CareFirst
Family of health care plans

Washington, D.C. Consumer Health Benefits 2018

Washington, D.C. CareFirst Plans	Bronze				Silver		Gold				Platinum		Catastrophic
	BlueChoice HMO Standard Bronze $6,000	**BluePreferred PPO Standard Bronze $6,000**	**BlueChoice HMO HSA Standard Bronze $6,200**	**BluePreferred PPO HSA Standard Bronze $6,200**	**BlueChoice HMO Standard Silver $3,500**	**BluePreferred PPO Standard Silver $3,500**	**BlueChoice HMO Standard Gold $500**	**BluePreferred PPO Standard Gold $500**	**BlueChoice HMO HSA Gold $1,500**	**BluePreferred PPO HSA Gold $1,500**	**BlueChoice HMO Standard Platinum $0**	**BluePreferred PPO Standard Platinum $0**	**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.*	HMO[1] *Underwritten by CareFirst BlueChoice, Inc.*	PPO[2] *Underwritten by Group Hospitalization and Medical Services, Inc.*	HMO[1] *Underwritten by CareFirst BlueChoice, Inc.*	PPO[2] *Underwritten by Group Hospitalization and Medical Services, Inc.*	HMO[1] *Underwritten by CareFirst BlueChoice, Inc.*	PPO[2] *Underwritten by Group Hospitalization and Medical Services, Inc.*	HMO[1] *Underwritten by CareFirst BlueChoice, Inc.*	PPO[2] *Underwritten by Group Hospitalization and Medical Services, Inc.*	HMO[1] *Underwritten by CareFirst BlueChoice, Inc.*	PPO[2] *Underwritten by Group Hospitalization and Medical Services, 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	BlueChoice HMO	BluePreferred PPO	BlueChoice HMO	BluePreferred PPO	BlueChoice HMO	BluePreferred PPO	BlueChoice HMO	BluePreferred PPO	BlueChoice HMO	BluePreferred PPO	BlueChoice HMO
Rewards	Earn up to $150 per eligible adult. Dependent children of any age are not eligible. Visit **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
1 Deductible[3]	Individual: $6,000 Family: $12,000	Individual: $6,000 Family: $12,000	Individual: $6,200 Family: $12,400	Individual: $6,200 Family: $12,400	Individual: $3,500 Family: $7,000	Individual: $3,500 Family: $7,000	Individual: $500 Family: $1,000	Individual: $500 Family: $1,000	Individual: $1,500 Family: $3,000	Individual: $1,500 Family: $3,000	Individual: $0 Family: $0	Individual: $0 Family: $0	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: $6,550 Family: $13,100	Individual: $6,550 Family: $13,100	Individual: $6,250 Family: $12,500	Individual: $6,250 Family: $12,500	Individual: $3,500 Family: $7,000	Individual: $3,500 Family: $7,000	Individual: $2,700 Family: $5,400	Individual: $2,700 Family: $5,400	Individual:$2,000 Family: $4,000	Individual:$2,000 Family: $4,000	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	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)	$50 copay, no deductible	$50 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	$40 copay, no deductible	$40 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$25 copay after deductible	$25 copay after deductible	$20 copay	$20 copay	Visits 1–3: No charge, no deductible Visits 4+: No charge after deductible
5 Specialist Visits—Office/Non-Hospital	$75 copay, no deductible	$75 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	$80 copay, no deductible	$80 copay, no deductible	$50 copay, no deductible	$50 copay, no deductible	$50 copay after deductible	$50 copay after deductible	$40 copay	$40 copay	No charge after deductible
6 HOSPITAL CHARGE—Add this charge if your primary care or specialist visit takes place in a hospital setting	25% coinsurance after deductible	25% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$75 copay, no deductible	$75 copay, no deductible	$75 copay after deductible	$75 copay after deductible	$75 copay	$75 copay	No charge after deductible
RETAIL CLINICS, URGENT AND EMERGENCY SERVICES													
7 Convenience Care/Retail Health Clinics	$50 copay, no deductible	$50 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	$40 copay, no deductible	$40 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$25 copay after deductible	$25 copay after deductible	$20 copay	$20 copay	No charge after deductible
8 Urgent Care Center	$100 copay, no deductible	$100 copay, no deductible	$50 copay after deductible	$50 copay after deductible	$90 copay, no deductible[10]	$90 copay, no deductible	$60 copay, no deductible	$60 copay, no deductible	$60 copay after deductible	$60 copay after deductible	$40 copay	$40 copay	No charge after deductible
9 Emergency Room (hospital charge—copays are waived if you are admitted)	25% coinsurance after deductible	25% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$250 copay after deductible[10]	$250 copay after deductible	$250 copay, no deductible	$250 copay, no deductible	$250 copay after deductible	$250 copay after deductible	$150 copay	$150 copay	No charge after deductible
DIAGNOSTIC SERVICES													
10 Labs[5]	$55 copay after deductible (LabCorp only)[10]	$55 copay after deductible	20% coinsurance after deductible (LabCorp only)[10]	20% coinsurance after deductible	$50 copay, no deductible (LabCorp only)[10]	$50 copay, no deductible	$30 copay, no deductible (LabCorp only)[10]	$30 copay, no deductible	$30 copay after deductible (LabCorp only)[10]	$30 copay after deductible	$20 copay (LabCorp Only)[10]	$20 copay	No charge after deductible (LabCorp only)[10]
12 X-rays[5]	$75 copay after deductible[10]	$75 copay after deductible	20% coinsurance after deductible[10]	20% coinsurance after deductible	$70 copay, no deductible[10]	$70 copay, no deductible	$50 copay, no deductible[10]	$50 copay, no deductible	$50 copay after deductible[10]	$50 copay after deductible	$40 copay[10]	$40 copay	No charge after deductible[10]
