surgical	Deductible, then \$50 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$100 per visit
Outpatient Non-Hospital Physician Surgical	Deductible, then \$60 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$30 per visit
Inpatient Facility Services	Deductible, then \$200 per admission
Inpatient Physician Services	Deductible, then \$30 per visit
<b>MATERNITY</b>	
Preventive Pre/Postnatal Office Visits	No charge
Delivery and Facility Services	Deductible, then \$200 per admission
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>	
Office Visits <sup>1</sup>	Deductible, then \$10 per visit
Outpatient Facility Services	Deductible, then \$20 per visit
Inpatient Facility Services	Deductible, then \$200 per admission
<b>PRESCRIPTION DRUGS—INTEGRATED (COMBINED MEDICAL AND PRESCRIPTION DRUG DEDUCTIBLE)</b>	
Preferred Insulin	No charge
Preventive Drugs	No charge
Generic Drugs	Deductible, then \$10 (30-day supply)/Deductible, then \$20 (90-day supply <sup>2</sup> )
Preferred Brand Name Drugs	Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply <sup>2</sup> )
Non-Preferred Brand Name Drugs	Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply <sup>2</sup> )
Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200 <sup>2</sup>
Non-Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300 <sup>2</sup>

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BlueChoice HMO Gold 3000 Ded Virtual Connect

General Information		In-Network BlueChoice HMO (in MD, DC and Northern VA only)	
Deductible (Ind/Fam)—Separate		\$3,000/\$6,000	
Out-of-Pocket Maximum (Ind/Fam)—Separate		\$7,300/\$14,600	
24-HOUR NURSE ADVICE LINE			
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.			
Services			
PREVENTIVE AND PHYSICIAN SERVICES			
Well-Child Care		No charge	
Adult Physical Exam		No charge	
Breast Cancer Screening/PAP Test		No charge	
Prostate/Colorectal Screening		No charge	
Office Visits <sup>1</sup>		Virtual Connect through CloseKnit—No charge; All other providers: \$15 per visit/ \$40 Specialist per visit	
Convenience Care (Retail Health Clinic)		\$15 per visit	
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>		\$40 per visit	
URGENT AND EMERGENCY CARE			
Urgent Care Center		\$50 per visit	
Hospital Emergency Room		Deductible, then \$250 (waived if admitted)	
Emergency Room—Physician Services		Deductible, then \$40 per visit	
DIAGNOSTIC SERVICES			
Lab Non-Hospital		\$15 per visit	
Lab Hospital		Deductible, then \$30 per visit	
X-ray Non-Hospital		\$30 per visit	
X-ray Hospital		Deductible, then \$60 per visit	
Imaging Non-Hospital		\$100 per visit	
Imaging Hospital		Deductible, then \$200 per visit	
HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)			
Outpatient Non-Hospital Facility Surgical		\$100 per visit	
Outpatient Hospital Facility Surgical		Deductible, then \$200 per visit	
Outpatient Non-Hospital Physician Surgical		\$40 per visit	
Outpatient Hospital Physician Surgical		Deductible, then \$40 per visit	
Inpatient Facility Services		Deductible, then \$200 per admission	
Inpatient Physician Services		Deductible, then \$40 per visit	
MATERNITY			
Preventive Pre/Postnatal Office Visits		No charge	
Delivery and Facility Services		Deductible, then \$200 per admission	
MENTAL HEALTH AND SUBSTANCE USE DISORDER			
Office Visits <sup>1</sup>		Virtual Connect through CloseKnit—No charge; All other providers: No Charge	
Outpatient Facility Services		No charge	
Inpatient Facility Services		Deductible, then \$200 per admission	
PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)			
Preferred Insulin		No charge	
Preventive Drugs		No charge	
Generic Drugs		\$10 (30-day supply)/\$20 (90-day supply <sup>2</sup> )	
Preferred Brand Name Drugs		Deductible, then \$40 (30-day supply)/Deductible, then \$80 (90-day supply <sup>2</sup> )	
Non-Preferred Brand Name Drugs		Deductible, then \$70 (30-day supply)/Deductible, then \$140 (90-day supply <sup>2</sup> )	
Preferred Specialty Drugs		Deductible, then \$100 (30-day supply)/Deductible, then \$200 (90-day supply <sup>2</sup> )	
Non-Preferred Specialty Drugs		Deductible, then \$150 (30-day supply)/Deductible, then \$300 (90-day supply <sup>2</sup> )	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.



