Virginia Consumer Health Benefits 2027

CareFirst
Family of health care plans

		Bronze		Silver			
	Virginia CareFirst Plans	**Bluechoice HMO Standard Bronze 7500 Med Ded 25 Dent Ded**	**BlueChoice HMO Referral Bronze 8250 Med Ded 25 Dent Ded Virtual Connect Plus**	**BlueChoice HMO HSA Silver 3700 Med Ded 25 Dent Ded Virtual Connect Plus**	**BluePreferred PPO HSA Silver 3700 Med Ded 25 Dent Ded Virtual Connect Plus**	**BlueChoice HMO Standard Silver 6000 Med Ded 25 Dent Ded**	**BluePreferred PPO Standard Silver 6000 Med Ded 25 Dent Ded**
	Plan Type	HMO[1]	HMO[1]	HMO[1]	PPO[2]	HMO[1]	PPO[2]
	Visit **carefirst.com/doctor** to view participating doctors and facilities—search by plan:	**BlueChoice HMO**	**BlueChoice HMO**	**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**[3]	Individual: $7,500/Family: $15,000	Individual: $8,250/Family: $16,500	Individual: $3,700/Family: $7,400	Individual: $3,700/Family: $7,400	Individual: $6,000/Family: $12,000	Individual: $6,000/Family: $12,000
2	**Out-of-Pocket Maximum**[4]	Individual: $10,500/Family: $21,000	Individual: $12,000/Family: $24,000	Individual: $7,750/Family: $15,500	Individual: $7,750/Family: $15,500	Individual: $8,900/Family: $17,800	Individual: $8,900/Family: $17,800
	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)	$50 copay, no deductible	Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge, no deductible (**carefirst.com/virtualconnect**). All other providers—$55 copay, no deductible	Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge, after deductible (**carefirst.com/virtualconnect**). All other providers—$30 copay after deductible	Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge, after deductible (**carefirst.com/virtualconnect**). All other providers—$30 copay after deductible	$40 copay, no deductible	$40 copay, no deductible
5	**Specialist Visits—Office/Non-Hospital**	$100 copay, no deductible	$65 copay after deductible	$40 copay after deductible	$40 copay 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	50% coinsurance after deductible	40% coinsurance after deductible	$100 copay after deductible	$100 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible
	RETAIL CLINICS, URGENT AND EMERGENCY SERVICES						
7	**Convenience Care/Retail Health Clinics**	$50 copay, no deductible	$55 copay, no deductible	$30 copay after deductible	$30 copay after deductible	$40 copay, no deductible	$40 copay, no deductible
8	**Urgent Care Center**	$75 copay, no deductible	$85 copay, no deductible	$60 copay after deductible	$60 copay after deductible	$60 copay, no deductible	$60 copay, no deductible
9	**Emergency Room** (hospital charge—copays are waived if you are admitted)	50% coinsurance after deductible	40% coinsurance after deductible	$300 copay after deductible	$300 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible
	DIAGNOSTIC SERVICES						
10	**Labs**[6] Office/Non-Hospital	50% coinsurance after deductible (Labcorp Only)	40% coinsurance after deductible (Labcorp Only)	$25 copay after deductible (Labcorp only)	$25 copay after deductible	40% coinsurance after deductible (Labcorp only)	40% coinsurance after deductible
11	Outpatient Hospital	50% coinsurance after deductible[7]	40% coinsurance after deductible[7]	$90 copay after deductible[7]	$90 copay after deductible	40% coinsurance after deductible[7]	40% coinsurance after deductible
12	**X-rays**[6] Office/Non-Hospital	50% coinsurance after deductible	40% coinsurance after deductible	$55 copay after deductible	$55 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible
13	Outpatient Hospital	50% coinsurance after deductible[7]	40% coinsurance after deductible[7]	$130 copay after deductible[7]	$130 copay after deductible	40% coinsurance after deductible[7]	40% coinsurance after deductible
14	**Imaging** (e.g., MRI, Cat Scan, CT Scan) Office/Non-Hospital	50% coinsurance after deductible	40% coinsurance after deductible	$250 copay after deductible	$250 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible
15	Outpatient Hospital	50% coinsurance after deductible[7]	40% coinsurance after deductible[7]	$500 copay after deductible[7]	$500 copay after deductible	40% coinsurance after deductible[7]	40% coinsurance after deductible
