Virginia Consumer Health Benefits 2014

CareFirst

		Catastrophic	Bronze					Silver						Gold						Platinum			
	Virginia CareFirst Plans	**BlueChoice Young Adult $6,350**	**BluePreferred HSA Bronze $3,500**		**BlueChoice HSA Bronze $4,000**	**BlueChoice Plus Bronze $5,500**		**BlueChoice HSA Bronze $6,000**	**BlueChoice HSA Silver $1,300**	**BluePreferred HSA Silver $1,500**		**BlueChoice Silver $2,000**	**BlueChoice Plus Silver $2,500**		**BlueChoice Gold $0**	**BluePreferred Gold $500**		**BlueChoice Gold $1,000**	**HealthyBlue Gold $1,500**		**HealthyBlue Platinum $0**		**BluePreferred Platinum $0**	
	Plan Type	BlueChoice HMO[1]	PPO[3]		BlueChoice HMO[1]	POS[2]		BlueChoice HMO[1]	BlueChoice HMO[1]	PPO[3]		BlueChoice HMO[1]	POS[2]		BlueChoice HMO[1]	PPO[3]		BlueChoice HMO[1]	POS[2]		POS[2]		PPO[3]	
	Your Premium: Plug in your estimated individual/family premium to give yourself a better idea of your healthcare costs...																						
1	**PROGRAM DETAILS**	In-Network Only	In-Network	Out-of-Network	In-Network Only	In-Network	Out-of-Network	In-Network	In-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
2	**HSA Compatible**	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No
3	**Primary Care Provider Selection (Encouraged)**		No	No		Yes	Yes			No	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	
4	**MEMBER RESPONSIBILITY**																						
5	**Deductible**	Individual: $6,350 Family: $12,700	Individual: $3,500 Family: $7,000	Individual: $7,000 Family: $14,000	Individual: $4,000 Family: $8,000	Individual: $5,500 Family: $11,000	Individual: $6,350 Family: $12,700	Individual: $6,000 Family: $12,000	Individual: $1,300 Family: $2,600	Individual: $1,500 Family: $3,000	Individual: $3,000 Family: $6,000	Individual: $2,000 Family: $4,000	Individual: $2,500 Family: $5,000	Individual: $5,000 Family: $10,000	Individual: $0 Family: $0	Individual: $500 Family: $1,000	Individual: $1,000 Family: $2,000	Individual: $1,000 Family: $2,000	Individual: $1,500 Family: $3,000	Individual: $2,500 Family: $5,000	Individual: $0 Family: $0	Individual: $1,000 Family: $2,000	Individual: $0 Family: $0	Individual: $1,000 Family: $2,000
6	**Out-of-Pocket Maximum**		Individual: $6,350 Family: $12,700	Individual: $12,700 Family: $25,400	Individual: $6,350 Family: $12,700	Individual: $6,350 Family: $12,700	Individual: $6,350 Family: $12,700		Individual: $6,350 Family: $12,700	Individual: $5,500 Family: $11,000	Individual: $11,000 Family: $22,000	Individual: $6,350 Family: $12,700	Individual: $6,350 Family: $12,700	Individual: $6,350 Family: $12,700	Individual: $6,350 Family: $12,700	Individual: $7,500 Family: $15,000	Individual: $3,750 Family: $7,500	Individual: $3,750 Family: $7,500	Individual: $3,450 Family: $6,900	Individual: $3,450 Family: $6,900	Individual: $2,000 Family: $4,000	Individual: $4,000 Family: $8,000	Individual: $1,800 Family: $3,600	Individual: $3,600 Family: $7,200
7	**Aggregate or Separate**	Separate	Aggregate	Aggregate	Aggregate	Separate	Separate	Aggregate	Aggregate	Aggregate	Aggregate	Separate	Separate	Separate	Separate	Separate	Separate	Separate	Separate	Separate	Separate	Separate	Separate	Separate
8	**PREVENTIVE SERVICES**																						
9	**Routine Adult Physical (including routine OB/GYN visits)**	No charge, no deductible	No charge, no deductible	No charge after deductible	No charge, no deductible	No charge, no deductible	No charge after deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge after deductible	No charge, no deductible	No charge, no deductible	No charge after deductible	No charge, no deductible	No charge, no deductible	No charge after deductible	No charge, no deductible	No charge, no deductible	No charge after deductible	No charge, no deductible	No charge after deductible	No charge, no deductible	No charge after deductible
10	**Well-Child Care (including exams and immunizations)**			No charge, no deductible			No charge, no deductible				No charge, no deductible			No charge, no deductible			No charge, no deductible			No charge, no deductible			
11	**Breast Cancer Screening**																						
12	**Cancer Screening (Pap test, Prostate Screening, and Colorectal Screening)**			No charge after deductible			No charge after deductible				No charge after deductible			No charge after deductible			No charge after deductible				No charge after deductible		No charge after deductible
13	**OFFICE VISITS, LABS & TESTING***																						