# BlueChoice HMO Referral Gold 0 Ded

General Information		In-Network BlueChoice HMO (in MD, DC and Northern VA only)	
Deductible (Ind/Fam)—Separate		\$0/\$0	
Out-of-Pocket Maximum (Ind/Fam)—Separate		\$8,900/\$17,800	
24-HOUR NURSE ADVICE LINE			
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.			
Services			
PREVENTIVE AND PHYSICIAN SERVICES			
Well-Child Care		No charge	
Adult Physical Exam		No charge	
Breast Cancer Screening/PAP Test		No charge	
Prostate/Colorectal Screening		No charge	
Office Visits <sup>1</sup>		\$30 PCP/\$60 Specialist per visit	
Convenience Care (Retail Health Clinic)		\$30 per visit	
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies <sup>1</sup>		\$60 per visit	
URGENT AND EMERGENCY CARE			
Urgent Care Center		\$50 per visit	
Hospital Emergency Room		\$350 per visit (waived if admitted)	
Emergency Room—Physician Services		\$60 per visit	
DIAGNOSTIC SERVICES			
LabCorp		\$30 per visit	
Lab Hospital		\$80 per visit	
X-ray Non-Hospital		\$40 per visit	
X-ray Hospital		\$100 per visit	
Imaging Non-Hospital		\$200 per visit	
Imaging Hospital		\$400 per visit	
HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)			
Outpatient Non-Hospital Facility Surgical		\$200 per visit	
Outpatient Hospital Facility Surgical		\$300 per visit	
Outpatient Non-Hospital Physician Surgical		\$60 per visit	
Outpatient Hospital Physician Surgical		\$60 per visit	
Inpatient Facility Services		\$500 per admission	
Inpatient Physician Services		\$60 per visit	
MATERNITY			
Preventive Pre/Postnatal Office Visits		No charge	
Delivery and Facility Services		\$500 per admission	
MENTAL HEALTH AND SUBSTANCE USE DISORDER			
Office Visits <sup>1</sup>		\$30 per visit	
Outpatient Facility Services		\$50 per visit	
Inpatient Facility Services		\$500 per admission	
PRESCRIPTION DRUGS—NON-INTEGRATED (\$0 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)			
Preferred Insulin		No charge	
Preventive Drugs		No charge	
Generic Drugs		\$10 (30-day supply)/\$20 (90-day supply <sup>2</sup> )	
Preferred Brand Name Drugs		\$45 (30-day supply)/\$90 (90-day supply <sup>2</sup> )	
Non-Preferred Brand Name Drugs		\$65 (30-day supply)/\$130 (90-day supply <sup>2</sup> )	
Preferred Specialty Drugs		30-day supply, 50% up to \$100 90-day supply, 50% up to \$200 <sup>2</sup>	
Non-Preferred Specialty Drugs		30-day supply, 50% up to \$150 90-day supply, 50% up to \$300 <sup>2</sup>	

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# BlueChoice HMO Referral Gold 800 Ded

