

Virginia Consumer Health Benefits 2026

Virginia CareFirst Plans	Bronze		Silver				Gold				Catastrophic	
	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 3400 Med Ded 25 Dent Ded Virtual Connect Plus	BluePreferred PPO HSA Silver 3400 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	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 Young Adult 10600 Med Ded Virtual Connect Plus	
Plan Type	HMO ¹	HMO ¹	HMO ¹	PPO ²	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	BlueChoice HMO	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	
Deductible ³	Individual: \$7,500/Family: \$15,000	Individual: \$8,250/Family: \$16,500	Individual: \$3,400/Family: \$6,800	Individual: \$3,400/Family: \$6,800	Individual: \$6,000/Family: \$12,000	Individual: \$6,000/Family: \$12,000	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: \$10,600/Family: \$21,200	
Out-of-Pocket Maximum ⁴	Individual: \$10,000/Family: \$20,000	Individual: \$10,150/Family: \$20,300	Individual: \$6,850/Family: \$13,700	Individual: \$6,850/Family: \$13,700	Individual: \$8,900/Family: \$17,800	Individual: \$8,900/Family: \$17,800	Individual: \$7,800/Family: \$15,600	Individual: \$7,800/Family: \$15,600	Individual: \$8,200/Family: \$16,400	Individual: \$8,200/Family: \$16,400	Individual: \$10,600/Family: \$21,200	
PREVENTIVE SERVICES												
Preventive Care (e.g. adult physical, well-child care, cancer screenings)	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	
PRIMARY CARE AND SPECIALIST SERVICES												
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	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	All providers—Visits 1–3: No charge, no deductible ⁵ . Visits 4+: No charge after deductible	
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	\$30 copay, no deductible	\$30 copay, no deductible	\$60 copay, no deductible	\$60 copay, no deductible	No charge after deductible	
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	\$75 copay after deductible	\$75 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible	
RETAIL CLINICS, URGENT AND EMERGENCY SERVICES												
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	No charge, no deductible	No charge, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	No charge after deductible	
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	\$50 copay, no deductible	\$50 copay, no deductible	\$45 copay, no deductible	\$45 copay, no deductible	No charge after deductible	
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	\$300 copay after deductible	\$300 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible	
DIAGNOSTIC SERVICES												
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	\$15 copay after deductible (LabCorp Only)	\$15 copay after deductible	25% coinsurance after deductible (LabCorp Only)	25% coinsurance after deductible	No charge after deductible (LabCorp Only)
	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	\$60 copay after deductible ⁷	\$60 copay after deductible	25% coinsurance after deductible ⁷	25% coinsurance after deductible	No charge after deductible ⁷
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	\$65 copay after deductible	\$65 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
	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	\$100 copay after deductible ⁷	\$100 copay after deductible	25% coinsurance after deductible ⁷	25% coinsurance after deductible	No charge after deductible ⁷
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	\$250 copay after deductible	\$250 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
	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	\$350 copay after deductible ⁷	\$350 copay after deductible	25% coinsurance after deductible ⁷	25% coinsurance after deductible	No charge after deductible ⁷
OUTPATIENT SURGERY (Members are responsible for both facility and physician charges)												
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	\$30 copay after deductible	\$30 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
	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	\$30 copay after deductible ⁷	\$30 copay after deductible	25% coinsurance after deductible ⁷	25% coinsurance after deductible	No charge after deductible ⁷
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	\$300 copay after deductible	\$300 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
	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	\$400 copay after deductible ⁷	\$400 copay after deductible	25% coinsurance after deductible ⁷	25% coinsurance after deductible	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)												
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	\$30 copay after deductible	\$30 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible	
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	\$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	No charge after deductible ⁷	
MATERNITY OFFICE VISITS												
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	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												
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	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	All providers—Visits 1–3: No charge, no deductible ⁵ . Visits 4+: No charge after deductible	
PRESCRIPTION DRUGS ⁹												
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	\$150 per person (Tiers 2–5)	\$150 per person (Tiers 2–5)	No drug deductible	No drug deductible	No separate drug deductible; Must meet medical deductible first	
Preventive Drugs (Tier 0)											No charge, no deductible	
Diabetic Supplies (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 deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge after deductible	
Preferred Brand Insulin (Tier 0)											No charge after deductible	
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	\$10 copay, no deductible	\$10 copay, no deductible	\$15 copay, no deductible	\$15 copay, no deductible	No charge after deductible	
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	\$50 copay after deductible	\$50 copay after deductible	\$30 copay, no deductible	\$30 copay, no deductible	No charge after deductible	
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	\$30 copay, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	No charge after deductible	
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	\$70 copay after deductible	\$70 copay after deductible	\$60 copay, no deductible	\$60 copay, no deductible	No charge after deductible	
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	\$100 copay after deductible	\$100 copay after deductible	\$250 copay, no deductible	\$250 copay, no deductible	No charge after deductible	
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	\$150 copay after deductible	\$150 copay after deductible	\$250 copay, no deductible	\$250 copay, no deductible	No charge after deductible	
Out-of-Network												
Deductible	N/A	N/A	N/A	Individual: \$6,800/Family: \$13,600	N/A	Individual: \$12,000/Family: \$24,000	N/A	Individual: \$3,500/Family: \$7,000	N/A	Individual: \$4,000/Family: \$8,000	N/A	
Out-of-Pocket Maximum	N/A	N/A	N/A	Individual: \$13,700/Family: \$27,400	N/A	Individual: \$17,800/Family: \$35,600	N/A	Individual: \$15,600/Family: \$31,200	N/A	Individual: \$16,400/Family: \$32,800	N/A	

