Washington, D.C. Consumer Health Benefits 2027

CareFirst Family of health care plans

		Bronze				Silver	
	Washington, D.C. CareFirst Plans	**BlueChoice HMO Essential Bronze 7500**	**BluePreferred PPO Essential Bronze 7500**	**BlueChoice HMO HSA Bronze 6500 Virtual Connect Plus**	**BluePreferred PPO HSA Bronze 6500 Virtual Connect Plus**	**BlueChoice HMO Essential Silver 4850**	**BluePreferred PPO Essential Silver 4850**
	Plan Type	HMO[1]	PPO[2]	HMO[1]	PPO[2]	HMO[1]	PPO[2]
	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
	DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
1	**Deductible**	Individual: $7,500 Family: $15,000[4]	Individual: $7,500 Family: $15,000[4]	Individual: $6,500 Family: $13,000[4]	Individual: $6,500 Family: $13,000[4]	Individual: $4,850 Family: $9,700[4]	Individual: $4,850 Family: $9,700[4]
2	**Out-of-Pocket Maximum**[5]	Individual: $11,500 Family: $23,000	Individual: $11,500 Family: $23,000	Individual: $8,700 Family: $17,400	Individual: $8,700 Family: $17,400	Individual: $10,500 Family: $21,000	Individual: $10,500 Family: $21,000
	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
	PRIMARY CARE AND SPECIALIST SERVICES						
4	**Primary Care Provider (PCP) Visits—Office/Non-Hospital** (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
5	**Specialist Visits—Office/Non-Hospital**	$105 copay, no deductible	$105 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	$80 copay, no deductible	$80 copay, no deductible
6	**HOSPITAL CHARGE**—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
	RETAIL CLINICS, URGENT AND EMERGENCY SERVICES						
7	**Convenience Care/Retail Health Clinics**	$45 copay, no deductible	$45 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	$40 copay, no deductible	$40 copay, no deductible
8	**Urgent Care Center**	$105 copay, no deductible	$105 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	$90 copay, no deductible	$90 copay, no deductible
9	**Emergency Room** (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[11]	$400 copay after deductible
	DIAGNOSTIC SERVICES						
10	**Labs**[6]	$55 copay after deductible (Labcorp only)[11]	$55 copay after deductible	20% coinsurance after deductible (Labcorp only)[11]	20% coinsurance after deductible	$60 copay, no deductible (Labcorp only)[11]	$60 copay, no deductible
11	**X-rays**[6]	$80 copay after deductible[11]	$80 copay after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible	$80 copay, no deductible[11]	$80 copay, no deductible
12	**Imaging** (e.g., MRI, Cat Scan, CT Scan)	$500 copay after deductible[11]	$500 copay after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible	$400 copay, no deductible[11]	$400 copay, no deductible
	OUTPATIENT SURGERY *(Members are responsible for both facility and physician charges)*						
13	**Outpatient Surgery** (facility charge)	40% coinsurance after deductible[11]	40% coinsurance after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible
14	**Outpatient Surgery** (physician charge)	40% coinsurance after deductible[11]	40% coinsurance after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible
	INPATIENT HOSPITAL SERVICES *including all inpatient surgery, labor & delivery, mental health related visits (Members are responsible for both hospital and physician charges)*						
15	**Inpatient Services** (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
16	**Inpatient Services** (hospital charge)	40% coinsurance after deductible[11]	40% coinsurance after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible	20% coinsurance after deductible[11]	20% coinsurance after deductible
	MATERNITY OFFICE VISITS[7]						
17	**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
	MENTAL HEALTH AND SUBSTANCE USE DISORDER						
18	**Office Visits**	$45 copay, no deductible	$45 copay, no deductible	20% coinsurance after deductible	20% coinsurance after deductible	$40 copay, no deductible	$40 copay, no deductible
	PRESCRIPTION DRUGS[8]						
19	**Prescription Drug Deductible**	$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)
20	**Preventive Drugs (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
21	**Diabetic Supplies (Tier 0)**						
22	**Preferred Brand Insulin (Tier 0)**						
23	**Generic Drugs (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
24	**Preferred Brand Drugs (Tier 2)**[9]	$75 copay after deductible	$75 copay after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$50 copay after deductible	$50 copay after deductible
25	**Non-Preferred Brand Insulin (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
26	**Non-Preferred Brand Drugs (Tier 3)**[10]	$100 copay after deductible	$100 copay after deductible	20% coinsurance after deductible	20% coinsurance after deductible	$70 copay after deductible	$70 copay after deductible
27	**Preferred and Non-Preferred Specialty Drugs (Tiers 4 & 5)**[12]	$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
	OUT-OF-NETWORK		Out-of-Network		Out-of-Network		Out-of-Network
28	**Deductible**	N/A	Individual: $20,300 Family: $46,000	N/A	Individual: $13,000 Family: $26,000	N/A	Individual: $9,700 Family: $19,400
29	**Out-of-Pocket Maximum**	N/A	Individual: $20,300 Family: $40,600	N/A	Individual: $17,400 Family: $34,800	N/A	Individual: $21,000 Family: $42,000

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.

