

# Washington, D.C. Consumer Health Benefits 2026

Washington, D.C. CareFirst Plans	Bronze				Silver		Gold				Platinum		Catastrophic
	BlueChoice HMO Essential Bronze 7500	BluePreferred PPO Essential Bronze 7500	BlueChoice HMO HSA Bronze 6350	BluePreferred PPO HSA Bronze 6350	BlueChoice HMO Essential Silver 4850	BluePreferred PPO Essential Silver 4850	BlueChoice HMO Essential Gold 500	BluePreferred PPO Essential Gold 500	BlueChoice HMO HSA Gold 1700 Virtual Connect Plus	BluePreferred PPO HSA Gold 1700 Virtual Connect Plus	BlueChoice HMO Essential Platinum 0	BluePreferred PPO Essential Platinum 0	BlueChoice HMO Young Adult 10600 Virtual Connect Plus
Plan Type	HMO <sup>1</sup>	PPO <sup>2</sup>	HMO <sup>1</sup>	PPO <sup>2</sup>	HMO <sup>1</sup>	PPO <sup>2</sup>	HMO <sup>1</sup>	PPO <sup>2</sup>	HMO <sup>1</sup>	PPO <sup>2</sup>	HMO <sup>1</sup>	PPO <sup>2</sup>	HMO <sup>1</sup>
Visit <a href="#">carefirst.com/doctor</a> 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
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 <b>Deductible</b>	Individual: \$7,500 Family: \$15,000 <sup>4</sup>	Individual: \$7,500 Family: \$15,000 <sup>4</sup>	Individual: \$6,350 Family: \$12,700 <sup>4</sup>	Individual: \$6,350 Family: \$12,700 <sup>4</sup>	Individual: \$4,850 Family: \$9,700 <sup>4</sup>	Individual: \$4,850 Family: \$9,700 <sup>4</sup>	Individual: \$500 Family: \$1,000 <sup>4</sup>	Individual: \$500 Family: \$1,000 <sup>4</sup>	Individual: \$1,700 Family: \$3,400 <sup>4</sup>	Individual: \$1,700 Family: \$3,400 <sup>4</sup>	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$10,600 Family: \$21,200 <sup>4</sup>
2 <b>Out-of-Pocket Maximum<sup>5</sup></b>	Individual: \$10,150 Family: \$20,300	Individual: \$10,150 Family: \$20,300	Individual: \$7,300 Family: \$14,600	Individual: \$7,300 Family: \$14,600	Individual: \$9,150 Family: \$18,300	Individual: \$9,150 Family: \$18,300	Individual: \$6,950 Family: \$13,900	Individual: \$6,950 Family: \$13,900	Individual: \$3,650 Family: \$7,300	Individual: \$3,650 Family: \$7,300	Individual: \$2,100 Family: \$4,200	Individual: \$2,100 Family: \$4,200	Individual: \$10,600 Family: \$21,200
<b>PREVENTIVE SERVICES</b>													
3 <b>Preventive Care</b> (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 charge	No charge, no deductible
<b>PRIMARY CARE AND SPECIALIST SERVICES</b>													
4 <b>Primary Care Provider (PCP) Visits—Office/Non-Hospital</b> (non-preventive)	\$45 copay, no deductible	\$45 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	Virtual Connect Plus through selected providers, including Closekni <sup>13</sup> —No charge after deductible ( <a href="#">carefirst.com/virtualconnect</a> ) All other providers—\$25 copay after deductible	Virtual Connect Plus through selected providers, including Closekni <sup>13</sup> —No charge after deductible ( <a href="#">carefirst.com/virtualconnect</a> ) All other providers—\$25 copay after deductible	\$20 copay	\$20 copay	All providers—Visits 1–3: No charge, no deductible <sup>14</sup> Visits 4+: No charge after deductible
5 <b>Specialist Visits—Office/Non-Hospital</b>	\$105 copay, no deductible	\$105 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 <b>HOSPITAL CHARGE</b> —Add this charge if your primary care or specialist visit takes place in a hospital setting	40% coinsurance after deductible	40% 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
<b>RETAIL CLINICS, URGENT AND EMERGENCY SERVICES</b>													
