Washington, D.C. Consumer Health Benefits 2024

CareFirst
Family of health care plans

Washington, D.C. CareFirst Plans	Bronze				Silver		Gold				Platinum		Catastrophic
	BlueChoice HMO Standard Bronze $7,500	BluePreferred PPO Standard Bronze $7,500	BlueChoice HMO HSA Standard Bronze $6,350	BluePreferred PPO HSA Standard Bronze $6,350	BlueChoice HMO Standard Silver $4,850	BluePreferred PPO Standard Silver $4,850	BlueChoice HMO Standard Gold $500	BluePreferred PPO Standard Gold $500	BlueChoice HMO HSA Gold $1,600	BluePreferred PPO HSA Gold $1,600	BlueChoice HMO Standard Platinum $0	BluePreferred PPO Standard Platinum $0	BlueChoice HMO Young Adult $9,450
Plan Type	HMO[1]	PPO[2]	HMO[1]	PPO[2]	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	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 Deductible	Individual: $7,500 Family: $15,000[4]	Individual: $7,500 Family: $15,000[4]	Individual: $6,350 Family: $12,700[4]	Individual: $6,350 Family: $12,700[4]	Individual: $4,850 Family: $9,700[4]	Individual: $4,850 Family: $9,700[4]	Individual: $500 Family: $1,000[4]	Individual: $500 Family: $1,000[4]	Individual: $1,600 Family: $3,200[3]	Individual: $1,600 Family: $3,200[3]	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $9,450 Family: $18,900[4]
2 Out-of-Pocket Maximum[5]	Individual: $9,150 Family: $18,300	Individual: $9,150 Family: $18,300	Individual: $7,200 Family: $14,400	Individual: $7,200 Family: $14,400	Individual: $8,850 Family: $17,700	Individual: $8,850 Family: $17,700	Individual: $5,800 Family: $11,600	Individual: $5,800 Family: $11,600	Individual: $3,200 Family: $6,400	Individual: $3,200 Family: $6,400	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000	Individual: $9,450 Family: $18,900
PREVENTIVE SERVICES													
3 Preventive Care (e.g. adult physical, well-child care, cancer screenings)	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	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)	$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	Visits 1–3: No charge, no deductible Visits 4+: No charge after 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	$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	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
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	$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	$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 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	$300 copay, no deductible	$300 copay, no deductible	$300 copay after deductible	$300 copay after deductible	$150 copay	$150 copay	No charge 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	$30 copay, no deductible (LabCorp only)[11]	$30 copay, no deductible	$30 copay after deductible (LabCorp only)[11]	$30 copay after deductible	$20 copay (LabCorp Only)[11]	$20 copay	No charge after deductible (LabCorp only)[11]
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	$50 copay, no deductible[11]	$50 copay, no deductible	$50 copay after deductible[11]	$50 copay after deductible	$40 copay[11]	$40 copay	No charge after deductible[11]
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	$250 copay, no deductible[11]	$250 copay, no deductible	$250 copay after deductible[11]	$250 copay after deductible	$150 copay[11]	$150 copay	No charge after deductible[11]
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	$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)	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	$125 copay, no deductible[11]	$125 copay, no deductible	$125 copay after deductible[11]	$125 copay after deductible	No charge	No charge	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)	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 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	$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)	$250 copay/day (up to a copay maximum of $1,250)[11]	$250 copay/day (up to a copay maximum of $1,250)	No charge after deductible[11]
MATERNITY OFFICE VISITS[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	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 & SUBSTANCE ABUSE													
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	$25 copay, no deductible	$25 copay, no deductible	$25 copay after deductible	$25 copay after deductible	$20 copay	$20 copay	Visits 1–3: No charge, no deductible Visits 4+: No charge after deductible
PRESCRIPTION DRUGS[8]													
19 Prescription Drug Deductible	$850 per person (Tiers 2–5)	$850 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 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	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)													No charge after deductible
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	$15 copay	$15 copay	$15 copay after deductible	$15 copay after deductible	$5 copay	$5 copay	No charge after deductible
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	$50 copay	$50 copay	$50 copay after deductible	$50 copay after deductible	$15 copay	$15 copay	No charge after deductible
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	$30 copay	$30 copay	$30 copay, no deductible	$30 copay, no deductible	$25 copay	$25 copay	No charge after deductible
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	$70 copay	$70 copay	$70 copay after deductible	$70 copay after deductible	$25 copay	$25 copay	No charge after deductible
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	$150 copay	$150 copay	$150 copay after deductible	$150 copay after deductible	$100 copay	$100 copay	
Out-of-Network		Out-of-Network		Out-of-Network		Out-of-Network		Out-of-Network		Out-of-Network		Out-of-Network	
24 Deductible	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: $3,200 Family: $6,400	N/A	Individual: $1,000 Family: $2,000	N/A
25 Out-of-Pocket Maximum	N/A	Individual: $18,300 Family: $36,600	N/A	Individual: $14,400 Family: $28,800	N/A	Individual: $17,700 Family: $35,400	N/A	Individual: $11,600 Family: $23,200	N/A	Individual: $6,400 Family: $12,800	N/A	Individual: $4,000 Family: $8,000	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 - 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.