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.

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.

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—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.

4 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.

5 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.

6 For HMO plans: For in-network benefits, members must use Labcorp for laboratory services and freestanding facilities for diagnostic services and X-rays.

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

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 in a hospital setting.

12 Specialty drugs must be obtained through mail order at CVS Specialty Pharmacy.

13 CloseKnit is the shared business name of Atlas Health, LLC, Comprehensive Primary Care and Associates, LLC, and CKNMG, LLC. Atlas Health, LLC and Comprehensive Primary Care and Associates, LLC provide in person and telehealth services to CareFirst members and are corporate affiliates within the CareFirst, Inc. corporate umbrella of companies. CKNMG, LLC is an independent company providing in person and telehealth services to CareFirst members.

14 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.

Washington, D.C. Consumer Health Benefits 2027 (continued)

CareFirst Family of health care plans

		Gold				Platinum		Catastrophic
	Washington, D.C. CareFirst Plans	**BlueChoice HMO Essential Gold 500**	**BluePreferred PPO Essential Gold 500**	**BlueChoice HMO HSA Gold 1750 Virtual Connect Plus**	**BluePreferred PPO HSA Gold 1750 Virtual Connect Plus**	**BlueChoice HMO Essential Platinum 0**	**BluePreferred PPO Essential Platinum 0**	**BlueChoice HMO Young Adult 12000 Virtual Connect Plus**
	Plan Type	HMO[1]	PPO[2]	HMO[1]	PPO[2]	HMO[1]	PPO[2]	HMO[1]
	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
	DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
1	**Deductible**	Individual: $500 Family: $1,000[4]	Individual: $500 Family: $1,000[4]	Individual: $1,750 Family: $3,500[3]	Individual: $1,750 Family: $3,500[3]	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $12,000 Family: $24,000[4]
2	**Out-of-Pocket Maximum**[5]	Individual: $7,950 Family: $15,900	Individual: $7,950 Family: $15,900	Individual: $3,900 Family: $7,800	Individual: $3,900 Family:$7,800	Individual: $3,600 Family: $7,200	Individual: $3,600 Family: $7,200	Individual: $12,000 Family: $24,000
	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 charge	No charge, no deductible
	PRIMARY CARE AND SPECIALIST SERVICES							
4	**Primary Care Provider (PCP) Visits—Office/Non-Hospital** (non-preventive)	$25 copay, no deductible	$25 copay, no deductible	Virtual Connect Plus through selected providers, including Closeknit[13]—No charge after deductible (**carefirst.com/virtualconnect**) All other providers—$25 copay after deductible	Virtual Connect Plus through selected providers, including Closeknit[13]—No charge after deductible (**carefirst.com/virtualconnect**) All other providers—$25 copay after deductible	$20 copay	$20 copay	All providers—Visits 1–3: No charge, no deductible[14] Visits 4+: No charge after deductible
5	**Specialist Visits—Office/Non-Hospital**	$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	$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**	$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**	$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)	$300 copay, no deductible	$300 copay, no deductible	$300 copay after deductible	$300 copay after deductible	$200 copay	200 copay	No charge after deductible
	DIAGNOSTIC SERVICES							
10	**Labs**[6]	$40 copay, no deductible (Labcorp only)[11]	$40 copay, no deductible	$40 copay after deductible (Labcorp only)[11]	$40 copay after deductible	$30 copay (Labcorp Only)[11]	$30 copay	No charge after deductible (Labcorp only)[11]
11	**X-rays**[6]	$60 copay, no deductible[11]	$60 copay, no deductible	$60 copay after deductible[11]	$60 copay after deductible	$50 copay[11]	$50 copay	No charge after deductible[11]
12	**Imaging** (e.g., MRI, Cat Scan, CT Scan)	$250 copay, no deductible[11]	$250 copay, no deductible	$250 copay after deductible[11]	$250 copay after deductible	$200 copay[11]	$200 copay	No charge after deductible[11]