	OUTPATIENT SURGERY *(Members are responsible for both facility and physician charges)*						
16	**Outpatient Surgery** (physician charge) Non-Hospital/Surgical Center	50% coinsurance after deductible	40% coinsurance after deductible	$40 copay after deductible	$40 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible
17	Hospital	50% coinsurance after deductible[7]	40% coinsurance after deductible[7]	$40 copay after deductible[7]	$40 copay after deductible	40% coinsurance after deductible[7]	40% coinsurance after deductible
18	**Outpatient Surgery** (facility charge) Non-Hospital/Surgical Center	50% coinsurance after deductible	40% coinsurance after deductible	$300 copay after deductible	$300 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible
19	Hospital	50% coinsurance after deductible[7]	40% coinsurance after deductible[7]	$450 copay after deductible[7]	$450 copay after deductible	40% coinsurance after deductible[7]	40% 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)*						
20	**Inpatient Services** (physician charge)	50% coinsurance after deductible	40% coinsurance after deductible	$40 copay after deductible	$40 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible
21	**Inpatient Services** (hospital charge)	50% coinsurance after deductible[7]	40% coinsurance after deductible[7]	$500 copay/day after deductible (up to a copay maximum of $2,500)[7]	$500 copay/day after deductible (up to a copay maximum of $2,500)	40% coinsurance after deductible[7]	40% coinsurance after deductible
	MATERNITY OFFICE VISITS						
22	**Preventive Prenatal & Postnatal Office Visits**[8]	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible
	MENTAL HEALTH AND SUBSTANCE USE DISORDER						
23	**Office Visits**	$50 copay, no deductible	Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge, no deductible (**carefirst.com/virtualconnect**). All other providers—$55 copay, no deductible	Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge, after deductible (**carefirst.com/virtualconnect**). All other providers—$30 copay after deductible	Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge, after deductible (**carefirst.com/virtualconnect**). All other providers—$30 copay after deductible	$40 copay, no deductible	$40 copay, no deductible
	PRESCRIPTION DRUGS[9]						
24	**Prescription Drug Deductible**	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first
25	**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
26	**Diabetic Supplies (Tier 0)**						
27	**Preferred Brand Insulin (Tier 0)**						
28	**Generic Drugs (Tier 1)**	$25 copay, no deductible	$25, no deductible	$10 copay after deductible	$10 copay after deductible	$20 copay, no deductible	$20 copay, no deductible
29	**Preferred Brand Drugs (Tier 2)**[10]	$50 copay after deductible	40% coinsurance after deductible	$50 copay after deductible	$50 copay after deductible	$40 copay, no deductible	$40 copay, no deductible
30	**Non-Preferred Brand Insulin (Tier 3)**	$30 copay after deductible	40% coinsurance after deductible ($30 max)	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible
31	**Non-Preferred Brand Drugs (Tier 3)**[11]	$100 copay after deductible	40% coinsurance after deductible	$70 copay after deductible	$70 copay after deductible	$80 copay after deductible	$80 copay after deductible
32	**Preferred Specialty Drugs (Tier 4)**[12]	$500 copay after deductible	40% coinsurance after deductible ($100 max)	$100 copay after deductible	$100 copay after deductible	$350 copay after deductible	$350 copay after deductible
33	**Non-Preferred Specialty Drugs (Tier 5)**[12]	$500 copay after deductible	40% coinsurance after deductible ($150 max)	$150 copay after deductible	$150 copay after deductible	$350 copay after deductible	$350 copay after deductible
	OUT-OF-NETWORK				Out-of-Network	Out-of-Network	Out-of-Network
34	**Deductible**	N/A	N/A	N/A	Individual: $7,400/Family: $14,800	N/A	Individual: $12,000/Family: $24,000
35	**Out-of-Pocket Maximum**	N/A	N/A	N/A	Individual: $15,500/Family: $31,000	N/A	Individual: $17,800/Family: $35,600

