CareFirst
The CareFirst BlueCross BlueShield family of health care plans

# Maryland/Virginia Consumer Health Benefits 2016

## Know before you go

*Your health, your money, your decision*

**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/Virginia CareFirst Plans** | | **BluePreferred PPO HSA $4,500** | **BlueChoice Plus Bronze $5,500** | **BlueChoice HMO HSA Bronze $6,000** | **BlueChoice HMO HSA Bronze $6,550** | **BlueChoice HMO HSA Silver $1,350** | **BluePreferred PPO HSA Silver $1,600** | **BlueChoice HMO Silver $2,000** | **BlueChoice Plus Silver $2,500** | **HealthyBlue HMO Gold $250** | **HealthyBlue PPO Gold $500** | **HealthyBlue Plus Gold $750** | **HealthyBlue HMO Gold $1,000** | **BlueChoice HMO Young Adult $6,850** |
| | Plan Type | | PPO[1] | POS[2] | HMO[3] | HMO[3] | HMO[3] | PPO[1] | HMO[3] | POS[2] | HMO[3] | PPO[1] | POS[2] | HMO[3] | HMO[3] |
| | Visit to view participating doctors and facilities—search by plan: | | BluePreferred | BlueChoice Plus | BlueChoice HMO | BlueChoice HMO | BlueChoice HMO | BluePreferred | BlueChoice HMO | BlueChoice Plus | HealthyBlue HMO | HealthyBlue PPO | HealthyBlue Plus | HealthyBlue HMO | BlueChoice Young Adult |
| | Rewards | | Earn $150 per adult and up to a $400 maximum per family toward your medical expenses. Visit **www.carefirst.com/bluerewards** for more information. | | | | | | | | | | | | |
| | **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 | In-Network | In-Network | In-Network |
| 1 | Deductible[6] | | Individual: $4,500<br>Family: $9,000 | Individual: $5,500<br>Family: $11,000 | Individual: $6,000<br>Family: $12,000 | Individual: $6,550<br>Family: $13,100 | Individual: $1,350<br>Family: $2,700 | Individual: $1,600<br>Family: $3,200 | Individual: $2,000<br>Family: $4,000 | Individual: $2,500<br>Family: $5,000 | Individual: $250<br>Family: $500 | Individual: $500<br>Family: $1,000 | Individual: $750<br>Family: $1,500 | Individual: $1,000<br>Family: $2,000 | Individual: $6,850<br>Family: $13,700 |
| 2 | Out-of-Pocket Maximum[7] | | Individual: $6,550<br>Family: $13,100 | Individual: $6,850<br>Family: $13,700 | Individual: $6,000<br>Family: $12,000 | Individual: $6,550<br>Family: $13,100 | Individual: $6,550<br>Family: $13,100 | Individual: $6,550<br>Family: $13,100 | Individual: $6,850<br>Family: $13,700 | Individual: $6,850<br>Family: $13,700 | Individual: $6,850<br>Family: $13,700 | Individual:$6,850<br>Family: $13,700 | Individual: $4,000<br>Family: $8,000 | Individual: $4,500<br>Family: $9,000 | Individual: $6,850<br>Family: $13,700 |
| | **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 | 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) | | $25 copay after deductible | Visits 1–2[4]: $25 copay, no deductible<br>Visits 3+: $25 copay after deductible | No charge after deductible | No charge after deductible | $30 copay after deductible | $30 copay after deductible | No charge, no deductible | $30 copay, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | Visits 1–3: No charge, no deductible[4]<br>Visits 4+: No charge after deductible |
| 5 | Specialist Visits—Office/Non-Hospital | | $50 copay after deductible | $50 copay after deductible | No charge after deductible | No charge after deductible | $40 copay after deductible | $40 copay after deductible | $50 copay, no deductible | $40 copay, no deductible | $30 copay, no deductible | $30 copay, no deductible | $30 copay, no deductible | $30 copay, no deductible | No charge after deductible |
| 6 | HOSPITAL CHARGE—Add this charge if your primary care or specialist visit takes place in a hospital setting | | $100 copay after deductible | $100 copay after deductible | No charge after deductible | No charge after deductible | $100 copay after deductible | 30% coinsurance after deductible | $100 copay after deductible | $100 copay after deductible | $75 copay after deductible | $75 copay after deductible | $75 copay after deductible | $75 copay after deductible | No charge after deductible |
| | **RETAIL CLINICS, URGENT AND EMERGENCY SERVICES** | | | | | | | | | | | | | | |