	OUTPATIENT SURGERY *(Members are responsible for both facility and physician charges)*							
13	**Outpatient Surgery** (facility charge)	$375 copay, no deductible[11]	$375 copay, no deductible	$375 copay after deductible[11]	$375 copay after deductible	$250 copay[11]	$250 copay	No charge after deductible[11]
14	**Outpatient Surgery** (physician charge)	$175 copay, no deductible[11]	$175 copay, no deductible	$175 copay after deductible[11]	$175 copay after deductible	$100 copay[11]	$100 copay	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)*							
15	**Inpatient Services** (physician charge)	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	**Inpatient Services** (hospital charge)	$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)	$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)	$300 copay/day (up to a copay maximum of $1,500)[11]	$300 copay/day (up to a copay maximum of $1,500)	No charge after deductible[11]
	MATERNITY OFFICE VISITS[7]							
17	**Preventive Prenatal & Postnatal Office Visits**	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge	No charge	No charge, no deductible
	MENTAL HEALTH AND SUBSTANCE USE DISORDER							
18	**Office Visits**	$25 copay, no deductible	$25 copay, no deductible	Virtual Connect Plus through selected providers, including Closeknit[13]—No charge after deductible (**carefirst.com/virtualconnect**) All other providers—$25 copay after deductible	Virtual Connect Plus through selected providers, including Closeknit[13]—No charge after deductible (**carefirst.com/virtualconnect**) All other providers—$25 copay after deductible	$20 copay	$20 copay	All providers—Visits 1–3: No charge, no deductible[14] Visits 4+: No charge after deductible
	PRESCRIPTION DRUGS[8]							
19	**Prescription Drug Deductible**	$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	**Preventive Drugs (Tier 0)**	No charge	No charge	No charge, no deductible	No charge, no deductible	No charge	No charge	No charge, no deductible
21	**Diabetic Supplies (Tier 0)**							
22	**Preferred Brand Insulin (Tier 0)**							
23	**Generic Drugs (Tier 1)**	$15 copay, no deductible	$15 copay, no deductible	$15 copay after deductible	$15 copay after deductible	$5 copay	$5 copay	No charge after deductible
24	**Preferred Brand Drugs (Tier 2)**[9]	$50 copay, no deductible	$50 copay, no deductible	$50 copay after deductible	$50 copay after deductible	$15 copay	$15 copay	No charge after deductible
25	**Non-Preferred Brand Insulin (Tier 3)**	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$25 copay	$25 copay	No charge, no deductible
26	**Non-Preferred Brand Drugs (Tier 3)**[10]	$70 copay, no deductible	$70 copay, no deductible	$70 copay after deductible	$70 copay after deductible	$25 copay	$25 copay	No charge after deductible
27	**Preferred and Non-Preferred Specialty Drugs (Tiers 4 & 5)**[12]	$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	
28	**Deductible**	N/A	Individual: $1,000 Family: $2,000	N/A	Individual: $3,500 Family: $7,000	N/A	Individual: $1,000 Family: $2,000	N/A
29	**Out-of-Pocket Maximum**	N/A	Individual: $15,900 Family: $31,800	N/A	Individual: $7,800 Family: $15,600	N/A	Individual: $7,200 Family: $14,400	N/A

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

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.

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12 Specialty drugs must be obtained through mail order at CVS Specialty Pharmacy.

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2027 WASHINGTON, D.C. POLICY FORM NUMBERS

BlueChoice HMO HSA Bronze 6500 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) or DC/CFBC/EXC/HMO REF/DOCS (R. 1/27); DC/CFBC/EXC/HMO HSA/BRZ 6500 VC+ (1/27); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO OA (R. 1/27) or DC/CFBC/CD/AUTH AMEND/HMO REF (R. 1/27); DC/CFBC/EXC/HMO OA/2027 AMEND (1/27); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25 and any amendments.

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) or DC/CFBC/EXC/HMO REF/DOCS (R. 1/27); DC/CFBC/EXC/HMO ESS/BRZ 7500 (1/27); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO OA (R. 1/27) or DC/CFBC/CD/AUTH AMEND/HMO REF (R. 1/27); DC/CFBC/EXC/HMO OA/2027 AMEND (1/27); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25 and any amendments.

