Maryland Consumer Health Benefits 2024

CareFirst
Family of health care plans

Know before you go

Your health, your money, your decision

Value plans are plan designs that have standardized cost-sharing (i.e., deductible, out-of-pocket maximum, copays and coinsurance) for covered health services. All insurance carriers are required to sell Value plans in MD. With Value plans, the main difference is the provider network offered by each insurer.

PCP visits: The lowest copays and the best option for consistent, quality care.

Caution: Services on a hospital campus may incur a separate hospital charge.

Retail health clinics: Low copays and after-hours care for minor health concerns.

Caution—Emergency room: Highest out-of-pocket costs; explore other options for non-emergency care.

Labs/X-rays/Imaging: Use non-hospital facilities for the lowest copays.

Caution: These services will cost more if performed in a hospital.

Surgeries: Non-hospital (ambulatory) surgery centers will save you money on many outpatient surgeries.

Generic drugs: Always your lowest cost option; some are no charge and no deductible.

Caution: For the lowest cost, always visit doctors who are in-network.

		Bronze				Silver		Gold			Catastrophic
	Maryland CareFirst Plans	**BlueChoice HMO Value Bronze $9,450**	**BluePreferred PPO Value Bronze $9,450**	**BlueChoice HMO Bronze $6,100 Virtual Connect**	**BlueChoice HMO HSA Bronze $6,150**	**BluePreferred PPO Value Silver $4,500**	**BlueChoice HMO Value Silver $4,500**	**BlueChoice HMO Value Gold $1,000**	**BlueChoice HMO Gold $1,750**	**BluePreferred PPO Value Gold $1,000**	**BlueChoice HMO Young Adult $9,450**
	Plan Type	HMO[1]	PPO[2]	HMO[1]	HMO[1]	PPO[2]	HMO[1]	HMO[1]	HMO[1]	PPO[2]	HMO[1]
	Visit **carefirst.com/doctor** to view participating doctors and facilities—search by plan:	BlueChoice HMO	BluePreferred PPO	BlueChoice HMO	BlueChoice HMO	BluePreferred PPO	BlueChoice HMO	BlueChoice HMO	BlueChoice HMO	BluePreferred PPO	BlueChoice HMO
	DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
1	**Deductible**[3]	Individual: $9,450 Family: $18,900	Individual: $9,450 Family: $18,900	Individual: $6,100 Family: $12,200	Individual: $6,150 Family: $12,300	Individual: $4,500 Family: $9,000	Individual: $4,500 Family: $9,000	Individual: $1,000 Family: $2,000	Individual: $1,750 Family: $3,500	Individual: $1,000 Family: $2,000	Individual: $9,450 Family: $18,900
2	**Out-of-Pocket Maximum**[4]	Individual: $9,450 Family: $18,900	Individual: $9,450 Family: $18,900	Individual: $9,400 Family: $18,800	Individual: $7,200 Family: $14,400	Individual: $7,600 Family: $15,200	Individual: $7,600 Family: $15,200	Individual: $6,750 Family: $13,500	Individual: $6,650 Family: $13,300	Individual: $6,750 Family: $13,500	Individual: $9,450 Family: $18,900
	PREVENTIVE SERVICES										
3	**Preventive Care** (e.g. adult physical, well-child care, cancer screenings)	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible
	PRIMARY CARE AND SPECIALIST SERVICES										
4	**Primary Care Provider (PCP) Visits—Office/Non-Hospital** (non-preventive)	$35 copay, no deductible	$35 copay, no deductible	$40 copay, no deductible	$30 copay after deductible	$35 copay, no deductible	$35 copay, no deductible	$10 copay, no deductible	No charge, no deductible	$10 copay, no deductible	Visits 1–3: No charge, no deductible[5] Visits 4+: No charge after deductible
5	**Specialist Visits—Office/Non-Hospital**	$90 copay, no deductible	$90 copay, no deductible	$50 copay after deductible	$40 copay after deductible	$90 copay, no deductible	$90 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	No charge after deductible
6	**HOSPITAL CHARGE** Add this charge if your primary care or specialist visit takes place in a hospital setting	No charge after deductible	No charge after deductible	$100 copay after deductible	$100 copay after deductible	$150 copay after deductible	$150 copay after deductible	$125 copay, no deductible	$75 copay after deductible	$125 copay, no deductible	No charge after deductible
	RETAIL CLINICS, URGENT AND EMERGENCY SERVICES										
7	**Convenience Care/Retail Health Clinics**	$35 copay, no deductible	$35 copay, no deductible	$40 copay, no deductible	$30 copay after deductible	$35 copay, no deductible	$35 copay, no deductible	$10 copay, no deductible	No charge, no deductible	$10 copay, no deductible	No charge after deductible
