District of Columbia Consumer Health Benefits 2017

CareFirst Family of health care plans

		BRONZE		SILVER		GOLD		PLATINUM		CATASTROPHIC
	District of Columbia CareFirst Plans	**BlueChoice HMO Standard Bronze $5,000**	**BluePreferred PPO Standard Bronze $5,000**	**BlueChoice HMO Standard Silver $2,000**	**BluePreferred PPO Standard Silver $2,000**	**BlueChoice HMO Standard Gold $500**	**BluePreferred PPO Standard Gold $500**	**BlueChoice HMO Standard Platinum $0**	**BluePreferred PPO Standard Platinum $0**	**BlueChoice HMO Young Adult $7,150**
	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.*
	Visit www.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
	Rewards	Earn up to $150 per eligible adult. Dependent children of any age are not eligible. 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
1	Deductible[3]	Individual: $5,000 Family: $10,000	Individual: $5,000 Family: $10,000	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000	Individual: $500 Family: $1,000	Individual: $500 Family: $1,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $7,150 Family: $14,300
2	Out-of-Pocket Maximum[4]	Individual: $7,150 Family: $14,300	Individual: $7,150 Family: $14,300	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:$2,000 Family: $4,000	Individual:$2,000 Family: $4,000	Individual: $7,150 Family: $14,300
	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
	PRIMARY CARE AND SPECIALIST SERVICES									
4	Primary Care Provider (PCP) Visits—Office/Non-Hospital (non-preventive)	$50 copay, no deductible	$50 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$20 copay	$20 copay	Visits 1–3: No charge, no deductible Visits 4+: No charge after deductible
5	Specialist Visits—Office/Non-Hospital	$50 copay, no deductible	$50 copay, no deductible	$50 copay, no deductible	$50 copay, no deductible	$50 copay, no deductible	$50 copay, no 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	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	$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	$25 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$20 copay	$20 copay	No charge after deductible
8	Urgent Care Center	$50 copay, no deductible	$50 copay, no deductible	$90 copay, no deductible	$90 copay, no deductible	$60 copay, no deductible	$60 copay, no deductible	$40 copay	$40 copay	No charge after deductible
9	Emergency Room (hospital charge—copays are waived if you are admitted)	20% coinsurance after deductible	20% coinsurance after deductible	$250 copay after deductible	$250 copay after deductible	$250 copay, no deductible	$250 copay, no deductible	$150 copay	$150 copay	No charge after deductible
	DIAGNOSTIC SERVICES									
10	Labs[5] Office/Non-Hospital	$50 copay after deductible (LabCorp only)	$50 copay after deductible	$45 copay, no deductible (LabCorp only)	$45 copay, no deductible	$30 copay, no deductible (LabCorp only)	$30 copay, no deductible	$20 copay (LabCorp Only)	$20 copay	No charge after deductible (LabCorp only)
11	Outpatient Hospital	$50 copay after deductible[11]	$50 copay after deductible	$45 copay, no deductible[11]	$45 copay, no deductible	$30 copay, no deductible[11]	$30 copay, no deductible	$20 copay[11]	$20 copay	No charge after deductible[11]
12	X-rays[5] Office/Non-Hospital	$50 copay after deductible	$50 copay after deductible	$65 copay, no deductible	$65 copay, no deductible	$50 copay, no deductible	$50 copay, no deductible	$40 copay	$40 copay	No charge after deductible
13	Outpatient Hospital	$50 copay after deductible[11]	$50 copay after deductible	$65 copay, no deductible[11]	$65 copay, no deductible	$50 copay, no deductible[11]	$50 copay, no deductible	$40 copay[11]	$40 copay	No charge after deductible[11]
14	Imaging (e.g. MRI, Cat Scan, CT Scan) Office/Non-Hospital	$500 copay after deductible	$500 copay after deductible	$250 copay, no deductible	$250 copay, no deductible	$250 copay, no deductible	$250 copay, no deductible	$150 copay	$150 copay	No charge after deductible
15	Outpatient Hospital	$500 copay after deductible[11]	$500 copay after deductible	$250 copay, no deductible[11]	$250 copay, no deductible	$250 copay, no deductible[11]	$250 copay, no deductible	$150 copay[11]	$150 copay	No charge after deductible[11]
	OUTPATIENT SURGERY (Members are responsible for both facility and physician charges)									
16	Outpatient Surgery (facility charge) Non-Hospital / Surgical Center	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$600 copay, no deductible	$600 copay, no deductible	$250 copay	$250 copay	No charge after deductible
17	Hospital	20% coinsurance after deductible[11]	20% coinsurance after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible	$600 copay, no deductible[11]	$600 copay, no deductible	$250 copay[11]	$250 copay	No charge after deductible[11]
18	Outpatient Surgery (physician charge) Non-Hospital / Surgical Center	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge after deductible
19	Hospital	20% coinsurance after deductible[11]	20% coinsurance after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge after deductible[11]
	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)	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, no deductible	No charge, no deductible	No charge after deductible
21	Inpatient Services (hospital charge)	20% coinsurance after deductible[11]	20% coinsurance after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible	$600 copay/day after deductible (up to a copay maximum of $3,000)[11]	$600 copay/day after deductible (up to a copay maximum of $3,000)	$250 copay/day (up to a copay maximum of $1,250)[11]	$250 copay/day (up to a copay maximum of $1,250)	No charge after deductible[11]
	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
	MENTAL HEALTH & SUBSTANCE ABUSE[7]									
23	Office Visits	$50 copay, no deductible	$50 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$25 copay, no deductible	$20 copay	$20 copay	Visits 1–3: No charge, no deductible Visits 4+: No charge after deductible
	PRESCRIPTION DRUGS[8]									
24	Prescription Drug Deductible	$300 per person (Tiers 2–4)	$300 per person (Tiers 2–4)	$250 per person (Tiers 2–4)	$250 per person (Tiers 2–4)	No drug deductible	No drug deductible	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	$15 copay, no deductible	$15 copay, no deductible	$15 copay, no deductible	$15 copay, no deductible	$5 copay	$5 copay	No charge after deductible
26	Preferred Brand Drugs (Tier 2)[9]	50% coinsurance after deductible	50% coinsurance after deductible	$50 copay after deductible	$50 copay after deductible	$50 copay, no deductible	$50 copay, no deductible	$15 copay	$15 copay	
27	Non-Preferred Brand Drugs (Tier 3)[10]	50% coinsurance after deductible	50% coinsurance after deductible	$70 copay after deductible	$70 copay after deductible	$70 copay, no deductible	$70 copay, no deductible	$25 copay	$25 copay	
28	Specialty Drugs (Tier 4)	50% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance, no deductible	20% coinsurance, no 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: $10,000 Family: $20,000	N/A	Individual: $4,000 Family: $8,000	N/A	Individual: $1,000 Family: $2,000	N/A	Individual: $1,000 Family: $2,000	N/A
30	Out-of-Pocket Maximum	N/A	Individual: $14,300 Family: $28,600	N/A	Individual: 12,500 Family: $25,000	N/A	Individual: $7,000 Family: $14,000	N/A	Individual: $4,000 Family: $8,000	N/A