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

¹ Health Maintenance Organization (HMO) plans underwritten by CareFirst BlueChoice, Inc.

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

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

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

⁵ 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 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. 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/acars. 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: 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 services 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.

2026 VIRGINIA POLICY FORM NUMBERS

BlueChoice HMO Gold 1750 Med Ded 150 Drug Ded 25 DENT DED VIRTUAL CONNECT PLUS
VA/CFBC/CD/HMO (1/26); VA/CFBC/CD/BC HMO/GOLD 1750 VC+ (1/26); MVAAP (7/25)

BLUECHOICE HMO HSA SILVER 3400 MED DED 25 DENT DED VIRTUAL CONNECT PLUS
VA/CFBC/CD/HMO (1/26); VA/CFBC/CD/HSA/SIL 3400 VC+ (1/26); MVAAP (7/25)

BLUECHOICE HMO STANDARD GOLD 2000 MED DED 25 DENT DED
VA/CFBC/CD/HMO (1/26); VA/CFBC/CD/HMO/STAND GOLD 2000 (1/26); MVAAP (7/25)

BLUECHOICE HMO STANDARD SILVER 6000 MED DED 25 DENT DED
VA/CFBC/CD/HMO (1/26); VA/CFBC/CD/HMO/STAND SIL 6000 (1/26); MVAAP (7/25)

BLUECHOICE HMO REFERRAL BRONZE 8250 MED DED 25 DENT DED VIRTUAL CONNECT PLUS
VA/CFBC/CD/HMO (1/26); VA/CFBC/CD/HMO REF/BRZ 8250 VC+ (1/26); MVAAP (7/25)

BLUECHOICE HMO STANDARD BRONZE 7500 MED DED 25 DENT DED
VA/CFBC/CD/HMO (1/26); VA/CFBC/CD/HMO/STAND BRZ 7500 (1/26); MVAAP (7/25)

BLUECHOICE HMO YOUNG ADULT 10600 MED DED VIRTUAL CONNECT PLUS
VA/CFBC/CD/HMO (1/26); VA/CFBC/CD/HMO/YA SOB VC+ (1/26); MVAAP (7/25)

BLUEPREFERRED PPO GOLD 1750 MED DED 150 DRUG DED 25 DENT DED VIRTUAL CONNECT PLUS
VA/CF/CD/BP (1/26); VA/CF/CD/BP PPO/GOLD 1750 VC+ (1/26); MVAAP (7/25)

BLUEPREFERRED PPO HSA SILVER 3400 MED DED 25 DENT DED VIRTUAL CONNECT PLUS
VA/CF/CD/BP (1/26); VA/CF/CD/BP PPO HSA/SIL 3400 VC+ (1/26); MVAAP (7/25)

BLUEPREFERRED PPO STANDARD GOLD 2000 MED DED 25 DENT DED
VA/CF/CD/BP (1/26); VA/CF/CD/BP PPO/STAND GOLD 2000 (1/26); MVAAP (7/25)

BLUEPREFERRED PPO STANDARD SILVER 6000 MED DED 25 DENT DED
VA/CF/CD/BP (1/26); VA/CF/CD/BP PPO/STAND SIL 6000 (1/26); MVAAP (7/25)

BLUEPREFERRED PPO STANDARD GOLD 2000 MED DED 25 DENT DED
VA/CF/CD/BP (1/26); VA/CF/CD/BP PPO/STAND GOLD 2000 (1/26); MVAAP (7/25)

BLUEPREFERRED PPO STANDARD SILVER 6000 MED DED 25 DENT DED
VA/CF/CD/BP (1/26); VA/CF/CD/BP PPO/STAND SIL 6000 (1/26); MVAAP (7/25)

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.



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., Trusted Health Plan (District of Columbia), Inc., CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.