General Information	In-Network BlueChoice HMO (in MD, DC and Northern VA only)
Deductible (Ind/Fam)—Separate	\$800/\$1,600
Out-of-Pocket Maximum (Ind/Fam)—Separate	\$8,850/\$17,700
24-HOUR NURSE ADVICE LINE	
When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health and treatment options.	
Services	
PREVENTIVE AND PHYSICIAN SERVICES	
Well-Child Care	No charge
Adult Physical Exam	No charge
Breast Cancer Screening/PAP Test	No charge
Prostate/Colorectal Screening	No charge
Office Visits¹	\$15 PCP/\$40 Specialist per visit
Convenience Care (Retail Health Clinic)	\$15 per visit
Outpatient Spinal Manipulation, Physical, Speech and Occupational Therapies¹	\$40 per visit
URGENT AND EMERGENCY CARE	
Urgent Care Center	\$50 per visit
Hospital Emergency Room	Deductible, then \$350 per visit (waived if admitted)
Emergency Room—Physician Services	Deductible, then \$40 per visit
DIAGNOSTIC SERVICES	
LabCorp	\$15 per visit
Lab Hospital	Deductible, then \$30 per visit
X-ray Non-Hospital	\$30 per visit
X-ray Hospital	Deductible, then \$60 per visit
Imaging Non-Hospital	\$200 per visit
Imaging Hospital	Deductible, then \$400 per visit
HOSPITALIZATION SERVICES (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)	
Outpatient Non-Hospital Facility Surgical	\$200 per visit
Outpatient Hospital Facility Surgical	Deductible, then \$300 per visit
Outpatient Non-Hospital Physician Surgical	\$40 per visit
Outpatient Hospital Physician Surgical	Deductible, then \$40 per visit
Inpatient Facility Services	Deductible, then \$400 per admission
Inpatient Physician Services	Deductible, then \$40 per visit
MATERNITY	
Preventive Pre/Postnatal Office Visits	No charge
Delivery and Facility Services	Deductible, then \$400 per admission
MENTAL HEALTH AND SUBSTANCE USE DISORDER	
Office Visits¹	\$15 per visit
Outpatient Facility Services	\$50 per visit
Inpatient Facility Services	Deductible, then \$400 per admission
PRESCRIPTION DRUGS—NON-INTEGRATED (\$250 ANNUAL PRESCRIPTION DRUG DEDUCTIBLE PER PERSON)	
Preferred Insulin	No charge
Preventive Drugs	No charge
Generic Drugs	\$10 (30-day supply)/\$20 (90-day supply²)
Preferred Brand Name Drugs	Deductible, then \$45 (30-day supply)/Deductible, then \$90 (90-day supply²)
Non-Preferred Brand Name Drugs	Deductible, then \$65 (30-day supply)/Deductible, then \$130 (90-day supply²)
Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$100 90-day supply, Deductible, then 50% up to \$200²
Non-Preferred Specialty Drugs	30-day supply, Deductible, then 50% up to \$150 90-day supply, Deductible, then 50% up to \$300²

<sup>1</sup> Facility charge: If a service is rendered on a hospital campus, you may receive two bills, one from the physician and one from the facility. It is the member's responsibility to determine if they will be billed separately.

<sup>2</sup> Applies to 90-day supply of maintenance drugs only.

# Federal Benefits

## Federal Employees' Dental and Vision Insurance Program

The Federal Employees' Dental and Vision Insurance Program (FEDVIP) Open Season begins November 13, 2023 and continues through December 11, 2023. During this period, if you are eligible for government benefits, you may enroll, cancel or make a change to your FEDVIP enrollment. The process for enrollment remains the same as last year and Open Season requests will be effective January 1, 2024.

### How to enroll?

To enroll, cancel or change your enrollment in a FEDVIP plan, you must visit **BENEFEDS.com** or call **877-888-3337** TTY: **877-889-5680**. Once an election is made, the BENEFEDS website will send information to the dental/vision carriers and to payroll. The carrier will send you a final confirmation of enrollment, your member ID cards and plan information.



## Federal Flexible Spending Account Program

The Federal Flexible Spending Account program, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or healthcare expenses. You pay less in taxes so you save money. Participating employees save an average of 30% on products and services they routinely pay for out of pocket.

### How do I enroll?

You enroll online at **BENEFEDS.com**. For those without access to a computer, call **877-888-3337** TTY: **877-889-5680**.

For more information, visit **FSAFEDS.com** or call an FSAFEDS benefits coordinator at **877-372-3337**, Monday–Friday, 9 a.m. to 9 p.m. ET. TTY: **866-353-8058**.

## Health Savings Account

A Health Savings Account (HSA) is a tax-exempt medical savings account that can be used to pay for your own—and your dependents'—eligible expenses. HSAs enable you to pay for eligible health expenses and save for future health expenses on a tax-free basis. We offer two health insurance plans that coordinate with an HSA. Look for HSA in the plan name.



*Open Season for enrolling in, or changing the elections of, your 2024 benefits is November 13, 2023 through December 11, 2023.*

# Online Resources

## Be the first to know about important news and updates from CareFirst

Choose convenient electronic delivery of alerts, reminders, explanation of benefits (EOBs) and other communications by giving us your e-consent.

1. Log in to **carefirst.com/myaccount**.
2. Click on your name at the top, then select *Communications Preferences*.
3. Click on *Edit* next to *Electronic Communications*.
4. Check the boxes for the information you want and hit *Save*.