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PCP visits: The lowest copays and the best option for consistent, quality care.

Caution: Services on a hospital campus may incur a separate hospital charge.

Retail health clinics: Low copays and after-hours care for minor health concerns.

Caution—Emergency room: Highest out-of-pocket costs; explore other options for non-emergency care.

Labs/X-rays/Imaging: Use non-hospital facilities for the lowest copays.

Caution: These sevices will cost more if performed in a hospital.

Surgeries: Non-hospital (ambulatory) surgery centers will save you money on many outpatient surgeries.

Generic drugs: Always your lowest cost option; some are no charge and no deductible.

Caution: For the lowest cost, always visit doctors who are in-network.

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

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2 Preferred Provider Organization (PPO) plans underwritten by Group Hospitalization and Medical Services, Inc.

3 For family coverage only—If one member on the policy meets the individual deductible, full benefits will begin for that member. That member will not be able to contribute more than the individual deductible amount towards the family deductible. Once the family deductible has been met, full benefits will be available to all members on the policy.

4 For family coverage only—When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the allowed benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the allowed benefit.

5 You receive up to 3 non-preventive primary care visits without needing to meet a deductible.

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

7 Prior authorization required.

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

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

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

11 If a provider prescribes a non-preferred brand drug and the member selects the non-preferred brand drug when a generic drug is available, the member shall pay the applicable copayment as stated above plus the difference between the price of the non-preferred brand drug and the generic drug up to the cost of the drug. This amount will not contribute to the in-network out-of-pocket maximum.

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.

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.

Virginia Consumer Health Benefits 2027 (continued)