7 <b>Convenience Care/Retail Health Clinics</b>	\$45 copay, no deductible	\$45 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 <b>Urgent Care Center</b>	\$100 copay, no deductible	\$100 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	\$90 copay, no deductible	\$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 <b>Emergency Room</b> (hospital charge—copays are waived if you are admitted)	40% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	\$400 copay after deductible <sup>11</sup>	\$400 copay after deductible	\$300 copay, no deductible	\$300 copay, no deductible	\$300 copay after deductible	\$300 copay after deductible	\$150 copay	\$150 copay	No charge after deductible
<b>DIAGNOSTIC SERVICES</b>													
10 <b>Labs<sup>6</sup></b>	\$55 copay after deductible (LabCorp only) <sup>11</sup>	\$55 copay after deductible	20% coinsurance after deductible (LabCorp only) <sup>11</sup>	20% coinsurance after deductible	\$60 copay, no deductible (LabCorp only) <sup>11</sup>	\$60 copay, no deductible	\$30 copay, no deductible (LabCorp only) <sup>11</sup>	\$30 copay, no deductible	\$30 copay after deductible (LabCorp only) <sup>11</sup>	\$30 copay after deductible	\$20 copay (LabCorp Only) <sup>11</sup>	\$20 copay	No charge after deductible (LabCorp only) <sup>11</sup>
11 <b>X-rays<sup>6</sup></b>	\$80 copay after deductible <sup>11</sup>	\$80 copay after deductible	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	\$80 copay, no deductible <sup>11</sup>	\$80 copay, no deductible	\$50 copay, no deductible <sup>11</sup>	\$50 copay, no deductible	\$50 copay after deductible <sup>11</sup>	\$50 copay after deductible	\$40 copay <sup>11</sup>	\$40 copay	No charge after deductible <sup>11</sup>
12 <b>Imaging</b> (e.g. MRI, Cat Scan, CT Scan)	\$500 copay after deductible <sup>11</sup>	\$500 copay after deductible	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	\$400 copay, no deductible <sup>11</sup>	\$400 copay, no deductible	\$250 copay, no deductible <sup>11</sup>	\$250 copay, no deductible	\$250 copay after deductible <sup>11</sup>	\$250 copay after deductible	\$150 copay <sup>11</sup>	\$150 copay	No charge after deductible <sup>11</sup>
<b>OUTPATIENT SURGERY (Members are responsible for both facility and physician charges)</b>													
13 <b>Outpatient Surgery</b> (facility charge)	40% coinsurance after deductible <sup>11</sup>	40% coinsurance after deductible	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	\$375 copay, no deductible <sup>11</sup>	\$375 copay, no deductible	\$375 copay after deductible <sup>11</sup>	\$375 copay after deductible	\$200 copay <sup>11</sup>	\$200 copay	No charge after deductible <sup>11</sup>
14 <b>Outpatient Surgery</b> (physician charge)	40% coinsurance after deductible <sup>11</sup>	40% coinsurance after deductible	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	\$125 copay, no deductible <sup>11</sup>	\$125 copay, no deductible	\$125 copay after deductible <sup>11</sup>	\$125 copay after deductible	\$50 copay <sup>11</sup>	\$50 copay	No charge after deductible <sup>11</sup>
<b>INPATIENT HOSPITAL SERVICES including all inpatient surgery, labor &amp; delivery, mental health related visits (Members are responsible for both hospital and physician charges)</b>													
15 <b>Inpatient Services</b> (physician charge)	40% coinsurance after deductible	40% 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 charge	No charge after deductible
16 <b>Inpatient Services</b> (hospital charge)	40% coinsurance after deductible <sup>11</sup>	40% coinsurance after deductible	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	\$600 copay/day after deductible (up to a copay maximum of \$3,000) <sup>11</sup>	\$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) <sup>11</sup>	\$600 copay/day after deductible (up to a copay maximum of \$3,000)	\$250 copay/day (up to a copay maximum of \$1,250) <sup>11</sup>	\$250 copay/day (up to a copay maximum of \$1,250)	No charge after deductible <sup>11</sup>