## Important websites

### Ready to enroll?

- DC Health Link: **DCHealthLink.com**
- Federal Employee Dental and Vision Insurance program (FEDEVIP): **BENEFEDS.com**
- Federal Flexible Spending Account program (FSAFEDS): **FSAFEDS.com**

### CareFirst plan & provider information

- CareFirst dedicated website for Congress: **carefirst.com/congress**
- My Account: **carefirst.com/myaccount**
- Find a Provider Tool: **carefirst.com/doctor**
- Office of Personnel Management (OPM) website: **opm.gov/healthcare-insurance**

### Still have questions?

Call our dedicated support line for Members of Congress and designated Congressional Staff:  
**855-541-3985**, Monday–Friday, 8 a.m. to 6 p.m. ET.



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# Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - ☐ Qualified sign language interpreters
  - ☐ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - ☐ Qualified interpreters
  - ☐ Information written in other languages

**If you need these services, please call 855-258-6518.**

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

**To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.**

## Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	<a href="mailto:civilrightscoordinator@carefirst.com">civilrightscoordinator@carefirst.com</a>
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

## Foreign Language Assistance

*Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.*

*አማርኛ (Amharic) ማሳሰቢያ፡- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላሉ። ይኸን መረጃ የማግኘት እና ያለምንም ከፍተኛ በቋንቋዎ አገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።*

*Èdè Yorùbá (Yoruba) Ìtètíléko: Àkíyèsí yìí ní iwífún nípa isẹ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ ní àwọn ojú gbèdèké kan. O ni ètò láti gba iwífún yìí àti irànlówó ní èdè rẹ lófèfè. Àwọn omọ-egbé gbòdò pe nóm̀bà fòdùn tò wà lẹ̀yìn káàdì ìdánimò wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò títí a ó fí sọ fún ọ láti tẹ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ a ó sì sọ ọ pọ̀ mọ̀ ògbufò kan.*

*Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.*

*Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawang ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikonekta ka sa isang interpreter.*

*Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.*

*Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.*

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsɔ̀ò-wùdù (Bassa) Tò Dùù Cáò! Bǝ nìà kɛ bá nyo bǝ kɛ m̃ gbo kpá bó nì fùà-fúá-tiĩn nyɛɛ jè dyí. Bǝ nìà kɛ bédé wé jéé bǝ bǝ m̃ kɛ dɛ wa mó m̃ kɛ nyuɛɛ nyu hwè bǝ wé bǝa kɛ zi. ɔ̀ mò nì kpé bǝ m̃ kɛ bǝ nìà kɛ kɛ gbo-kpá-kpá m̃ móɛ dyé dɛ nì bídí-wùdù mú bǝ m̃ kɛ se wídí dò péè. Kpooò nyo bǝ m̃ dǝ fúùn-nòbà nìà dɛ waa I.D. káàò dɛín nyɛ. Nyo tòò séín m̃ dǝ nòbà nìà kɛ: 855-258-6518, kɛ m̃ m̃ fò tee bǝ wa kɛ m̃ gbo cǝ bǝ m̃ kɛ nòbà mòò 0 kɛ dyi pàdàin hwè. ɔ̀ jǝ kɛ nyo dò dyi m̃ gǝ jǝin, po wuqu m̃ mó poɛ dyie, kɛ nyo dò mu bó nìin bǝ ɔ̀ kɛ nì wuquò mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ: یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه: يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة. يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة. ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم. يمكن للأخريين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

*Igbo (Igbo)* Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughi ugwo o buia. Ndi otu kwesiri ikpo akara ekwent di n'azu nke kaadi njirimara ha. Ndi ozọ niile nwere ike ikpo 855-258-6518 wee chere ububo ahụ ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa okwu.

*Deutsch (German)* Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

*Français (French)* Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

*한국어(Korean)* 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아닌 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

*Diné Bizaad (Navajo)* Ge': Díí bee íł hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ááh naanil ník'ist'í'ígíí bá. Bii' dahólǫq doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyííligíí da yókeedgo t'áá doo bee e'e'aahí ájiil'ííh. Bee ná ahóót'í' díí bee íł hane' dóó níká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nitł'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóó náánáta' éi koji' dahódoonih 855-258-6518 dóó yii diiłts'ííł yałtí'ígíí t'áá níléljį áádóó éi bikéé'dóó naasbaqas bił adidiilchil. Áká'anidaalwó'ígíí neidiitąągo, saad bee yáníłt'í'ígíí yii diikił dóó ata' halne'é lá níká'ádoowoł.





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