CareFirst
Family of health care plans

			Gold					Catastrophic
	Virginia CareFirst Plans		BlueChoice HMO Gold 1750 Med Ded 150 Drug Ded 25 Dent Ded Virtual Connect Plus	BluePreferred PPO Gold 1750 Med Ded 150 Drug Ded 25 Dent Ded Virtual Connect Plus	BlueChoice HMO Standard Gold 2000 Med Ded 25 Dent Ded	BluePreferred PPO Standard Gold 2000 Med Ded 25 Dent Ded	BlueChoice HMO Gold 0 Virtual Connect Plus	BlueChoice HMO Young Adult 12000 Med Ded Virtual Connect Plus
	Plan Type		HMO[1]	PPO[2]	HMO[1]	PPO[2]	HMO[1]	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	BlueChoice HMO
	DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM		In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
1	**Deductible**[3]		Individual: $1,750/Family: $3,500	Individual: $1,750/Family: $3,500	Individual: $2,000/Family: $4,000	Individual: $2,000/Family: $4,000	Individual: $0/Family: $0	Individual: $12,000/Family: $24,000
2	**Out-of-Pocket Maximum**[4]		Individual: $8,550/Family: $17,100	Individual: $8,550/Family: $17,100	Individual: $8,200/Family: $16,400	Individual: $8,200/Family: $16,400	Individual: $10,000/Family: $20,000	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 deductible
	PRIMARY CARE AND SPECIALIST SERVICES							
4	**Primary Care Provider (PCP) Visits— Office/Non-Hospital** (non-preventive)		Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge, no deductible (**carefirst.com/virtualconnect**). All other providers—No charge, no deductible	Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge, no deductible (**carefirst.com/virtualconnect**). All other providers—No charge, no deductible	$30 copay, no deductible	$30 copay, no deductible	Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge (**carefirst.com/virtualconnect**). All other providers—$30 copay	All providers—Visits 1–3: No charge, no deductible[5] Visits 4+: No charge after deductible
5	**Specialist Visits—Office/Non-Hospital**		$40 copay, no deductible	$40 copay, no deductible	$60 copay, no deductible	$60 copay, no deductible	$65 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 after deductible	$75 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	$100 copay	No charge after deductible
	RETAIL CLINICS, URGENT AND EMERGENCY SERVICES							
7	**Convenience Care/Retail Health Clinics**		No charge, no deductible	No charge, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay	No charge after deductible
8	**Urgent Care Center**		$50 copay, no deductible	$50 copay, no deductible	$45 copay, no deductible	$45 copay, no deductible	$80 copay	No charge after deductible
9	**Emergency Room** (hospital charge—copays are waived if you are admitted)		$300 copay after deductible	$300 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	$500 copay	No charge after deductible
	DIAGNOSTIC SERVICES							
10	**Labs**[6]	Office/Non-Hospital	$15 copay after deductible (Labcorp only)	$15 copay after deductible	25% coinsurance after deductible (Labcorp only)	25% coinsurance after deductible	$30 copay (Labcorp only)	No charge after deductible (Labcorp only)
11		Outpatient Hospital	$60 copay after deductible[7]	$60 copay after deductible	25% coinsurance after deductible[7]	25% coinsurance after deductible	$80 copay[7]	No charge after deductible[7]
12	**X-rays**[6]	Office/Non-Hospital	$65 copay after deductible	$65 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	$65 copay	No charge after deductible
13		Outpatient Hospital	$100 copay after deductible[7]	$100 copay after deductible	25% coinsurance after deductible[7]	25% coinsurance after deductible	$100 copay[7]	No charge after deductible[7]
14	**Imaging** (e.g., MRI, Cat Scan, CT Scan)	Office/Non-Hospital	$250 copay after deductible	$250 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	$250 copay	No charge after deductible
15		Outpatient Hospital	$350 copay after deductible[7]	$350 copay after deductible	25% coinsurance after deductible[7]	25% coinsurance after deductible	$500 copay[7]	No charge after deductible[7]
	OUTPATIENT SURGERY *(Members are responsible for both facility and physician charges)*							
16	**Outpatient Surgery** (physician charge)	Non-Hospital/Surgical Center	$40 copay after deductible	$40 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	$65 copay[7]	No charge after deductible
17		Hospital	$40 copay after deductible[7]	$40 copay after deductible	25% coinsurance after deductible[7]	25% coinsurance after deductible	$65 copay[7]	No charge after deductible[7]
18	**Outpatient Surgery** (facility charge)	Non-Hospital/Surgical Center	$300 copay after deductible	$300 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	$300 copay[7]	No charge after deductible
19		Hospital	$400 copay after deductible[7]	$400 copay after deductible	25% coinsurance after deductible[7]	25% coinsurance after deductible	$400 copay[7]	No charge after deductible[7]
	INPATIENT HOSPITAL SERVICES *including all inpatient surgery, labor & delivery, mental health related visits (Members are responsible for both hospital and physician charges)*							
20	**Inpatient Services** (physician charge)		$40 copay after deductible	$40 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge	No charge after deductible
21	**Inpatient Services** (hospital charge)		$450 copay/day after deductible (up to a copay maximum of $2,250)[7]	$450 copay/day after deductible (up to a copay maximum of $2,250)	25% coinsurance after deductible[7]	25% coinsurance after deductible	$500 copay/day (up to a maximum of $2,500)[7]	No charge after deductible[7]
	MATERNITY OFFICE VISITS							
22	**Preventive Prenatal & Postnatal Office Visits**[8]		No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible
	MENTAL HEALTH AND SUBSTANCE USE DISORDER							
23	**Office Visits**		Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge, no deductible (**carefirst.com/virtualconnect**). All other providers—No charge, no deductible	Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge, no deductible (**carefirst.com/virtualconnect**). All other providers—No charge, no deductible	$30 copay, no deductible	$30 copay, no deductible	Virtual Connect Plus through selected providers, including CloseKnit[13]—No charge (**carefirst.com/virtualconnect**). All other providers—$30 copay	All providers—Visits 1–3: No charge, no deductible[5] Visits 4+: No charge after deductible
	PRESCRIPTION DRUGS[9]							
24	**Prescription Drug Deductible**		$150 per person (Tiers 2–5)	$150 per person (Tiers 2–5)	No drug deductible	No drug deductible	No separate drug deductible	No separate drug deductible; Must meet medical deductible first
25	**Preventive Drugs (Tier 0)**		No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge	No charge, no deductible
26	**Diabetic Supplies (Tier 0)**							No charge after deductible
27	**Preferred Brand Insulin (Tier 0)**							
28	**Generic Drugs (Tier 1)**		$10 copay, no deductible	$10 copay, no deductible	$15 copay, no deductible	$15 copay, no deductible	$15 copay	No charge after deductible
29	**Preferred Brand Drugs (Tier 2)**[10]		$50 copay after deductible	$50 copay after deductible	$30 copay, no deductible	$30 copay, no deductible	$50 copay	
30	**Non-Preferred Brand Insulin (Tier 3)**		$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay	
31	**Non-Preferred Brand Drugs (Tier 3)**[11]		$70 copay after deductible	$70 copay after deductible	$60 copay, no deductible	$60 copay, no deductible	$75 copay	
32	**Preferred Specialty Drugs (Tier 4)**[12]		$100 copay after deductible	$100 copay after deductible	$250 copay, no deductible	$250 copay, no deductible	$100 copay	
33	**Non-Preferred Specialty Drugs (Tier 5)**[12]		$150 copay after deductible	$150 copay after deductible	$250 copay, no deductible	$250 copay, no deductible	$150 copay	
	OUT-OF-NETWORK			Out-of-Network	Out-of-Network	Out-of-Network		
34	**Deductible**		N/A	Individual: $3,500/Family: $7,000	N/A	Individual: $4,000/Family: $8,000	N/A	N/A
35	**Out-of-Pocket Maximum**		N/A	Individual: $17,100/Family: $34,200	N/A	Individual: $16,400/Family: $32,800	N/A	N/A