| 7 | Convenience Care/Retail Health Clinics (e.g. CVS MinuteClinic, Rite Aid RediClinic) | | $25 copay after deductible | Visits 1–2: $25 copay, no deductible<br>Visits 3+: $25 copay after deductible | No charge after deductible | No charge after deductible | $30 copay after deductible | $30 copay after deductible | No charge, no deductible | $30 copay, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge after deductible |
| 8 | Urgent Care Center (e.g. Patient First, ExpressCare) | | $75 copay after deductible | $75 copay, no deductible | No charge after deductible | No charge after deductible | $60 copay after deductible | $60 copay after deductible | $60 copay, no deductible | $60 copay, no deductible | $50 copay, no deductible | $50 copay, no deductible | $50 copay, no deductible | $50 copay, no deductible | No charge after deductible |
| 9 | Emergency Room (hospital charge—copays are waived if you are admitted) | | $300 copay after deductible | $300 copay after deductible | No charge after deductible | No charge after deductible | $300 copay after deductible | 30% coinsurance after deductible | $300 copay after deductible | $300 copay after deductible | $300 copay after deductible | $300 copay after deductible | $300 copay after deductible | $300 copay after deductible | No charge after deductible |
| | **DIAGNOSTIC SERVICES** | | | | | | | | | | | | | | |
| 10 | Labs[8] | Office/Non-Hospital | $25 copay after deductible | $25 copay, no deductible (LabCorp only) | No charge after deductible (LabCorp only) | No charge after deductible (LabCorp only) | $25 copay after deductible (LabCorp only) | $25 copay after deductible | $25 copay, no deductible (LabCorp only) | $25 copay, no deductible (LabCorp only) | $15 copay, no deductible (LabCorp only) | $15 copay, no deductible | No charge, no deductible (LabCorp only) | $15 copay, no deductible (LabCorp only) | No charge after deductible (LabCorp only) |
| 11 | | Outpatient Hospital | $100 copay after deductible | $100 copay after deductible[5] | No charge after deductible[5] | No charge after deductible[5] | $90 copay after deductible[5] | 30% coinsurance after deductible | $90 copay after deductible[5] | $90 copay after deductible[5] | $60 copay after deductible[5] | $60 copay after deductible | $60 copay after deductible[5] | $60 copay after deductible[5] | No charge after deductible[5] |
| 12 | X-rays[8] | Office/Non-Hospital | $100 copay after deductible | $100 copay, no deductible | No charge after deductible | No charge after deductible | $55 copay after deductible | $55 copay after deductible | $55 copay, no deductible | $55 copay, no deductible | $65 copay, no deductible | $65 copay, no deductible | No charge, no deductible | $65 copay, no deductible | No charge after deductible |
| 13 | | Outpatient Hospital | $150 copay after deductible | $150 copay after deductible[5] | No charge after deductible[5] | No charge after deductible[5] | $130 copay after deductible[5] | 30% coinsurance after deductible | $130 copay after deductible[5] | $130 copay after deductible[5] | $100 copay after deductible[5] | $100 copay after deductible | $100 copay after deductible[5] | $100 copay after deductible[5] | No charge after deductible[5] |
| 14 | Imaging (e.g. MRI, Cat Scan, CT Scan) | Office/Non-Hospital | $500 copay after deductible | $500 copay after deductible | No charge after deductible | No charge after deductible | $250 copay after deductible | $250 copay after deductible | $250 copay, no deductible | $250 copay, no deductible | $250 copay, no deductible | $250 copay, no deductible | $250 copay, no deductible | $250 copay, no deductible | No charge after deductible |
| 15 | | Outpatient Hospital | $750 copay after deductible | $750 copay after deductible[5] | No charge after deductible[5] | No charge after deductible[5] | $500 copay after deductible[5] | 30% coinsurance after deductible | $500 copay after deductible[5] | $500 copay after deductible[5] | $350 copay after deductible[5] | $350 copay after deductible | $350 copay after deductible[5] | $350 copay after deductible[5] | No charge after deductible[5] |
| | **OUTPATIENT SURGERY** (Members are responsible for both facility and physician charges) | | | | | | | | | | | | | | |