<b>MATERNITY OFFICE VISITS<sup>7</sup></b>													
17 <b>Preventive Prenatal &amp; Postnatal Office Visits</b>	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 charge	No charge, no deductible
<b>MENTAL HEALTH AND SUBSTANCE USE DISORDER</b>													
18 <b>Office Visits</b>	\$45 copay, no deductible	\$45 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	Virtual Connect Plus through selected providers, including Closekni <sup>13</sup> —No charge after deductible ( <a href="#">carefirst.com/virtualconnect</a> ) All other providers—\$25 copay after deductible	Virtual Connect Plus through selected providers, including Closekni <sup>13</sup> —No charge after deductible ( <a href="#">carefirst.com/virtualconnect</a> ) All other providers—\$25 copay after deductible	\$20 copay	\$20 copay	All providers—Visits 1–3: No charge, no deductible <sup>14</sup> Visits 4+: No charge after deductible
<b>PRESCRIPTION DRUGS<sup>8</sup></b>													
19 <b>Prescription Drug Deductible</b>	\$1,000 per person (Tiers 2–5)	\$1,000 per person (Tiers 2–5)	No separate drug deductible; must meet medical deductible first	No separate drug deductible; must meet medical deductible first	\$350 per person (Tiers 2–5)	\$350 per person (Tiers 2–5)	\$0	\$0	No separate drug deductible; must meet medical deductible first	No separate drug deductible; must meet medical deductible first	\$0	\$0	No separate drug deductible; must meet medical deductible first
20 <b>Preventive Drugs</b> (Tier 0)	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 charge	No charge, no deductible	No charge, no deductible	No charge	No charge	No charge, no deductible
21 <b>Diabetic Supplies</b> (Tier 0)	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 charge	No charge, no deductible	No charge, no deductible	No charge	No charge	No charge, no deductible
22 <b>Preferred Brand Insulin</b> (Tier 0)	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 charge	No charge, no deductible	No charge, no deductible	No charge	No charge	No charge, no deductible
23 <b>Generic Drugs</b> (Tier 1)	\$25 copay, no deductible	\$25 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	\$20 copay, no deductible	\$20 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
<b>Preferred Brand Drugs</b> (Tier 2) <sup>9</sup>	\$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	No charge after deductible
<b>Non-Preferred Brand Insulin</b> (Tier 3)	\$30 copay, no deductible	\$30 copay, no deductible	20% coinsurance, no deductible (\$30 max)	20% coinsurance, no deductible (\$30 max)	\$30 copay, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	\$25 copay	\$25 copay	No charge, no deductible
<b>Non-Preferred Brand Drugs</b> (Tier 3) <sup>10</sup>	\$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	No charge after deductible
<b>Preferred and Non-Preferred Specialty Drugs</b> (Tiers 4 & 5) <sup>12</sup>	\$150 copay after deductible	\$150 copay after deductible	20% coinsurance after deductible (\$150 max)	20% coinsurance after deductible (\$150 max)	\$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	No charge after deductible
<b>Out-of-Network</b>													
24 <b>Deductible</b>	N/A	Individual: \$15,000 Family: \$30,000	N/A	Individual: \$12,700 Family: \$25,400	N/A	Individual: \$9,700 Family: \$19,400	N/A	Individual: \$1,000 Family: \$2,000	N/A	Individual: \$3,400 Family: \$6,800	N/A	Individual: \$1,000 Family: \$2,000	N/A
25 <b>Out-of-Pocket Maximum</b>	N/A	Individual: \$20,300 Family: \$40,600	N/A	Individual: \$14,600 Family: \$29,200	N/A	Individual: \$18,300 Family: \$36,600	N/A	Individual: \$13,900 Family: \$27,800	N/A	Individual: \$7,300 Family: \$14,600	N/A	Individual: \$4,200 Family: \$8,400	N/A

