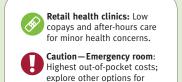
# District of Columbia Consumer Health Benefits 2016



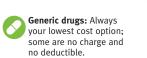
District of Columbia CareFirst Plans	BRONZE				SILVER				GOLD				PLATINUM		CATASTROPHIC
	BlueChoice HMO Standard Bronze \$4,500	BluePreferred PPO Standard Bronze \$4,500	BlueChoice HMO HSA Bronze \$6,000	BlueChoice HMO HSA Bronze \$6,550	BlueChoice HMO HSA Silver \$1,350	Blue Cross Blue Shield Preferred 1600, a Multi-State Plan	BlueChoice HMO Standard Silver \$2,000	BluePreferred PPO Standard Silver \$2,000	BlueChoice HMO Standard Gold \$500	BluePreferred PPO Standard Gold \$500	Blue Cross Blue Shield Preferred 750, a Multi-State Plan	HealthyBlue HMO Gold \$1,000	BlueChoice HMO Standard Platinum \$0	BluePreferred PPO Standard Platinum \$0	BlueChoice HA Young Adult \$6,850
Plan Type	HMO¹	PPO <sup>2</sup>	HMO¹	HMO¹	HMO¹	PPO <sup>2</sup>	HMO¹	PPO <sup>2</sup>	HMO¹	PPO <sup>2</sup>	PPO <sup>2</sup>	HMO¹	HMO¹	PPO <sup>2</sup>	HMO¹
Visit www.carefirst.com/doctor to view participating doctors and facilities—search by plan:	BlueChoice HMO	BluePreferred	BlueChoice HMO	BlueChoice HMO	BlueChoice HMO	BluePreferred	BlueChoice HMO	BluePreferred	BlueChoice HMO	BluePreferred	BluePreferred	HealthyBlue HMO	BlueChoice HMO	BluePreferred	BlueChoice Young A
Rewards	Earn \$150 per adult and up t	o a \$400 maximum per family	toward your premium or medica	al expenses. Visit www.carefirs	t.com/bluerewards for more info	ormation.									
PEDUCTIBLE 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	In-Network	In-Network
Deductible <sup>3</sup>	Individual: \$4,500 Family: \$9,000	Individual: \$4,500 Family: \$9,000	Individual: \$6,000 Family: \$12,000	Individual: \$6,550 Family: \$13,100	Individual: \$1,350 Family: \$2,700	Individual: \$1,600 Family: \$3,200	Individual: \$2,000 Family: \$4,000	Individual: \$2,000 Family: \$4,000	Individual: \$500 Family: \$1,000	Individual: \$500 Family: \$1,000	Individual: \$750 Family: \$1,500	Individual: \$1,000 Family: \$2,000	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$6,8 Family: \$13,70
Out-of-Pocket Maximum <sup>4</sup>	Individual: \$6,850 Family: \$13,700	Individual: \$6,850 Family: \$13,700	Individual: \$6,000 Family: \$12,000	Individual: \$6,550 Family: \$13,100	Individual: \$6,550 Family: \$13,100	Individual: \$6,550 Family: \$13,100	Individual: \$6,250 Family: \$12,500	Individual: \$6,250 Family: \$12,500	Individual: \$3,500 Family: \$7,000	Individual: \$3,500 Family: \$7,000	Individual: \$4,000 Family: \$8,000	Individual: \$4,500 Family: \$9,000	Individual:\$2,000 Family: \$4,000	Individual:\$2,000 Family: \$4,000	Individual: \$6,8 Family: \$13,70
PREVENTIVE SERVICES	, ay, \$15,, 50	. uy. \$15,7 00	7 diliny, \$12,000	raimy, ¢15,100	, a.m.y, \$13,100	Ταιιιί, 1 φ12,100	1 dillikyi	1 anniyî \$12,500	rumnyi qryocc	, a.m.y, 47,000	r annity r pose o o	rannyr 49,000	ranny v 1,000	ranny, ¢ 1,000	rumnyr <del>413</del> ,7
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	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no ded
PRIMARY CARE AND SPECIALIST SERVICES															
Primary Care Provider (PCP) Visits— Office/Non-Hospital (non-preventive)	\$50 copay, no deductible	\$50 copay, no deductible	No charge after deductible	No charge after deductible	\$30 copay after deductible	\$30 copay after deductible	\$25 copay, no deductible	\$25 copay, no deductible	\$25 copay, no deductible	\$25 copay, no deductible	No charge, no deductible	No charge, no deductible	\$20 copay	\$20 copay	Visits 1–3: No ch no deductibl Visits 4+: No ch after deductik
Specialist Visits—Office/Non-Hospital	\$50 copay, no deductible	\$50 copay, no deductible	No charge after deductible	No charge after deductible	\$40 copay after deductible	\$40 copay after deductible	\$50 copay, no deductible	\$50 copay, no deductible	\$50 copay, no deductible	\$50 copay, no deductible	\$30 copay, no deductible	\$30 copay, no deductible	\$40 copay	\$40 copay	No charge after de