8	**Urgent Care Center**	$75 copay, no deductible	$75 copay, no deductible	$70 copay, no deductible	$60 copay after deductible	$75 copay, no deductible	$75 copay, no deductible	$40 copay, no deductible	$50 copay, no deductible	$40 copay, no deductible	No charge after deductible
9	**Emergency Room** (hospital charge—copays are waived if you are admitted)	No charge after deductible	No charge after deductible	40% coinsurance after deductible	$300 copay after deductible	$500 copay after deductible	$500 copay after deductible	$350 copay after deductible	$300 copay after deductible	$350 copay after deductible	No charge after deductible
	DIAGNOSTIC SERVICES										
10	**Labs**[6] Office/Non-Hospital	$80 copay, no deductible (LabCorp only)	$80 copay, no deductible	$25 copay after deductible (LabCorp only)	$25 copay after deductible (LabCorp only)	$80 copay, no deductible	$80 copay, no deductible (LabCorp Only)	$25 copay, no deductible (LabCorp only)	$15 copay, no deductible (LabCorp only)	$25 copay, no deductible	No charge after deductible (LabCorp only)
11	**Labs**[6] Outpatient Hospital	$80 copay, no deductible[7]	$80 copay, no deductible	$90 copay after deductible[7]	$90 copay after deductible[7]	$80 copay, no deductible	$80 copay, no deductible[7]	$25 copay, no deductible[7]	$60 copay after deductible[7]	$25 copay, no deductible	No charge after deductible[7]
12	**X-rays**[6] Office/Non-Hospital	$150 copay, no deductible	$150 copay, no deductible	$55 copay after deductible	$55 copay after deductible	$150 copay, no deductible	$150 copay, no deductible	$50 copay, no deductible	$65 copay, no deductible	$50 copay, no deductible	No charge after deductible
13	**X-rays**[6] Outpatient Hospital	$150 copay, no deductible[7]	$150 copay, no deductible	$130 copay after deductible[7]	$130 copay after deductible[7]	$150 copay, no deductible	$150 copay, no deductible[7]	$50 copay, no deductible[7]	$100 copay after deductible[7]	$50 copay, no deductible	No charge after deductible[7]
14	**Imaging** (e.g. MRI, Cat Scan, CT Scan) Office/Non-Hospital	No charge after deductible	No charge after deductible	$250 copay after deductible	$250 copay after deductible	$600 copay after deductible	$600 copay after deductible	$400 copay after deductible	$250 copay, no deductible	$400 copay, no deductible	No charge after deductible
15	**Imaging** (e.g. MRI, Cat Scan, CT Scan) Outpatient Hospital	No charge after deductible[7]	No charge after deductible	$500 copay after deductible[7]	$500 copay after deductible[7]	$600 copay after deductible	$600 copay after deductible[7]	$400 copay after deductible[7]	$350 copay after deductible[7]	$400 copay after deductible	No charge after deductible[7]
	OUTPATIENT SURGERY *(Members are responsible for both facility and physician charges)*										
16	**Outpatient Surgery** (physician charge) Non-Hospital/Surgical Center	No charge after deductible	No charge after deductible	$50 copay after deductible	$40 copay after deductible	$150 copay after deductible	$150 copay after deductible	$125 copay, no deductible	$30 copay, no deductible	$125 copay, no deductible	No charge after deductible
17	**Outpatient Surgery** (physician charge) Hospital	No charge after deductible[7]	No charge after deductible	$50 copay after deductible[7]	$40 copay after deductible[7]	$150 copay after deductible	$150 copay after deductible[7]	$125 copay, no deductible[7]	$30 copay after deductible[7]	$125 copay, no deductible	No charge after deductible[7]
18	**Outpatient Surgery** (facility charge) Non-Hospital/Surgical Center	No charge after deductible	No charge after deductible	$300 copay after deductible	$300 copay after deductible	$150 copay after deductible	$150 copay after deductible	$250 copay, no deductible	$300 copay, no deductible	$250 copay, no deductible	No charge after deductible
19	**Outpatient Surgery** (facility charge) Hospital	No charge after deductible[7]	No charge after deductible	$450 copay after deductible[7]	$450 copay after deductible[7]	$150 copay after deductible	$150 copay after deductible[7]	$250 copay, no deductible[7]	$400 copay after deductible[7]	$250 copay, no deductible	No charge after deductible[7]
	INPATIENT HOSPITAL SERVICES *including all inpatient surgery, labor & delivery, mental health related visits (Members are responsible for both hospital and physician charges)*										
20	**Inpatient Services** (physician charge)	No charge after deductible	No charge after deductible	$50 copay after deductible	$40 copay after deductible	$40 copay, no deductible	$40 copay, no deductible	$30 copay, no deductible	$30 copay after deductible	$30 copay, no deductible	No charge after deductible