| 16 | Outpatient Surgery (physician charge) | Non-Hospital/ Surgical Center | $50 copay after deductible | $50 copay after deductible | No charge after deductible | No charge after deductible | $40 copay after deductible | $40 copay after deductible | $50 copay, no deductible | $40 copay, no deductible | $30 copay, no deductible | $30 copay, no deductible | $30 copay, no deductible | $30 copay, no deductible | No charge after deductible |
| 17 | | Hospital | $50 copay after deductible | $50 copay after deductible[5] | No charge after deductible[5] | No charge after deductible[5] | $40 copay after deductible[5] | $40 copay after deductible | $50 copay after deductible[5] | $40 copay after deductible[5] | $30 copay after deductible[5] | $30 copay after deductible | $30 copay after deductible[5] | $30 copay after deductible[5] | No charge after deductible[5] |
| 18 | Outpatient Surgery (facility charge) | Non-Hospital/ Surgical Center | $300 copay after deductible | $300 copay after deductible | No charge after deductible | No charge after deductible | $300 copay after deductible | $300 copay after deductible | $300 copay, no deductible | $300 copay, no deductible | $300 copay, no deductible | $300 copay, no deductible | $300 copay, no deductible | $300 copay, no deductible | No charge after deductible |
| 19 | | Hospital | $450 copay after deductible | $450 copay after deductible[5] | No charge after deductible[5] | No charge after deductible[5] | $450 copay after deductible[5] | 30% coinsurance after deductible | $450 copay after deductible[5] | $450 copay after deductible[5] | $400 copay after deductible[5] | $400 copay after deductible | $400 copay after deductible[5] | $400 copay after deductible[5] | No charge after deductible[5] |
| | **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) | | $50 copay after deductible | $50 copay after deductible | No charge after deductible | No charge after deductible | $40 copay after deductible | $40 copay after deductible | $50 copay after deductible | $40 copay after deductible | $30 copay after deductible | $30 copay after deductible | $30 copay after deductible | $30 copay after deductible | No charge after deductible |
| 21 | Inpatient Services (hospital charge) | | $500 copay/day after deductible | $500 copay/day after deductible[5] | No charge after deductible[5] | No charge after deductible[5] | $500 copay/day after deductible (up to a copay maximum of $2,500)[5] | 30% coinsurance after deductible | $500 copay/day after deductible (up to a copay maximum of $2,500)[5] | $500 copay/day after deductible (up to a copay maximum of $2,500)[5] | $450 copay/day after deductible (up to a copay maximum of $2,250)[5] | $450 copay/day after deductible (up to a copay maximum of $2,250) | $450 copay/day after deductible (up to a copay maximum of $2,250)[5] | $450 copay/day after deductible (up to a copay maximum of $2,250)[5] | No charge after deductible[5] |
| | **MATERNITY OFFICE VISITS** | | | | | | | | | | | | | | |
| 22 | Preventive Prenatal & Postnatal Office Visits[13] | | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible |
| | **MENTAL HEALTH & SUBSTANCE ABUSE**[9] | | | | | | | | | | | | | | |
| 23 | Office Visits | | $25 copay after deductible | Visits 1–2[4]: $25 copay, no deductible<br>Visits 3+: $25 copay after deductible | No charge after deductible | No charge after deductible | $30 copay after deductible | $30 copay after deductible | No charge, no deductible | $30 copay, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | Visits 1–3: No charge, no deductible[4]<br>Visits 4+: No charge after deductible |
| | **PRESCRIPTION DRUGS**[10] | | | | | | | | | | | | | | |
| 24 | Prescription Drug Deductible | | No separate drug deductible; Must meet medical deductible first | $150 per person (Tiers 2–4) | 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 | $150 per person (Tiers 2–4) | $250 per person (Tiers 2–4) | $150 per person (Tiers 2–4) | $150 per person (Tiers 2–4) | $250 per person (Tier 2–4) | $150 per person (Tiers 2–4) | No separate drug deductible; Must meet medical deductible first |
