Virginia Consumer Health Benefits 2018

CareFirst
Family of health care plans

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.

			Silver		Gold		Catastrophic
		Virginia CareFirst Plans	**BlueChoice HMO SIlver $3,500**	**BluePreferred PPO Silver $3,500**	**HealthyBlue HMO Gold $1,000**	**HealthyBlue PPO Gold $1,000**	**BlueChoice HMO Young Adult $7,350**
		Plan Type	HMO[1] *Underwritten by CareFirst BlueChoice, Inc.*	PPO[2] *Underwritten by Group Hospitalization and Medical Services, Inc. or CareFirst of Maryland, Inc.*	HMO[1] *Underwritten by CareFirst BlueChoice, Inc.*	PPO[2] *Underwritten by Group Hospitalization and Medical Services, Inc. or CareFirst of Maryland, Inc.*	HMO[1] *Underwritten by CareFirst BlueChoice, Inc.*
		Visit **carefirst.com/doctor** to view participating doctors and facilities—search by plan:	**BlueChoice HMO**	**BluePreferred PPO**	**HealthyBlue HMO**	**HealthyBlue PPO**	**BlueChoice HMO**
		Rewards					
		DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM		In-Network	In-Network	In-Network	In-Network
1		**Deductible**[3]	Individual: $3,500 Family: $7,000	Individual: $3,500 Family: $7,000	Individual: $1,000 Family: $2,000	Individual: $1,000 Family: $2,000	Individual: $7,350 Family: $14,700
2		**Out-of-Pocket Maximum**[4]	Individual: $7,350 Family: $14,700	Individual: $7,350 Family: $14,700	Individual: $6,500 Family: $13,000	Individual:$6,500 Family: $13,000	Individual: $7,350 Family: $14,700
		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
		PRIMARY CARE AND SPECIALIST SERVICES					
4		**Primary Care Provider (PCP) Visits—Office/Non-Hospital** (non-preventive)	$30 copay, no deductible	$30 copay, no deductible	No charge, no deductible	No charge, no deductible	Visits 1–3: No charge, no deductible[5] Visits 4+: No charge after deductible
5		**Specialist Visits—Office/Non-Hospital**	$40 copay, no deductible	$40 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	$75 copay after deductible	$75 copay after deductible	No charge after deductible
		RETAIL CLINICS, URGENT AND EMERGENCY SERVICES					
7		**Convenience Care/Retail Health Clinics**	$30 copay, no deductible	$30 copay, no deductible	No charge, no deductible	No charge, no deductible	No charge after deductible
8		**Urgent Care Center**	$60 copay, no deductible	$60 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	$300 copay after deductible	$300 copay after deductible	No charge after deductible
		DIAGNOSTIC SERVICES					
10	Office/Non-Hospital	**Labs**[6]	$25 copay, no deductible (LabCorp only)	$25 copay, no deductible	$15 copay, no deductible (LabCorp only)	$15 copay, no deductible	No charge after deductible (LabCorp only)
11	Outpatient Hospital		$90 copay after deductible[7]	$90 copay after deductible	$60 copay after deductible[7]	$60 copay after deductible	No charge after deductible[7]
12	Office/Non-Hospital	**X-rays**[6]	$55 copay, no deductible	$55 copay, no deductible	$65 copay, no deductible	$65 copay, no deductible	No charge after deductible
13	Outpatient Hospital		$130 copay after deductible[7]	$130 copay after deductible	$100 copay after deductible[7]	$100 copay after deductible	No charge after deductible[7]
14	Office/Non-Hospital	**Imaging** (e.g. MRI, Cat Scan, CT Scan)	$250 copay, no deductible	$250 copay, no deductible	$250 copay, no deductible	$250 copay, no deductible	No charge after deductible
15	Outpatient Hospital		$500 copay after deductible[7]	$500 copay after deductible	$350 copay after deductible[7]	$350 copay after deductible	No charge after deductible[7]
		OUTPATIENT SURGERY *(Members are responsible for both facility and physician charges)*					
16	Non-Hospital/Surgical Center	**Outpatient Surgery** (physician charge)	$40 copay, no deductible	$40 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	No charge after deductible
17	Hospital		$40 copay after deductible[7]	$40 copay after deductible	$30 copay after deductible[7]	$30 copay after deductible	No charge after deductible[7]
18	Non-Hospital/Surgical Center	**Outpatient Surgery** (facility charge)	$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[7]	$450 copay after deductible	$400 copay after deductible[7]	$400 copay after 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)	$40 copay after deductible	$40 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 (up to a copay maximum of $2,500)[7]	$500 copay/day after deductible (up to a copay maximum of $2,500)	$450 copay/day after deductible (up to a copay maximum of $2,250)[7]	$450 copay/day after deductible (up to a copay maximum of $2,250)	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
		MENTAL HEALTH & SUBSTANCE ABUSE					
23		**Office Visits**	$30 copay, no deductible	$30 copay, no deductible	No charge, no deductible	No charge, no deductible	Visits 1–3: No charge, no deductible[5] Visits 4+: No charge after deductible
		PRESCRIPTION DRUGS[9]					
24		**Prescription Drug Deductible**	$250 per person (Tiers 2–5)	$250 per person (Tiers 2–5)	$150 per person (Tiers 2–5)	$150 per person (Tiers 2–5)	No separate drug deductible; Must meet medical deductible first
25		**Generic Drugs (Tier 1)**	$10 copay, no deductible	$10 copay, no deductible	No charge, no deductible	No charge, no deductible	No charge after deductible
26		**Preferred Brand Drugs (Tier 2)**[10]	$50 copay after deductible	$50 copay after deductible	$50 copay after deductible	$50 copay after deductible	
27		**Non-Preferred Brand Drugs (Tier 3)**[11]	$70 copay after deductible	$70 copay after deductible	$70 copay after deductible	$70 copay after deductible	
28		**Preferred Specialty Drugs (Tier 4)**	$100 copay after deductible	$100 copay after deductible	$100 copay after deductible	$100 copay after deductible	
29		**Non-Preferred Specialty Drugs (Tier 5)**	$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	
30		**Deductible**	N/A	Individual: $7,000 Family: $14,000	N/A	Individual: $2,000 Family: $4,000	N/A
31		**Out-of-Pocket Maximum**	N/A	Individual: $14,700 Family: $29,400	N/A	Individual: $13,000 Family: $26,000	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.
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.