14	**Office Visits for Illness (office setting)**	No charge after deductible.* The deductible does not apply to covered preventive services and up to 3 non-preventive primary care visits for Covered Services per Benefit Period.	$30 PCP/$40 Specialist after deductible	20% after deductible	$30 PCP/$40 Specialist after deductible	$35 PCP, no deductible $45 Specialist after deductible	40% after deductible	No charge after deductible	$30 PCP/$40 Specialist after deductible	$30 PCP/$40 Specialist after deductible	20% after deductible	$30 PCP copay, no deductible $40 Specialist copay after deductible.	$20 PCP copay, no deductible $40 Specialist copay after deductible.	40% after deductible	$20 PCP/$30 Specialist copay	$30 PCP/$40 Specialist after deductible	20% after deductible	$20 PCP copay, no deductible $30 Specialist copay after deductible	$0 PCP, no deductible $40 Specialist, no deductible	$40 copay after deductible	$0 PCP/$30 Specialist copay	$30 copay after deductible	$20 PCP/$30 Specialist copay	20% after deductible
15	**Office Visits for Chiropractic, Physical, Occupational and Speech Therapy**		$40 copay after deductible		$40 copay after deductible	$45 copay after deductible			$40 copay after deductible	$40 copay after deductible		$40 copay after deductible	$40 copay after deductible		$30 copay	$40 copay after deductible		$30 copay after deductible	$40 copay, no deductible		$30 copay		$30 copay	
16	**Diagnostic/Lab Tests/Xrays**		20% after deductible	40% after deductible	30% after deductible	20% after deductible			20% after deductible	30% after deductible	50% after deductible	20% after deductible	20% after deductible		30% coinsurance	20% after deductible	40% after deductible	10% after deductible	No charge, no deductible	No charge after deductible	No charge, no deductible	No charge after deductible	10% coinsurance	30% after deductible
17	**Any service provided in outpatient department of hospital, add facility charge**																		$40 copay after deductible	$125 copay after deductible	$30 copay	$100 copay after deductible		
18	**EMERGENCY CARE**																							
19	**Emergency Room (waived if admitted)**	No charge after deductible	20% after deductible	20% after deductible	30% after deductible	20% after deductible	20% after deductible	No charge after deductible	20% after deductible	30% after deductible	30% after deductible	20% after deductible	20% after deductible	20% after deductible	30% coinsurance	20% after deductible	20% after deductible	10% after deductible	$200 copay, no deductible	$200 copay, no deductible	$200 copay	$200 copay	10% coinsurance	10% coinsurance
20	**Urgent Care Center (participating)**		20% after deductible	40% after deductible		$45 copay, no deductible	40% after deductible		20% after deductible	30% after deductible	50% after deductible	$40 copay, no deductible	$40 copay after deductible	40% after deductible		20% after deductible	40% after deductible	$30 copay, no deductible	$50 copay, no deductible	$50 copay, no deductible	$50 copay	$50 copay	10% coinsurance	30% after deductible
21	**Ambulance (when medically necessary)**					20% after deductible						20% after deductible	20% after deductible					10% after deductible						
22	**HOSPITALIZATION**																							
23	**Inpatient Facility & Physician Services (includes Delivery and Nursery care of a newborn)**	No charge after deductible	20% after deductible	40% after deductible	30% after deductible	20% after deductible	40% after deductible	No charge after deductible	20% after deductible	30% after deductible	50% after deductible	20% after deductible	20% after deductible	40% after deductible	30% coinsurance	20% after deductible	40% after deductible	10% after deductible	Facility: $450/ day copay after deductible Physician: $40 copay after deductible	Facility: $700/ day copay after deductible Physician: $125 copay after deductible	Facility: $150/day copay Physician: $30 copay	Facility: $400/ day copay after deductible Physician: $100 copay after deductible	10% coinsurance	30% after deductible
24	**Outpatient Facility & Physician Services**																		$40 copay after deductible	$125 copay after deductible	$30 copay	$100 copay after deductible		
25	**ADDITIONAL NURSING SERVICES**																							
26	**Hospice (Inpatient)/Skilled Nursing Facility**	No charge after deductible	20% after deductible	40% after deductible	30% after deductible	20% after deductible	40% after deductible	No charge after deductible	20% after deductibe	30% after deductible	50% after deductible	20% after deductible	20% after deductible	40% after deductible	30% coinsurance	20% after deductible	40% after deductible	10% after deductible	$40 copay after deductible	$125 copay after deductible	$30 copay	$100 copay after deductible	10% coinsurance	30% after deductible
27	**Hospice (Outpatient)**		No charge after deductible	20% after deductible	No charge after deductible	No charge after deductible			No charge after deductible	No charge after deductible	20% after deductible	No charge after deductible	No charge after deductible		No charge, no deductible	No charge after deductible	20% after deductible	No charge after deductible	No charge after deductible		No charge, no deductible		No charge, no deductible	20% after deductible
