Virginia Consumer Health Benefits 2024

CareFirst Family of health care plans

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.

			Silver				Gold				Catastrophic
	Virginia CareFirst Plans		**BlueChoice HMO HSA Silver 3200 Med Ded 25 Dent Ded**	**BluePreferred PPO HSA Silver 3200 Med Ded 25 Dent Ded**	**BlueChoice HMO Standard Silver 5900 Med Ded 25 Dent Ded**	**BluePreferred PPO Standard Silver 5900 Med Ded 25 Dent Ded**	**BlueChoice HMO Gold 1750 Med Ded 150 Drug Ded 25 Dent Ded**	**BluePreferred PPO Gold 1750 Med Ded 150 Drug Ded 25 Dent Ded**	**BlueChoice HMO Standard Gold 1500 Med Ded 25 Dent Ded**	**BluePreferred PPO Standard Gold 1500 Med Ded 25 Dent Ded**	**BlueChoice HMO Young Adult 9450 Med Ded**
	Plan Type		**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**
	DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM		In-Network	In-Network			In-Network	In-Network			In-Network
1	**Deductible**[3]		Individual: $3,200/Family: $6,400	Individual: $3,200/Family: $6,400	Individual: $5,900/Family: $11,800	Individual: $5,900/Family: $11,800	Individual: $1,750/Family: $3,500	Individual: $1,750/Family: $3,500	Individual: $1,500/Family: $3,000	Individual: $1,500/Family: $3,000	Individual: $9,450/Family: $18,900
2	**Out-of-Pocket Maximum**[4]		Individual: $6,500/Family: $13,000	Individual: $6,500/Family: $13,000	Individual: $9,100/Family: $18,200	Individual: $9,100/Family: $18,200	Individual: $6,650/Family: $13,300	Individual: $6,650/Family: $13,300	Individual: $8,700/Family: $17,400	Individual: $8,700/Family: $17,400	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
	PRIMARY CARE AND SPECIALIST SERVICES										
4	**Primary Care Provider (PCP) Visits—Office/Non-Hospital** (non-preventive)		$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	Visits 1–3: No charge, no deductible[5] Visits 4+: No charge after deductible
5	**Specialist Visits—Office/Non-Hospital**		$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
6	**HOSPITAL CHARGE** Add this charge if your primary care or specialist visit takes place in a hospital setting		$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										
7	**Convenience Care/Retail Health Clinics**		$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
8	**Urgent Care Center**		$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
9	**Emergency Room** (hospital charge—copays are waived if you are admitted)		$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										
10	**Labs**[6]	Office/Non-Hospital	$25 copay after deductible (LabCorp only)	$25 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$15 copay, no deductible (LabCorp only)	$15 copay, no deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible (LabCorp only)
11		Outpatient Hospital	$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]
12	**X-rays**[6]	Office/Non-Hospital	$55 copay after deductible	$55 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$65 copay, no deductible	$65 copay, no deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
13		Outpatient Hospital	$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]
14	**Imaging** (e.g. MRI, Cat Scan, CT Scan)	Office/Non-Hospital	$250 copay after deductible	$250 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$250 copay, no deductible	$250 copay, no deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
15		Outpatient Hospital	$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)*										
16	**Outpatient Surgery** (physician charge)	Non-Hospital/Surgical Center	$40 copay after deductible	$40 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$30 copay, no deductible	$30 copay, no deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
17		Hospital	$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]
18	**Outpatient Surgery** (facility charge)	Non-Hospital/Surgical Center	$300 copay after deductible	$300 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$300 copay, no deductible	$300 copay, no deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
19		Hospital	$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)*										
20	**Inpatient Services** (physician charge)		$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
21	**Inpatient Services** (hospital charge)		$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										
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	No charge, no deductible	No charge, no deductible	No charge, no deductible
	MENTAL HEALTH & SUBSTANCE ABUSE										
23	**Office Visits**		$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	Visits 1–3: No charge, no deductible[5] Visits 4+: No charge after 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	$150 per person (Tiers 2–5)	$150 per person (Tiers 2–5)	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	No charge, no deductible	No charge, no deductible	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 after deductible	$10 copay after deductible	$20 copay, no deductible	$20 copay, no deductible	No charge, no deductible	No charge, no deductible	$15 copay, no deductible	$15 copay, no deductible	No charge after deductible
29	**Preferred Brand Drugs (Tier 2)**[10]		$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, 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]		$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]		$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	
	Non-Preferred Specialty Drugs (Tier 5)[12]		$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	
	OUT-OF-NETWORK			Out-of-Network	Out-of-Network	Out-of-Network		Out-of-Network	Out-of-Network	Out-of-Network	
30	**Deductible**		N/A	Individual: $6,400/Family: $12,800	N/A	Individual: $11,800/Family: $23,600	N/A	Individual: $3,500/Family: $7,000	N/A	Individual: $3,000/Family: $6,000	N/A
31	**Out-of-Pocket Maximum**		N/A	Individual: $13,000/Family: $26,000	N/A	Individual: $18,200/Family: $36,400	N/A	Individual: $13,300/Family: $26,600	N/A	Individual: $17,400/Family: $34,800	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.

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.

2024 Virginia Policy Form Numbers:

BlueChoice HMO HSA Silver $3,200 Ded
VA/CFBC/DB/HMO (1/24); VA/CFBC/EXC/HMO HSA/SIL 3200 (1/24); MVAAP (2/23)

BlueChoice HMO Standard Silver $5,900 Ded
VA/CFBC/DB/HMO (1/24); VA/CFBC/EXC/HMO STAND/SIL 5900 (1/24); MVAAP (2/23)

BlueChoice HMO Gold $1,750 Ded
VA/CFBC/DB/HMO (1/24); VA/CFBC/EXC/BC HMO/GOLD 1750 (1/24); MVAAP (2/23)

BlueChoice HMO Standard Gold $1,500 Ded
VA/CFBC/DB/HMO (1/24); VA/CFBC/EXC/HMO STAND/GOLD 1500 (1/24); MVAAP (2/23)

BlueChoice HMO Young Adult $9,450 Ded
VA/CFBC/DB/HMO (1/24); VA/CFBC/EXC/HMO/YA SOB (1/24); MVAAP (2/23)

BluePreferred PPO HSA Silver $3,200 Ded
VA/CF/DB/BP (1/24); VA/CF/EXC/BP PPO HSA/SIL 3200 (1/24); MVAAP (2/23)

BluePreferred PPO Standard Silver $5,900 Ded
VA/CF/DB/BP (1/24); VA/CF/EXC/BP PPO/STAND SIL 5900 (1/24); MVAAP (2/23)

BluePreferred PPO Gold $1,750 Ded
VA/CF/DB/BP (1/24); VA/CF/EXC/BP PPO/GOLD 1750 (1/24); MVAAP (2/23)

BluePreferred PPO Standard Gold $1,500 Ded
VA/CF/DB/BP (1/24); VA/CF/EXC/BP PPO/STAND GOLD 1500 (1/24); MVAAP (2/23)

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.

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