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.

2018 Virginia Policy Form Numbers:

BlueChoice HMO Silver $3,500
On-Exchange:
VA/CFBC/DB/2018 AMEND (1/18)-HIX; VA/CFBC/DB/HMO (1/17)-HIX; VA/CFBC/DB/HMO/INCENT (R. 1/18)-HIX; VA/CFBC/EXC/HMO/SIL 3500 (1/18)-HIX (Silver Metal Level); VA/CFBC/EXC/HMO/SIL 3500 A (1/18)-HIX (Silver Metal Level 200-250 FPL); VA/CFBC/EXC/HMO/SIL 3500 B (1/18-HIX (Silver Metal Level 150-200 FPL); VA/CFBC/EXC/HMO/SIL 3500 C (1/18)-HIX (Silver Metal Level 100-150 FPL)

Off-Exchange:
VA/CFBC/DB/2018 AMEND (1/18); VA/CFBC/DB/HMO (1/17); VA/CFBC/DB/HMO/INCENT (R. 1/18); VA/CFBC/EXC/HMO/SIL 3500 (1/18); VA/CFBC/DB/HMO/INCENT (R. 1/18); MVAAP (4.17)

BluePreferred PPO Silver $3,500
On-Exchange:
VA/CF/CD/2018 AMEND (1/18)-HIX; VA/CF/DB/BP (1/17)-HIX; VA/CF/DB/PPO/INCENT (R. 1/18)-HIX; VA/CF/EXC/BP PPO/SIL 3500 (1/18)-HIX (Silver Metal Level); VA/CF/EXC/BP PPO/SIL 3500 A (1/18)-HIX (Silver Metal Level 200-250 FPL); VA/CF/EXC/BP PPO /SIL 3500 B (1/18)-HIX (Silver Metal Level 150-200 FPL); VA/CF/EXC/BP PPO/SIL 3500 C (1/18)-HIX (Silver Metal Level 100-150 FPL)

Off-Exchange:
VA/CF/DB/BP (1/17); VA/CF/CD/2018 AMEND (1/18); VA/CF/DB/PPO/INCENT (R. 1/18); VA/CF/EXC/BP PPO/SIL 3500 (1/18); MVAAP (4.17)

HealthyBlue HMO Gold $1,000
On-Exchange:
VA/CFBC/DB/2018 AMEND (1/18)-HIX; VA/CFBC/DB/HMO (1/17)-HIX; VA/CFBC/DB/HMO/INCENT (R. 1/18)-HIX; VA/CFBC/EXC/HB HMO/GOLD 1000 (1/18)-HIX (Gold Metal Level)

Off-Exchange:
VA/CFBC/DB/2018 AMEND (1/18); VA/CFBC/DB/HMO (1/17); VA/CFBC/DB/HMO/INCENT (R. 1/18); VA/CFBC/EXC/HB HMO/GOLD 1000 (1/18); MVAAP (4.17)

HealthyBlue PPO Gold $1,000
On-Exchange:
VA/CF/CD/2018 AMEND (1/18)-HIX; VA/CF/DB/BP (1/17)-HIX; VA/CF/DB/PPO/INCENT (R. 1/18)-HIX; VA/CF/EXC/HB PPO/GOLD 1000 (1/18)-HIX

Off-Exchange:
VA/CF/CD/2018 AMEND (1/18); VA/CF/DB/BP (1/17); VA/CF/DB/PPO/INCENT (R. 1/18); VA/CF/EXC/HB PPO/GOLD 1000 (1/18); MVAAP (4.17)

BlueChoice HMO Young Adult $7,350
On-Exchange:
VA/CFBC/DB/2018 AMEND (1/18)-HIX; ; VA/CFBC/DB/HMO (1/17)-HIX; VA/CFBC/DB/HMO/INCENT (R. 1/18)-HIX; VA/CFBC/EXC/HMO/YA SOB (1/18)-HIX

Off-Exchange:
VA/CFBC/DB/2018 AMEND (1/18); VA/CFBC/DB/HMO (1/17); VA/CFBC/DB/HMO/INCENT (R. 1/18); VA/CFBC/EXC/HMO/YA SOB (1/18); MVAAP (4.17)

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.

CareFirst
Family of health care plans

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