21	**Inpatient Services** (hospital charge)	No charge after deductible[7]	No charge after deductible	40% coinsurance after deductible[7]	$500 copay/day after deductible (up to a copay maximum of $2,500)[7]	$550 copay after deductible	$550 copay after deductible[7]	$450 copay after deductible[7]	$450 copay/day after deductible (up to a copay maximum of $2,250)[7]	$450 copay after deductible	No charge after deductible[7]
	MATERNITY OFFICE VISITS										
22	**Preventive Prenatal & Postnatal Office Visits**[8]	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible
	ARTIFICIAL AND INTRAUTERINE INSEMINATION AND IN VITRO FERTILIZATION PROCEDURES										
23	**AI/IVF** (physician charge)	$35 copay, no deductible[7]	$35 copay, no deductible[7]	$40 copay, no deductible[7]	$30 copay after deductible[7]	$35 copay, no deductible[7]	$35 copay, no deductible[7]	$10 copay, no deductible[7]	No charge, no deductible[7]	$10 copay, no deductible[7]	No charge after deductible[7]
	MENTAL HEALTH AND SUBSTANCE USE DISORDER										
24	**Office Visits**	$35 copay, no deductible	$35 copay, no deductible	$40 copay, no deductible	$30 copay after deductible	$35 copay, no deductible	$35 copay, no deductible	$10 copay, no deductible	No charge, no deductible	$10 copay, no deductible	Visits 1–3: No charge, no deductible[5] Visits 4+: No charge after deductible
	PRESCRIPTION DRUGS[9]										
25	**Prescription Drug Deductible**	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first	Individual: $750 Family: $1,500	Individual: $750 Family: $1,500	Individual: $150 Family: $300	$150 per person (Tiers 2–5)	Individual: $150 Family: $300	No separate drug deductible; Must meet medical deductible first
	Prescription Drug Out-of-Pocket Maximum	No separate drug out-of-pocket maximum	No separate drug out-of-pocket maximum	No separate drug out-of-pocket maximum	No separate drug out-of-pocket maximum	Individual: $1,500 Family: $3,000	Individual: $1,500 Family: $3,000	Individual: $600 Family: $1,200	No separate drug out-of-pocket maximum	Individual: $600 Family: $1,200	No separate drug out-of-pocket maximum
26	**Preventive Drugs (Tier 0)**	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible
27	**Diabetic Supplies (Tier 0)**				No charge, after deductible						No charge after deductible
28	**Preferred Brand Insulin (Tier 0)**										
29	**Generic Drugs (Tier 1)**	$25 copay, no deductible	$25 copay, no deductible	$20 copay, no deductible	$10 copay after deductible	$25 copay, no deductible	$25 copay, no deductible	$10 copay, no deductible	No charge, no deductible	$10 copay, no deductible	No charge after deductible
30	**Preferred Brand Drugs (Tier 2)**[10]	No charge after deductible	No charge after deductible	$50 copay after deductible	$50 copay after deductible	$75 copay after deductible	$75 copay after deductible	$30 copay, no deductible	$50 copay after deductible	$30 copay, no deductible	No charge after deductible
	Non-Preferred Brand Insulin (Tier 3)	No charge, no deductible	No charge, no deductible	$30 copay, no deductible	$30 copay after deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	No charge after deductible
	Non-Preferred Brand Drugs (Tier 3)[11]	No charge after deductible	No charge after deductible	$70 copay after deductible	$70 copay after deductible	$80 copay after deductible	$80 copay after deductible	$60 copay after deductible	$70 copay after deductible	$60 copay after deductible	No charge, after deductible
	Preferred Specialty Drugs (Tier 4)[12]			$100 copay after deductible	$100 copay after deductible	$100 copay after deductible	$100 copay after deductible	$75 copay after deductible	$100 copay after deductible	$75 copay after deductible	
	Non-Preferred Specialty Drugs (Tier 5)[12]			$150 copay after deductible	$150 copay after deductible	$100 copay after deductible	$100 copay after deductible	$75 copay after deductible	$150 copay after deductible	$75 copay after deductible	
	OUT-OF-NETWORK		Out-of-Network			Out-of-Network				Out-of-Network	
31	**Deductible**	N/A	Individual: $18,900 Family: $37,800	N/A	N/A	Individual: $9,000 Family: $18,000	N/A	N/A	N/A	Individual: $2,000 Family: $4,000	N/A
32	**Out-of-Pocket Maximum**	N/A	Individual: $18,900 Family: $37,800	N/A	N/A	Individual: $15,200 Family: $30,400	N/A	N/A	N/A	Individual: $13,500 Family: $27,000	N/A