14 Imaging (e.g. MRI, Cat Scan, CT Scan)	$500 copay after deductible[10]	$500 copay after deductible	20% coinsurance after deductible[10]	20% coinsurance after deductible	$250 copay, no deductible[10]	$250 copay, no deductible	$250 copay, no deductible[10]	$250 copay, no deductible	$250 copay after deductible[10]	$250 copay after deductible	$150 copay[10]	$150 copay	No charge after deductible[10]
OUTPATIENT SURGERY *(Members are responsible for both facility and physician charges)*													
16 Outpatient Surgery (facility charge)	25% coinsurance after deductible[10]	25% coinsurance after deductible	20% coinsurance after deductible[10]	20% coinsurance after deductible	20% coinsurance after deductible[10]	20% coinsurance after deductible	$525 copay, no deductible[10]	$525 copay, no deductible	$525 copay after deductible[10]	$525 copay after deductible	$175 copay[10]	$175 copay	No charge after deductible[10]
18 Outpatient Surgery (physician charge)	25% coinsurance after deductible[10]	25% coinsurance after deductible	20% coinsurance after deductible[10]	20% coinsurance after deductible	20% coinsurance after deductible[10]	20% coinsurance after deductible	$75 copay, no deductible[10]	$75 copay, no deductible	$75 copay after deductible[10]	$75 copay after deductible	$75 copay[10]	$75 copay	No charge after deductible[10]
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)	25% coinsurance after deductible	25% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge, no deductible	No charge, no deductible	No charge after deductible
21 Inpatient Services (hospital charge)	25% coinsurance after deductible[10]	25% coinsurance after deductible	20% coinsurance after deductible[10]	20% coinsurance after deductible	20% coinsurance after deductible[10]	20% coinsurance after deductible	$600 copay/day after deductible (up to a copay maximum of $3,000)[10]	$600 copay/day after deductible (up to a copay maximum of $3,000)	$600 copay/day after deductible (up to a copay maximum of $3,000)[10]	$600 copay/day after deductible (up to a copay maximum of $3,000)	$250 copay/day (up to a copay maximum of $1,250)[10]	$250 copay/day (up to a copay maximum of $1,250)	No charge after deductible[10]
MATERNITY OFFICE VISITS[6]													
22 Preventive Prenatal & Postnatal Office Visits	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													
23 Office Visits	$50 copay, no deductible	$50 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	$40 copay, no deductible	$40 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$25 copay after deductible	$25 copay after deductible	$20 copay	$20 copay	Visits 1–3: No charge, no deductible Visits 4+: No charge after deductible
PRESCRIPTION DRUGS[7]													
24 Prescription Drug Deductible	$600 per person (Tiers 2–5)	$600 per person (Tiers 2–5)	No separate drug deductible; must meet medical deductible first	No separate drug deductible; must meet medical deductible first	$250 per person (Tiers 2–5)	$250 per person (Tiers 2–5)	No drug deductible	No drug deductible	No separate drug deductible; must meet medical deductible first	No separate drug deductible; must meet medical deductible first	No drug deductible	No drug deductible	No separate drug deductible; Must meet medical deductible first
25 Generic Drugs (Tier 1)	$25 copay, no deductible	$25 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	$15 copay, no deductible	$15 copay, no deductible	$15 copay, no deductible	$15 copay, no deductible	$15 copay after deductible	$15 copay after deductible	$5 copay	$5 copay	No charge after deductible
26 Preferred Brand Drugs (Tier 2)[8]	$75 copay after deductible	$75 copay after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$50 copay after deductible	$50 copay after deductible	$50 copay, no deductible	$50 copay, no deductible	$50 copay after deductible	$50 copay after deductible	$15 copay	$15 copay	
27 Non-Preferred Brand Drugs (Tier 3)[9]	$100 copay after deductible	$100 copay after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$70 copay after deductible	$70 copay after deductible	$70 copay, no deductible	$70 copay, no deductible	$70 copay after deductible	$70 copay after deductible	$25 copay	$25 copay	
28 Preferred and Non-Preferred Specialty Drugs (Tiers 4 & 5)	$150 copay after deductible	$150 copay after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$150 copay after deductible	$150 copay after deductible	$150 copay, no deductible	$150 copay, no deductible	$150 copay after deductible	$150 copay after deductible	$100 copay	$100 copay	
Out-of-Network		Out-of-Network				Out-of-Network		Out-of-Network				Out-of-Network	
29 Deductible	N/A	Individual: $12,000 Family: $24,000	N/A	Individual: $12,400 Family: $24,800	N/A	Individual: $7,000 Family: $14,000	N/A	Individual: $1,000 Family: $2,000	N/A	Individual: $3,000 Family: $6,000	N/A	Individual: $1,000 Family: $2,000	N/A
30 Out-of-Pocket Maximum	N/A	Individual: $14,700 Family: $29,400	N/A	Individual: $13,100 Family: $26,200	N/A	Individual: 12,500 Family: $25,000	N/A	Individual: $7,000 Family: $14,000	N/A	Individual: $5,400 Family: $10,800	N/A	Individual: $4,000 Family: $8,000	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 For HMO plans: For in-network benefits, members must use LabCorp for laboratory services and freestanding facilities for diagnostic services and X-rays.