| 25 | Generic Drugs (Tier 1) | | $10 copay after deductible | $10 copay, no deductible | No charge after deductible | No charge after deductible | $10 copay after deductible | $10 copay after deductible | $10 copay, no deductible | $10 copay, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge, no deductible | No charge after deductible |
| 26 | Preferred Brand Drugs (Tier 2)[11] | | $75 copay after deductible | $75 copay after deductible | | | $75 copay after deductible | $50 copay after deductible | $50 copay after deductible | $50 copay after deductible | $50 copay after deductible | $50 copay after deductible | $50 copay after deductible | $50 copay after deductible | |
| 27 | Non-Preferred Brand Drugs (Tier 3)[12] | | $150 copay after deductible | $150 copay after deductible | | | $150 copay after deductible | $70 copay after deductible | $70 copay after deductible | $70 copay after deductible | $70 copay after deductible | $70 copay after deductible | $70 copay after deductible | $70 copay after deductible | |
| 28 | Specialty Drugs (Tier 4) | | $150 copay after deductible | $150 copay after deductible | | | $150 copay after deductible | $150 copay after deductible | $150 copay after deductible | $150 copay after deductible | $150 copay after deductible | $150 copay after deductible | $150 copay after deductible | $150 copay after deductible | |
| | **OUT-OF-NETWORK** | | Out-of-Network | Out-of-Network | | | | Out-of-Network | | Out-of-Network | | Out-of-Network | Out-of-Network | | |
| 29 | Deductible | | Individual: $8,000<br>Family: $16,000 | Individual: $8,000<br>Family: $16,000 | N/A | N/A | N/A | Individual: $3,200<br>Family: $6,400 | N/A | Individual: $5,000<br>Family: $10,000 | N/A | Individual: $1,000<br>Family: $2,000 | Individual: $1,500<br>Family: $3,000 | N/A | N/A |
| 30 | Out-of-Pocket Maximum | | Individual: $10,000<br>Family: $20,000 | Individual: $10,000<br>Family: $20,000 | N/A | N/A | N/A | Individual: $9,000<br>Family: $18,000 | N/A | Individual: $9,000<br>Family: $18,000 | N/A | Individual: $9,000<br>Family: $18,000 | Individual: $8,000<br>Family: $16,000 | N/A | 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 Preferred Provider Organization (PPO) plans underwritten by Group Hospitalization and Medical Services, Inc.
2 Point of Service (POS) plans underwritten by CareFirst BlueChoice, Inc. for in-network benefits and by Group Hospitalization and Medical Services, Inc. or CareFirst of Maryland, Inc. for out-of-network benefits.
3 Health Maintenance Organization (HMO) plans underwritten by CareFirst BlueChoice, Inc.
4 You receive up to 2 (BlueChoice Plus Bronze $5,500) and up to 3 (BlueChoice HMO Young Adult $6,850) non-preventive primary care visits without needing to meet a deductible.
5 Prior authorization required.
6 For family coverage only – For BlueChoice HMO HSA Silver $1,350 and BluePreferred PPO HSA Silver $1,600: The family deductible must be met before full benefits will be available to any member on the policy. Once the family deductible has been met, full benefits will become available to everyone covered. All other plans: If one member on the policy meets the individual deductible, full benefits will begin for that member. That member will not be able to contribute more than the individual deductible amount towards the family deductible. Once the family deductible has been met, full benefits will be available to all members on the policy.
7 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.
8 For HMO and POS plans: For in-network benefits, members must use LabCorp for laboratory services and freestanding facilities for diagnostic services and X-rays. Other providers/facilities may be used in POS plans but will be considered out-of-network.
9 For HMO and POS plans: To receive in-network coverage, mental health and substance abuse coverage must be performed by Magellan behavioral health providers. Other providers may be used for out-of-network coverage for POS plans.
10 All out-of-pocket drug costs contribute to the in-network out-of-pocket maximum.
11 If a generic drug becomes available for a preferred brand drug, the preferred brand drug moves to the non-preferred brand drug tier.
12 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.
13 For non-routine obstetrical care or complications of pregnancy, cost-sharing may apply.