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.

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] 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.

[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] For HMO plans: To receive in-network coverage, mental health and substance abuse coverage must be performed by Magellan behavioral health providers.

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

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

[10] 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.

[11] Prior authorization required.

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.

2017 D.C. POLICY FORM NUMBERS

BlueChoice HMO Standard Bronze $5,000
DC/CFBC/EXC/HMO/IEA (R 1/17); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/EXC/HMO/DOCS (1/17); DC/CFBC/EXC/HMO STD/BRZ 5000 (1/17); DC/CFBC/MEM/BLCRD (1/17); DC/CFBC/PT PROTECT (9/10); DC/CFBC/DB/INCENT (1/17)

BluePreferred PPO Standard Bronze $5,000
DC/CF/EXC/BP/IEA (R. 1/17); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/BRZ 5000 (1/17); DC/CF/MEM/BLCRD (1/17); DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10); DC/CF/DB/INCENT (1/17)

BlueChoice HMO Standard Silver $2,000
DC/CFBC/EXC/HMO/IEA (R 1/17); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/EXC/HMO/DOCS (1/17); DC/CFBC/EXC/HMO STD/SIL 2000 (1/17); DC/CFBC/MEM/BLCRD (1/17); DC/CFBC/PT PROTECT (9/10); DC/CFBC/DB/INCENT (1/17)

BluePreferred PPO Standard Silver $2,000
DC/CF/EXC/BP/IEA (R. 1/17); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/SIL 2000 (1/17); DC/CF/MEM/BLCRD (1/17); DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10); DC/CF/DB/INCENT (1/17)

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

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

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

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

BlueChoice HMO Young Adult $7,150
DC/CFBC/EXC/HMO/IEA (R 1/17); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/EXC/HMO/DOCS (1/17); DC/CFBC/EXC/HMO/YA 7150 SOB (1/17); DC/CFBC/MEM/BLCRD (1/17); DC/CFBC/PT PROTECT (9/10); DC/CFBC/DB/INCENT (1/17)

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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