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) or DC/CFBC/EXC/HMO REF/DOCS (R. 1/27); DC/CFBC/EXC/HMO ESS/SIL 4850 (1/27); DC/CFBC/EXC/HMO ESS/SIL 4850 A (1/27); DC/CFBC/EXC/HMO ESS/SIL 4850 B (1/27); DC/CFBC/EXC/HMO ESS/SIL 4850 C (1/27); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO OA (R. 1/27) or DC/CFBC/CD/AUTH AMEND/HMO REF (R. 1/27); DC/CFBC/EXC/HMO OA/2027 AMEND (1/27); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25 and any amendments.

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) or DC/CFBC/EXC/HMO REF/DOCS (R. 1/27); DC/CFBC/EXC/HMO ESS/GOLD 500 (1/27); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO OA (R. 1/27) or DC/CFBC/CD/AUTH AMEND/HMO REF (R. 1/27); DC/CFBC/EXC/HMO OA/2027 AMEND (1/27); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25 and any amendments.

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) or DC/CFBC/EXC/HMO REF/DOCS (R. 1/27); DC/CFBC/EXC/HMO ESS /PLAT 0 (1/27); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO OA (R. 1/27) or DC/CFBC/CD/AUTH AMEND/HMO REF (R. 1/27); DC/CFBC/EXC/HMO OA/2027 AMEND (1/27); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25 and any amendments.

BlueChoice HMO HSA Gold 1750 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) or DC/CFBC/EXC/HMO REF/DOCS (R. 1/27); DC/CFBC/EXC/HMO HSA/GOLD 1750 VC+ (1/27); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO OA (R. 1/27) or DC/CFBC/CD/AUTH AMEND/HMO REF (R. 1/27); DC/CFBC/EXC/HMO OA/2027 AMEND (1/27); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25 and any amendments.

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) or DC/CFBC/CD/AUTH AMEND/HMO REF (R. 1/27); DC/CFBC/EXC/HMO/YA 12000 VC+ SOB (1/27); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/CD/AUTH AMEND/HMO OA (R. 1/27) or DC/CFBC/CD/AUTH AMEND/HMO REF (R. 1/27); DC/CFBC/EXC/HMO OA/2027 AMEND (1/27); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23); DC CFBC – HEALTH GUARANTY 6/25 and any amendments.

BluePreferred PPO HSA Bronze 6500 Virtual Connect Plus
DC/CF/EXC/BP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/BP/EXC/DOCS (R. 1/26); DC/CF/EXC/BP HSA/BRZ 6500 VC+ (1/27); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/27); DC/CF/EXC/2027 AMEND (1/27); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/BP/INCENT (1/23) and any amendments.

BluePreferred PPO Essential Bronze 7500
DC/CF/EXC/BP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/BP/EXC/DOCS (R. 1/26); DC/CF/EXC/BP ESS/BRZ 7500 (1/27); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/27); DC/CF/EXC/2027 AMEND (1/27); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/BP/INCENT (1/23) and any amendments.

BluePreferred PPO Essential Silver 4850
DC/CF/EXC/BP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/BP/EXC/DOCS (R. 1/26); DC/CF/EXC/BP ESS/SIL 4850 (1/27); DC/CF/EXC/BP ESS/SIL 4850 A (1/27); DC/CF/EXC/BP ESS/SIL 4850 B (1/27); DC/CF/EXC/BP ESS/SIL 4850 C (1/27); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/27); DC/CF/EXC/2027 AMEND (1/27); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/BP/INCENT (1/23) and any amendments.

BluePreferred PPO Essential Gold 500
DC/CF/EXC/BP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/BP/EXC/DOCS (R. 1/26); DC/CF/EXC/BP ESS/GOLD 500 (1/27); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/27); DC/CF/EXC/2027 AMEND (1/27); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/BP/INCENT (1/23) and any amendments.

BluePreferred PPO Essential Platinum 0
DC/CF/EXC/BP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/BP/EXC/DOCS (R. 1/26); DC/CF/EXC/BP PPO ESS/PLAT 0 (1/27); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/27); DC/CF/EXC/2027 AMEND (1/27); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/BP/INCENT (1/23) and any amendments.

BluePreferred PPO HSA Gold 1750 Virtual Connect Plus
DC/CF/EXC/BP/IEA (R. 1/26); DC/GHMSI/DOL APPEAL (R. 1/26); DC/CF/BP/EXC/DOCS (R. 1/26); DC/CF/EXC/BP HSA/GOLD 1750 VC+ (1/27); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/CD/AUTH AMEND PPO (R. 1/27); DC/CF/EXC/2027 AMEND (1/27); DC CFBC – HEALTH GUARANTY 6/25; DC/CF/PT PROTECT (9/10); DC/CF/CD/BP/INCENT (1/23) and any amendments.

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