To view participating pharmacies and find out how drugs are covered (e.g. generic vs. non-preferred brand) please visit **www.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 **www.carefirst.com/individual**. Just enter your zip code, gender and date of birth to view and compare plans. Look for the Summary of Benefits & Coverage and Uniform Glossary of Coverage & Medical Terms links for each plan by clicking on the plan name and scrolling to the bottom of the box. **Questions?** Ask your broker or call one of our product specialists at 410-356-8000 or toll-free at 800-544-8703 Monday–Friday, 8 a.m.–6 p.m. and Saturday, 8 a.m.–noon.

**2016 MARYLAND POLICY FORM NUMBERS:**

**BluePreferred HSA Bronze $4,500**
MD/CF/BP/IEA (1/14); MD/GHMSI/DOL APPEAL (R. 9/11); MD/CF/EXC/BP/DOCS (1/14); MD/CF/EXC/BP HSA/BRZ 4500 (1/16); MD/CF/DB/PPO HSA/INCENT (1/16); CFMI/BP/IEA (1/14); CFMI/DOL APPEAL (R. 9/11); CFMI/EXC/BP/DOCS (1/14); CFMI/EXC/BP HSA/BRZ 4500 (1/16); CFMI/DB/PPO HSA/INCENT (1/16) and any amendments

**BlueChoice Plus Bronze $5,500**
MD/CFBC/BC+ IN/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/BC+ IN/DOCS (1/14); MD/CFBC/EXC/BC+ IN/BRZ 5500 (1/16); MD/CFBC/DB/POS/INCENT (R. 1/16); MD/CF/BC+ OON/IEA (1/14); MD/GHMSI/DOL APPEAL (R. 9/11); MD/CF/BC+ OON/DOCS (1/14); MD/CF/EXC/BC+ OON/BRZ 5500 (1/16); CFMI/BC+ OON/IEA (1/14); CFMI/DOL APPEAL (R. 9/11); CFMI/EXC/BC+ OON/DOCS (1/14); CFMI/EXC/BC+ OON/BRZ 5500 (1/16) and any amendments

**BlueChoice HMO HSA Bronze $6,000**
MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/CFBC/EXC/HMO HSA/BRZ 6000 (1/16); MD/CFBC/DB/HMO HSA/INCENT (1/16) and any amendments

**BlueChoice HMO Bronze $6,550**
MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/CFBC/EXC/HMO/BRZ 6550 (1/16); MD/CFBC/DB/HMO/INCENT (R. 1/16) and any amendments

**BlueChoice HMO HSA Silver $1,350**
MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/CFBC/EXC/HMO HSA/SIL 1350 (1/16); MD/CFBC/DB/HMO HSA/INCENT (1/16) and any amendments

**BluePreferred HSA Silver $1,600**
MD/CF/BP/IEA (1/14); MD/GHMSI/DOL APPEAL (R. 9/11); MD/CF/EXC/BP/DOCS (1/14); MD/CF/EXC/BP HSA/SIL 1600 (1/16); MD/CF/DB/PPO HSA/INCENT (1/16); CFMI/BP/IEA (1/14); CFMI/DOL APPEAL (R. 9/11); CFMI/EXC/BP/DOCS (1/14); CFMI/EXC/BP HSA/SIL 1600 (1/16); CFMI/DB/PPO HSA/INCENT (1/16) and any amendments

**BlueChoice HMO Silver $2,000**
MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/CFBC/EXC/HMO/SIL 2000 (1/16); MD/CFBC/DB/HMO/INCENT (R. 1/16) and any amendments