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

7 All out-of-pocket drug costs contribute to the in-network out-of-pocket maximum.

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

9 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 or coinsurance 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.

10 Prior authorization required in a hospital setting.

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.

Know before you go

Your health, your money, your decision

PCP visits: In most cases, 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.

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.

2018 D.C. POLICY FORM NUMBERS

BlueChoice HMO Young Adult $7,350
$7,350; DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO/ YA 7350 SOB (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BlueChoice HMO Young Adult Native American Zero
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO/NATAMER SOB (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BlueChoice HMO Standard Native American Zero
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD /NATAMER 0 (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO Standard Native American Zero
DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/NATAMER SOB (1/18); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 1/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2018 AMEND (1/18); DC/CF/DB/INCENT (R. 1/18); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10)

BlueChoice HMO HSA Standard Bronze $6,200
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO HSA STD/BRZ 6200 (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO HSA Standard Bronze $6,200
DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP HSA STD/BRZ 6200 (1/18); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 1/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2018 AMEND (1/18); DC/CF/DB/INCENT (R. 1/18); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10)

BlueChoice HMO Standard Bronze $6,000
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/BRZ 6000 (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO Standard Bronze $6,000
DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/BRZ 6000 (1/18); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 1/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2018 AMEND (1/18); DC/CF/DB/INCENT (R. 1/18); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10)

BlueChoice HMO Standard Silver $3,500
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/SIL 3500 (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BlueChoice HMO Standard Silver $3,500 A
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/SIL 3500 A (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BlueChoice HMO Standard Silver $3,500 B
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/SIL 3500 B (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BlueChoice HMO Standard Silver $3,500 C
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/SIL 3500 C (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO Standard Silver $3,500
DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/SIL 3500 (1/18); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 1/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2018 AMEND (1/18); DC/CF/DB/INCENT (R. 1/18); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10)

BluePreferred PPO Standard Silver $3,500 A
DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/SIL 3500 A (1/18); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 1/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2018 AMEND (1/18); DC/CF/DB/INCENT (R. 1/18); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10)

BluePreferred PPO Standard Silver $3,500 B
DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/SIL 3500 B (1/18); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 1/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2018 AMEND (1/18); DC/CF/DB/INCENT (R. 1/18); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10)

BluePreferred PPO Standard Silver $3,500 C
DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/SIL 3500 C (1/18); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 1/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2018 AMEND (1/18); DC/CF/DB/INCENT (R. 1/18); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10)

BlueChoice HMO Standard Gold $1,500
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO HSA STD/GOLD 1500 (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO Standard Gold $1,500
DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP HSA STD/GOLD 1500 (1/18); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 1/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2018 AMEND (1/18); DC/CF/DB/INCENT (R. 1/18); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10)

BlueChoice HMO Standard Gold $500
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/GOLD 500 (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO Standard Gold $500
DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/GOLD 500 (1/18); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 1/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2018 AMEND (1/18); DC/CF/DB/INCENT (R. 1/18); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10)

BlueChoice HMO Standard Platinum $0
DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/PLAT 0 (1/18); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 1/18); DC/CFBC/EXC/2018 AMEND (1/18); DC/CFBC/DB/INCENT (R. 1/18); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO Standard Platinum $0
DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/PLAT 0 (1/18); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 1/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2018 AMEND (1/18); DC/CF/DB/INCENT (R. 1/18); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10)

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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.

Family of health care plans

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