Note: When multiple services are rendered on the same day by more than one provider, member payments are required for each provider.

<sup>1</sup> Health Maintenance Organization (HMO) plans underwritten by CareFirst BlueChoice, Inc.  
<sup>2</sup> Preferred Provider Organization (PPO) plans underwritten by Group Hospitalization and Medical Services, Inc.  
<sup>3</sup> For family coverage only—the family deductible must be met before the plan starts to pay toward services for any one member. The deductible may be met by one member or any combination of members.  
<sup>4</sup> 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.  
<sup>5</sup> 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.  
<sup>6</sup> For HMO plans: For in-network benefits, members must use LabCorp for laboratory services and freestanding facilities for diagnostic services and X-rays.  
<sup>7</sup> For non-routine obstetrical care or complications of pregnancy, cost-sharing may apply.  
<sup>8</sup> All out-of-pocket drug costs contribute to the in-network out-of-pocket maximum.  
<sup>9</sup> If a generic drug becomes available for a preferred brand drug, the preferred brand drug moves to the non-preferred brand drug tier.  
<sup>10</sup> 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.  
<sup>11</sup> Prior authorization required in a hospital setting.  
<sup>12</sup> Specialty drugs must be obtained through mail order at CVS Specialty Pharmacy.  
<sup>13</sup> Closekni is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a and is providing in person and telehealth services to CareFirst members. Atlas Health, LLC is a corporate affiliate within the CareFirst, Inc. corporate umbrella of companies.  
<sup>14</sup> You receive up to 3 non-preventative PCP visits without needing to meet a deductible.  
Benefit designs are subject to and may be impacted by certain state regulations.  
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.  
For more information on Out-of-area care and benefit coverage please visit the [Health Plan Information page](#).  
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.

**2026 WASHINGTON, D.C. POLICY FORM NUMBERS**

**BlueChoice HMO HSA Bronze 6350**

DC/CFBC/EXC/HMO/IEA (R. 1/26); DC/CFBC/DOL APPEAL (R. 1/26); DC/CFBC/EXC/HMO/DOCS (R. 1/26); DC/CFBC/EXC/HMO HSA/BRZ 6350 (1/26); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO (R. 1/26); DC/CFBC/EXC/CD MAP AMEND (1/26); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25

**BlueChoice HMO Essential Bronze 7500**

DC/CFBC/EXC/HMO/IEA (R. 1/26); DC/CFBC/DOL APPEAL (R. 1/26); DC/CFBC/EXC/HMO/DOCS (R. 1/26); DC/CFBC/EXC/HMO ESS/BRZ 7500 (1/26); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO (R. 1/26); DC/CFBC/EXC/CD MAP AMEND (1/26); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25

**BlueChoice HMO Essential Silver 4850**

DC/CFBC/EXC/HMO/IEA (R. 1/26); DC/CFBC/DOL APPEAL (R. 1/26); DC/CFBC/EXC/HMO/DOCS (R. 1/26); DC/CFBC/EXC/HMO ESS/SIL 4850 (1/26); DC/CFBC/EXC/HMO ESS/SIL 4850 A (1/26); DC/CFBC/EXC/HMO ESS/SIL 4850 B (1/26); DC/CFBC/EXC/HMO ESS/SIL 4850 C (1/26); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO (R. 1/26); DC/CFBC/EXC/CD MAP AMEND (1/26); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25

**BlueChoice HMO Essential Gold 500**

DC/CFBC/EXC/HMO/IEA (R. 1/26); DC/CFBC/DOL APPEAL (R. 1/26); DC/CFBC/EXC/HMO/DOCS (R. 1/26); DC/CFBC/EXC/HMO ESS/GOLD 500 (1/26); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO (R. 1/26); DC/CFBC/EXC/CD MAP AMEND (1/26); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25