**BlueChoice Plus Silver $2,500**
MD/CFBC/BC+ IN/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/BC+ IN/DOCS (1/14); MD/CFBC/EXC/BC+ IN/SIL 2500 (1/16); MD/CFBC/DB/POS/INCENT (R. 1/16); MD/CF/BC+ OON/IEA (1/14); MD/GHMSI/DOL APPEAL (R. 9/11); MD/CF/EXC/BC+ OON/DOCS (1/14); MD/CF/EXC/BC+ OON/SIL 2500 (1/16); CFMI/BC+ OON/IEA (1/14); CFMI/DOL APPEAL (R.9/11); CFMI/EXC/BC+ OON/DOCS (1/14); CFMI/EXC/BC+ OON/SIL 2500 (1/16) and any amendments

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

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

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

**HealthyBlue HMO Gold $1,000**
MD/CFBC/HMO/IEA (1/14); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/EXC/HMO/DOCS (1/14); MD/CFBC/EXC/HB HMO/GOLD 1000 (1/16); MD/CFBC/DB/HMO/INCENT (R. 1/16) and any amendments

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

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

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

**2016 VIRGINIA POLICY FORM NUMBERS:**

**BluePreferred PPO HSA Bronze $4,500**
VA/CF/DB/BP (1/14)-HIX; VA/CF/EXC/BP HSA/BRZ 4500 (1/16)-HIX (Bronze Metal Level); VA/CF/EXC/PPO/2016 AMEND (1/16)-HIX; VA/CF/DB/PPO HSA/INCENT (1/16)-HIX

**BlueChoice Plus Bronze $5,500**
VA/CFBC/DB/BCOO/INN (1/14); VA/CFBC/EXC/BC+ IN/BRZ 5500 (1/16); VA/CFBC/DB/POS IN/2016 AMEND (1/16); VA/CFBC/DB/POS/INCENT (R. 1/16); MVAPP (4/15)

**BlueChoice HMO HSA Bronze $6,000**
VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO HSA/BRZ 6000 (1/16) (Bronze Metal Level); VA/CFBC/DB/HMO/2016 AMEND (1/16); VA/CFBC/ DB/HMO HSA/INCENT (1/16); MVAPP (4/15)

**BlueChoice HMO HSA Bronze $6,550**
VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/HSA/BRZ 6550 (1/16) (Bronze Metal Level); VA/CFBC/DB/HMO/2016 AMEND (1/16); VA/CFBC/DB/HMO HSA/INCENT (1/16) (HSA plans only)

**BlueChoice HMO HSA Silver $1,350**
VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/SIL 2000 (1/16) (Silver Metal Level); VA/CFBC/DB/HMO/2016 AMEND (1/16); VA/CFBC/DB/HMO HSA/INCENT (R. 1/16); MVAPP (4/15)

**BluePreferred PPO HSA Silver $1,600**
VA/CF/DB/BP (1/14)-HIX; VA/CF/EXC/BP HSA/SIL 1600 (1/16)-HIX (Silver Metal Level); VA/CF/EXC/PPO/2016 AMEND (1/16)-HIX; VA/CF/DB/PPO HSA/INCENT (1/16)-HIX (HSA plans only)

**BlueChoice HMO Silver $2,000**
VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/SIL 2000 (1/16); VA/CFBC/DB/HMO/2016 AMEND (1/16); VA/CFBC/DB/HMO/INENT (R. 1/16); MVAPP (4/15)

**BlueChoice Plus Silver $2,500**
VA/CFBC/DB/BCOO/INN (1/14); VA/CFBC/EXC/BC+ IN/SIL 2500 (1/16); VA/CFBC/DB/POS IN/2016 AMEND (1/16); VA/CFBC/DB/POS/INCENT (R. 1/16); MVAPP (4/15)

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

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

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

**HealthyBlue HMO Gold $1,000**
VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HB HMO/GOLD 1000 (1/16) (Gold Metal Level); VA/CFBC/DB/HMO/2016 AMEND (1/16); VA/CFBC/HMO/INCENT (R.1/16); MVAPP (4/15)

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

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

**BlueDental Preferred LOW Option:**
VA/CF/DB/PREF DENT LOW (1/15); VA/CF/DB/2016 DENTAL AMD LOW (1/16)

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

CareFirst
The CareFirst BlueCross BlueShield family of health care plans



CDS1143-1P (9/15)