Note: When multiple services are rendered on the same day by more than one provider, member payments are required for each provider.

[1] Health Maintenance Organization (HMO) plans underwritten by CareFirst BlueChoice, Inc.

[2] Preferred Provider Organization (PPO) plans underwritten by Group Hospitalization and Medical Services, Inc. or CareFirst of Maryland, Inc.

[3] For family coverage only—If one member on the policy meets the individual deductible, full benefits will begin for that member. That member will not be able to contribute more than the individual deductible amount towards the family deductible. Once the family deductible has been met, full benefits will be available to all members on the policy.

[4] For family coverage only—When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the allowed benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the allowed benefit.

[5] You receive up to 3 non-preventive primary care visits without needing to meet a deductible.

[6] HMO plans: For in-network benefits, members must use LabCorp for laboratory services and freestanding facilities for diagnostic services and X-rays.

[7] Prior authorization required.

[8] For non-routine obstetrical care or complications of pregnancy, cost-sharing may apply.

[9] All out-of-pocket drug costs contribute to the in-network out-of-pocket maximum.

[10] If a generic drug becomes available for a preferred brand drug, the preferred brand drug moves to the non-preferred brand drug tier.

[11] If a provider prescribes a non-preferred brand drug and the member selects the non-preferred brand drug when a generic drug is available, the member shall pay the applicable copayment as stated above plus the difference between the price of the non-preferred brand drug and the generic drug up to the cost of the drug. This amount will not contribute to the in-network out-of-pocket maximum.

[12] Specialty drugs must be obtained through mail order at CVS Specialty Pharmacy.

To view participating pharmacies and find out how drugs are covered (e.g. generic vs. non-preferred brand) please visit **carefirst.com/acarx**. Please note there are coverage limitations for using non-participating pharmacies.

See a summary of any plan and a glossary of common health insurance terms by visiting **carefirst.com/individual**. Just enter your zip code, gender and date of birth to view and compare plans. Look for the Summary of Benefits & Coverage and Uniform Glossary of Coverage & Medical Terms links for each plan by clicking on the plan name and scrolling to the bottom of the box.

Questions? Ask your broker or call one of our product specialists at 410-356-8000 or toll-free at 800-544-8703 Monday–Friday, 8 a.m.– 6 p.m. and Saturday, 8 a.m.– noon.