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

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2027 VIRGINIA POLICY FORM NUMBERS

BlueChoice HMO Young Adult 12000 Med Ded Virtual Connect Plus
VA/CFBC/CD/HMO (1/27); VA/CFBC/CD/HMO/YA SOB VC+ (1/27); MVAAP (5/26) and any amendments.

BlueChoice HMO Referral Bronze 8250 Med Ded 25 Dent Ded Virtual Connect Plus
VA/CFBC/CD/HMO (1/27); VA/CFBC/CD/HMO REF/BRZ 8250 VC+ (1/27); MVAAP (5/26) and any amendments.

BlueChoice HMO Standard Bronze 7500 Med Ded 25 Dent Ded
VA/CFBC/CD/HMO (1/27); VA/CFBC/CD/HMO/STAND BRZ 7500 (1/27); MVAAP (5/26) and any amendments.

BlueChoice HMO Standard Silver 6000 Med Ded 25 Dent Ded
VA/CFBC/CD/HMO (1/27); VA/CFBC/CD/HMO/STAND SIL 6000 (1/27); MVAAP (5/26) and any amendments.

BluePreferred PPO Standard Silver 6000 Med Ded 25 Dent Ded
VA/CF/CD/BP (1/27); VA/CF/CD/BP PPO/STAND SIL 6000 (1/27); MVAAP (5/26) and any amendments.

BlueChoice HMO HSA Silver 3700 Med Ded 25 Dent Ded Virtual Connect Plus
VA/CFBC/CD/HMO (1/27); VA/CFBC/CD/HMO HSA/SIL 3700 VC+ (1/27); MVAAP (5/26) and any amendments.

BluePreferred PPO HSA Silver 3700 Med Ded 25 Dent Ded Virtual Connect Plus
VA/CF/CD/BP (1/27); VA/CF/CD/BP PPO HSA/SIL 3400 VC+ (1/27); MVAAP (5/26) and any amendments.

BlueChoice HMO Standard Gold 2000 Med Ded 25 Dent Ded
VA/CFBC/CD/HMO (1/27); VA/CFBC/CD/HMO/STAND GOLD 2000 (1/27); MVAAP (5/26) and any amendments.

BluePreferred PPO Standard Gold 2000 Med Ded 25 Dent Ded
VA/CF/CD/BP (1/27); VA/CF/CD/BP PPO/STAND GOLD 2000 (1/27); MVAAP (5/26) and any amendments.

BlueChoice HMO Gold 1750 Med Ded 150 Drug Ded 25 Dent Ded Virtual Connect Plus
VA/CFBC/CD/HMO (1/27); VA/CFBC/CD/HMO/GOLD 1750 VC+ (1/27); MVAAP (5/26) and any amendments.

BluePreferred PPO Gold 1750 Med Ded 150 Drug Ded 25 Dent Ded Virtual Connect Plus
VA/CF/CD/BP (1/27); VA/CF/CD/BP PPO/GOLD 1750 VC+ (1/27); MVAAP (5/26) and any amendments.

BlueChoice HMO Gold 0 Med Ded 150 Drug Ded 25 Dent Ded Virtual Connect Plus
VA/CFBC/CD/HMO (1/27); VA/CFBC/CD/HMO/GOLD 0 VC+ (1/27); MVAAP (5/26) and any amendments.

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