28	**MENTAL HEALTH & SUBSTANCE ABUSE****																							
29	**Inpatient Facility Services & Physician Services**	No charge after deductible	20% after deductible	40% after deductible	30% after deductible	20% after deductible	40% after deductible	No charge after deductible	20% after deductible	30% after deductible	50% after deductible	20% after deductible	20% after deductible	40% after deductible	30% coinsurance	20% after deductible	40% after deductible	10% after deductible	Facility: $450/ day copay after deductible Physician: $40 copay after deductible	Facility: $700/ day copay after deductible Physician: $125 copay after deductible	Facility: $150/day copay Physician: $30 copay	Facility: $400/ day copay after deductible Physician: $100 copay after deductible	10% coinsurance	30% after deductible
30	**Outpatient Facility & Physician Services**																		$40 copay, no deductible	$40 copay after deductible	$30 copay	$30 copay after deductible	10% coinsurance	
31	**Office Visits**		$30 copay after deductible	20% after deductible	$30 copay after deductible	$35 copay, no deductible			$30 copay after deductible	$30 copay after deductible	20% after deductible	$30 copay, no deductible	$20 copay, no deductible		$20 copay	$30 copay after deductible	20% after deductible	$20 copay, no deductible	No charge, no deductible		No charge, no deductible		$20 copay	20% after deductible
32	**DURABLE MEDICAL EQUIPMENT**																							
33	**DME (excludes hearing aids)**	No charge after deductible	20% after deductible	40% after deductible	30% after deductible	20% after deductible	40% after deductible	No charge after deductible	20% after deductible	30% after deductible	50% after deductible	20% after deductible	20% after deductible	40% after deductible	30% coinsurance	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible	20% coinsurance	40% coinsurance after deductible	10% coinsurance	30% after deductible
34	**MATERNITY SERVICES**																							
35	**Office Visits (pre and postnatal)**	No charge after deductible	$40 copay after deductible	20% after deductible	$40 copay after deductible	$45 copay after deductible	40% after deductible	No charge after deductible	$40 copay after deductible	$40 copay after deductible	20% after deductible	$40 copay, after deductible	$40 copay, after deductible	40% after deductible	$30 copay	$40 copay after deductible	20% after deductible	$30 copay, no deductible	$40 copay after deductible	$40 copay after deductible	$30 copay	$30 copay after deductible	$30 copay	20% after deductible
36	**Office Visits (routine, preventive prenatal)**	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		No charge, no deductible		No charge, no deductible	
37	**PRESCRIPTION DRUG COVERAGE†**																							
38	**Integrated Medical & Drug Deductible or Separate**	Integrated	Integrated	Integrated	Integrated	Integrated (excluding Preferred Generics)	Integrated (excluding Preferred Generics)	Integrated	Integrated	Integrated	Integrated	Integrated (excluding Preferred Generics)	$400 Separate Drug Deductible (excluding Preferred Generics)	$400 Separate Drug Deductible (excluding Preferred Generics)	N/A	Integrated	Integrated	Integrated (excluding Preferred Generics)	$400 Individual Drug Deductible (excluding Preferred Generics)	$400 Individual Drug Deductible (excluding Preferred Generics)	N/A	N/A	N/A	N/A
39	**Preferred Generics**	No charge after deductible	20% after deductible	20% after deductible	20% after deductible	$10 copay, no deductible	$10 copay, no deductible	No charge after deductible	20% after deductible	20% after deductible	20% after deductible	$10 copay, no deductible	$10 copay, no deductible	$10 copay, no deductible	20% coinsurance	20% after deductible	20% after deductible	$10 copay, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	20% coinsurance	20% coinsurance
40	**Non-Preferred Generics**					20% after deductible	20% after deductible					20% after deductible	20% after deductible	20% after deductible				20% after deductible						
41	**Preferred Brand**		30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible		30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% coinsurance	30% after deductible	30% after deductible	30% after deductible	$45 copay after deductible	$45 copay after deductible	$45 copay	$45 copay	30% coinsurance	30% coinsurance
42	**Non-Preferred Brand**		50% after deductible	50% after deductible	50% after deductible	40% after deductible	40% after deductible		50% after deductible	50% after deductible	50% after deductible	40% after deductible	40% after deductible	40% after deductible	50% coinsurance	50% after deductible	50% after deductible	40% after deductible	$200 copay after deductible	$200 copay after deductible	$100 copay	$100 copay	50% coinsurance	50% coinsurance
43	**Specialty**																				$200 copay	$200 copay		