2024 MARYLAND POLICY FORM NUMBERS:

BLUECHOICE HMO OPEN ACCESS
MD/CFBC/ HMO/IEA (R. 1/24); MD/CFBC/DOL APPEAL (R. 1/24); MD/CFBC/EXC/HMO/DOCS (R. 1/24); MD/CFBC/EXC/HMO/VAL BRZ 9450 (1/24); MD/CFBC/DB/BC HMO/VAL SIL 4500 (1/24); MD/CFBC/EXC/BC HMO/VAL SIL 4500 (1/24); MD/CFBC/EXC/BC HMO/VAL GOLD 1000 (1/24); MD/CFBC/EXC/BC HMO/GOLD 1750 (1/24); MD/CFBC/EXC/BC HMO/BRZ 6100 (1/24) (VIRTUAL CONNECT); MD/CFBC/EXC/BC HMO HSA/BRZ 6150 (1/24); MD/CFBC/DB/HB2/BLUECARD (1/20); MD/CFBC/EXC/2018 VIS+ AMEND (1/18) (SILVER PLANS ONLY); MD/PT PROTECT (9/10); CFBC – DISCLOSURE 10/15; CFBC HEALTH GUARANTY 1/22; MD/CFBC/DB/AUTH AMEND (1/24); MD/CFBC/CD/HMO/INCENT (1/23)

YOUNG ADULT
MD/CFBC/YA/IEA (1/24); MD/CFBC/DOL APPEAL (R. 1/24); MD/CFBC/EXC/HMO/DOCS (R. 1/24); MD/CFBC/EXC/HMO/YA 9450 (1/24); MD/CFBC/DB/HB2/BLUECARD (1/20); MD/PT PROTECT (9/10); CFBC – DISCLOSURE 10/15; CFBC HEALTH GUARANTY 1/22; MD/CFBC/DB/AUTH AMEND (1/24)I; MD/CFBC/CD/HMO/INCENT (1/23)

BLUEPREFERRED PPO (GHMSI)
MD/CF/PPO/IEA (R. 1/24); MD/GHMSI/DOL APPEAL (R. 1/24); MD/CF/EXC/PPO/DOCS (R. 1/24); MD/CF/EXC/BP PPO/VAL GOLD 1000 (1/24); MD/CF/DB/BP PPO/VAL SIL 4500 (1/24); MD/CF/EXC/BP PPO/VAL SIL 4500 (1/24); MD/CF/EXC/BP PPO/VAL BRZ 9450 (1/24); MD/CF/DB/BLCRD (1/12); MD/CF/EXC/2018 VIS+ AMEND (1/18) WITH FORM NUMBER MD/CF/EXC/BP PPO/VAL SIL 4500 (1/24) ONLY; MD/CF/ANCILLARY AMEND (10/12); MD/PT PROTECT (9/10); GHMSI – DISCLOSURE 10/15; MD NCA–HEALTH GUARANTY 1/22; MD/CF/DB/AUTH AMEND (1/24); MD/CF/CD/BP/INCENT (1/23)

BLUEPREFERRED PPO (CFMI)
CFMI/PPO/IEA (R. 1/24); CFMI/DOL APPEAL (R. 1/24); CFMI/EXC/PPO/DOCS (R. 1/24); CFMI/EXC/BP PPO/VAL GOLD 1000 (1/24); CFMI/DB/BP PPO/VAL SIL 4500 (1/24); CFMI/EXC/BP PPO/VAL SIL 4500 (1/24); CFMI/EXC/BP PPO/VAL BRZ 9450 (1/24); CFMI/BLUECARD-DB (1/12); MD/CFMI/ANCILLARY AMEND (10/12); CFMI/EXC/2018 VIS+ AMEND (1/18) WITH FORM NUMBER CFMI/EXC/BP PPO/VAL SIL 4500 (1/24) ONLY; MD/PT PROTECT (9/10); CFMI – DISCLOSURE 10/15; CFMI HEALTH GUARANTY 1/22; CFMI//DB/AUTH AMEND (1/24); CFMI/CD/BP/INCENT (1/23)

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518

Not all services and procedures are covered by your benefits contract.
This benefit summary is for comparison purposes only and does not create rights not given through the benefit plan.
The policies may have exclusions, limitations or terms under which the policy may be continued in force or discontinued.
For costs and complete details of the coverage, call your insurance agent or CareFirst.

CareFirst
Family of health care plans

CDS1217-1P (10/23)