**BlueChoice HMO Essential Platinum 0**

DC/CFBC/EXC/HMO/IEA (R. 1/26); DC/CFBC/DOL APPEAL (R. 1/26); DC/CFBC/EXC/HMO/DOCS (R. 1/26); DC/CFBC/EXC/HMO ESS/PLAT 0 (1/26); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO (R. 1/26); DC/CFBC/EXC/CD MAP AMEND (1/26); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25

**BlueChoice HMO HSA Gold 1700 Virtual Connect Plus**

DC/CFBC/EXC/HMO/IEA (R. 1/26); DC/CFBC/DOL APPEAL (R. 1/26); DC/CFBC/EXC/HMO/DOCS (R. 1/26); DC/CFBC/EXC/HMO HSA/GOLD 1700 VC+ (1/26); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO (R. 1/26); DC/CFBC/EXC/CD MAP AMEND (1/26); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25

**BlueChoice HMO Young Adult 10600 Virtual Connect Plus**

DC/CFBC/EXC/HMO/IEA (R. 1/26); DC/CFBC/DOL APPEAL (R. 1/26); DC/CFBC/EXC/HMO/DOCS (R. 1/26); DC/CFBC/EXC/HMO/ YA 10600 VC+ SOB (1/26); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO (R. 1/26); DC/CFBC/EXC/CD MAP AMEND (1/26); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25

**BluePreferred PPO HSA Bronze 6350**

DC/CF/EXC/HP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/HP/EXC/DOCS (R. 1/26); DC/CF/EXC/HP HSA/BRZ 6350 (1/26); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/26); DC/CF/CD MAP AMEND (1/26); DC/CF/MSP/EXCLUSION (1/14); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/HP/INCENT (1/23)

**BluePreferred PPO Essential Bronze 7500**

DC/CF/EXC/HP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/HP/EXC/DOCS (R. 1/26); DC/CF/EXC/HP ESS/BRZ 7500 (1/26); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/26); DC/CF/CD MAP AMEND (1/26); DC/CF/MSP/EXCLUSION (1/14); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/HP/INCENT (1/23)

**BluePreferred PPO Essential Silver 4850**

DC/CF/EXC/HP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/HP/EXC/DOCS (R. 1/26); DC/CF/EXC/HP ESS/SIL 4850 (1/26); DC/CF/EXC/HP ESS/SIL 4850 A (1/26); DC/CF/EXC/HP ESS/SIL 4850 B (1/26); DC/CF/EXC/HP ESS/SIL 4850 C (1/26); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/26); DC/CF/CD MAP AMEND (1/26); DC/CF/MSP/EXCLUSION (1/14); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/HP/INCENT (1/23)

**BluePreferred PPO Essential Gold 500**

DC/CF/EXC/HP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/HP/EXC/DOCS (R. 1/26); DC/CF/EXC/HP ESS/GOLD 500 (1/26); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/26); DC/CF/CD MAP AMEND (1/26); DC/CF/MSP/EXCLUSION (1/14); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/HP/INCENT (1/23)

**BluePreferred PPO Essential Platinum 0**

DC/CF/EXC/HP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/HP/EXC/DOCS (R. 1/26); DC/CF/EXC/HP PPO ESS/PLAT 0 (1/26); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/26); DC/CF/CD MAP AMEND (1/26); DC/CF/MSP/EXCLUSION (1/14); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/HP/INCENT (1/23)

**BluePreferred PPO HSA Gold 1700 Virtual Connect Plus**

DC/CF/EXC/HP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/HP/EXC/DOCS (R. 1/26); DC/CF/EXC/HP HSA/GOLD 1700 VC+ (1/26); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/26); DC/CF/CD MAP AMEND (1/26); DC/CF/MSP/EXCLUSION (1/14); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/HP/INCENT (1/23)

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. The policies may have exclusions, limitations or terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call your insurance agent or CareFirst.



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