[1] Health Maintenance Organization (HMO) plans underwritten by CareFirst BlueChoice, 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] Preferred Provider Organization (PPO) plans underwritten by Group Hospitalization and Medical Services, Inc.
* For all HMO and POS plans: To receive in-network coverage, lab tests must be performed at LabCorp and X-Rays must be performed at freestanding facilities. Out-of-network coverage available with POS plans.
** For all HMO and POS plans: To receive in-network coverage, mental health and substance abuse office visits must be performed through Magellan providers. Out-of-network coverage available with POS plans.
† To view prescription drugs grouped by category or for more information about a single drug, please visit **www.carefirst.com/rx**.

See a personalized 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 Consultants at (410) 356-8000 or toll-free at (800) 544-8703 Monday–Friday, 8 a.m. – 8 p.m.

POLICY NUMBERS:

CAT: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/CAT SOB (1/14)

BluePreferred HSA Bronze $3,500: VA/CF/DB/BP (1/14); VA/CF/EXC/BP/BRZ SOB (1/14)

BlueChoice HSA Bronze $4,000: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO HSA/4000 BRZ SOB (1/14)

BlueChoice Plus Bronze $5,500: **In-Network:** VA/CFBC/DB/BCOO/INN (1/14); VA/CFBC/EXC/BC+ IN/BRZ SOB (1/14). **Out-of-Network**: VA/CF/DB/BCOO/OON (1/14); VA/CF/EXC/BC+ OON/BRZ SOB (1/14)

BlueChoice HSA Bronze $6,000: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO HSA/6000 BRZ SOB (1/14)

BlueChoice HSA Silver $1,300: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO HSA/SIL SOB (1/14)

BluePreferred HSA Silver $1,500: VA/CF/DB/BP/MSP (1/14); VA/CF/EXC/BP/SIL SOB (1/14)

BlueChoice Silver $2,000: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/SIL SOB (1/14)

BlueChoice Plus Silver $2,000: **In-Network**: VA/CFBC/DB/BCOO/INN (1/14); VA/CFBC/EXC/BC+ IN/SIL SOB (1/14). **Out-of-Network**: VA/CF/DB/BCOO/OON (1/14); VA/CF/EXC/BC+ OON/SIL SOB (1/14)

BlueChoice Gold $0: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/GOLD 0 SOB (1/14)

BluePreferred Gold $500: VA/CF/DB/BP MSP (1/14; VA/CF/EXC/BP/GOLD SOB (1/14)

BlueChoice Gold $1,000: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/GOLD 1000 SOB (1/14)

HealthyBlue Gold $1,500: **In-Network**: VA/CFBC/DB/HB/INN (1/14); VA/CFBC/EXC/HB IN/GOLD SOB (1/14). **Out-of-Network**: VA/CF/DB/HB/OON (1/14); VA/CF/EXC/HB OON/GOLD SOB (1/14)

HealthyBlue Platinum $0: **In-Network**: VA/CFBC/DB/HB/INN (1/14); VA/CFBC/EXC/HB IN/PLAT SOB (1/14). **Out-of-Network**: VA/CF/DB/HB/OON (1/14); VA/CF/EXC/HB OON/PLAT SOB (1/14)

BluePreferred Platinum $0: VA/CF/DB/BP (1/14); VA/CF/EXC/BP/PLAT SOB (1/14)

AND ANY AMENDMENTS.

CareFirst

The CareFirst BlueCross BlueShield family of health care plans.

CDS1112-1P (10/3/13)