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.

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.

2024 WASHINGTON, D.C. POLICY FORM NUMBERS

BlueChoice HMO Standard Plans
DC/CFBC/EXC/HMO/IEA (R. 1/23); DC/CFBC/DOL APPEAL (R. 1/22); DC/CFBC/EXC/HMO/DOCS (R. 1/23); DC/CFBC/EXC/HMO HSA/GOLD 1600 (1/24); DC/CFBC/EXC/HMO HSA STD/BRZ 6350 (1/24); DC/CFBC/EXC/HMO STD/BRZ 7500 (1/24); DC/CFBC/EXC/HMO STD/GOLD 500 (1/24); DC/CFBC/EXC/HMO/NATAMER SOB (1/24); DC/CFBC/EXC/HMO STD/PLAT 0 (1/24); DC/CFBC/EXC/HMO STD/SIL 4850 (1/24); DC/CFBC/EXC/HMO STD/SIL 4850 A (1/24); DC/CFBC/EXC/HMO STD/SIL 4850 B (1/24); DC/CFBC/EXC/HMO STD/SIL 4850 C (1/24); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/NO SURP ACT/AMEND (R. 1/23); DC/CFBC/CD/AUTH AMEND/HMO (R. 1/24); DC/CFBC/EXC/2024 AMEND (1/24); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23)

BlueChoice HMO Young Adult
DC/CFBC/EXC/HMO/IEA (R. 1/23); DC/CFBC/DOL APPEAL (R. 1/22); DC/CFBC/EXC/HMO/DOCS (R. 1/23); DC/CFBC/EXC/HMO/NATAMER SOB (1/24); DC/CFBC/EXC/HMO/ YA 9450 SOB (1/24); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/NO SURP ACT/AMEND (R. 1/23); DC/CFBC/CD/AUTH AMEND/HMO (R. 1/24); DC/CFBC/EXC/2024 AMEND (1/24); DC/CFBC/PT PROTECT (9/10); DC/CFBC/CD/HMO/INCENT (1/23)

BluePreferred PPO Standard Plans
DC/CF/EXC/BP/IEA (R. 1/23); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/BP/EXC/DOCS (R. 1/23); DC/CF/EXC/BP HSA/GOLD 1600 (1/24); DC/CF/EXC/BP HSA STD/BRZ 6350 (1/24); DC/CF/EXC/BP STD/BRZ 7500 (1/24); DC/CF/EXC/BP STD/GOLD 500 (1/24); DC/CF/EXC/BP STD/NATAMER SOB (1/24); DC/CF/EXC/BP STD/PLAT 0 (1/24); DC/CF/EXC/BP STD/SIL 4850 (1/24); DC/CF/EXC/BP STD/SIL 4850 A (1/24); DC/CF/EXC/BP STD/SIL 4850 B (1/24); DC/CF/EXC/BP STD/SIL 4850 C (1/24) DC/CF/EXC/NATAMER (1/14); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/NO SURP ACT/AMEND (R. 1/23); DC/CF/CD/AUTH AMEND PPO (R. 1/24); DC/CF/EXC/2024 AMEND (1/24); DC GHMSI – HEALTH GUARANTY 5/21; DC/CF/PT PROTECT (9/10); DC/CF/CD/BP/INCENT (1/23)

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518

Not all services and procedures are covered by your benefits contract. This benefit summary is for comparison purposes only and does not create rights not given through the benefit plan.
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.

CDS1218-1P (10/23)