HOSPITAL CHARGE— <b>Add</b> this charge if your primary care or specialist visit takes place in a	20% coinsurance after	20% coinsurance after	No charge after deductible	No charge after deductible	\$100 copay after deductible	30% coinsurance after	20% coinsurance after	20% coinsurance after	\$75 copay, no deductible	\$75 copay, no deductible	\$75 copay after deductible	\$75 copay after deductible	\$75 copay	\$75 copay	No charge after ded
nospital setting RETAIL CLINICS, URGENT AND EMERGENCY SERVICES	deductible	deductible				deductible	deductible	deductible				,			
onvenience Care/Retail Health Clinics e.g. CVS MinuteClinic, Rite Aid RediClinic)	\$50 copay, no deductible	\$50 copay, no deductible	No charge after deductible	No charge after deductible	\$30 copay after deductible	\$30 copay after deductible	\$25 copay, no deductible	\$25 copay, no deductible	\$25 copay, no deductible	\$25 copay, no deductible	No charge, no deductible	No charge, no deductible	\$20 copay	\$20 copay	No charge after de
Irgent Care Center	\$50 copay, no deductible	\$50 copay, no deductible	No charge after deductible			\$60 copay after deductible	\$90 copay, no deductible	\$90 copay, no deductible	\$60 copay, no deductible	\$60 copay, no deductible	\$50 copay, no deductible	\$50 copay, no deductible	\$40 copay	\$40 copay	No charge after de
e.g. Patient First, ExpressCare) mergency Room	20% coinsurance after	20% coinsurance after	and a second			30% coinsurance after	, , , , , , , , , , , , , , , , , , ,	, no academic		,					
nospital charge—copays are waived you are admitted) IAGNOSTIC SERVICES	deductible	deductible	No charge after deductible	No charge after deductible	\$300 copay after deductible	deductible	\$250 copay after deductible	\$250 copay after deductible	\$250 copay, no deductible	\$250 copay, no deductible	\$300 copay after deductible	\$300 copay after deductible	\$150 copay	\$150 copay	No charge after de
	\$50 copay after deductible		No charge after deductible	No charge after deductible	\$25 copay after deductible		\$45 copay, no deductible		\$30 copay, no deductible			\$15 copay, no deductible	\$20 copay		No charge after de
Office/Non-Hospital	(LabCorp only)	\$50 copay after deductible	(LabCorp only)	(LabCorp only)	(LabCorp only)	\$25 copay after deductible	(LabCorp only)	\$45 copay, no deductible	(LabCorp only)	\$30 copay, no deductible	No charge, no deductible	(LabCorp only)	(LabCorp Only)	\$20 copay	(LabCorp on
Outpatient Hospital	\$50 copay after deductible <sup>11</sup>	\$50 copay after deductible	No charge after deductible <sup>11</sup>	No charge after deductible <sup>11</sup>	\$90 copay after deductible11	30% coinsurance after deductible	\$45 copay, no deductible <sup>11</sup>	\$45 copay, no deductible	\$30 copay, no deductible <sup>11</sup>	\$30 copay, no deductible	\$60 copay after deductible	\$60 copay after deductible <sup>11</sup>	\$20 copay <sup>11</sup>	\$20 copay	No charge after dec
Office/Non-Hospital	\$50 copay after deductible	\$50 copay after deductible	No charge after deductible	No charge after deductible	\$55 copay after deductible	\$55 copay after deductible	\$65 copay, no deductible	\$65 copay, no deductible	\$50 copay, no deductible	\$50 copay, no deductible	No charge, no deductible	\$65 copay, no deductible	\$40 copay	\$40 copay	No charge after de
Outpatient Hospital	\$50 copay after deductible <sup>11</sup>	\$50 copay after deductible	No charge after deductible <sup>11</sup>	No charge after deductible <sup>11</sup>	\$130 copay after deductible11	30% coinsurance after deductible	\$65 copay, no deductible <sup>11</sup>	\$65 copay, no deductible	\$50 copay, no deductible <sup>11</sup>	\$50 copay, no deductible	\$100 copay after deductible	\$100 copay after deductible <sup>11</sup>	\$40 copay <sup>11</sup>	\$40 copay	No charge after ded
maging (e.g. MRI,					\$250 copay after deductible	\$250 copay after deductible 30% coinsurance after	\$250 copay, no deductible	\$250 copay, no deductible	\$250 copay, no deductible	\$250 copay, no deductible	\$250 copay, no deductible	\$250 copay, no deductible	\$150 copay	\$150 copay	No charge after de
at Scan, CT Scan) Outpatient Hospital OUTPATIENT SURGERY	\$500 copay after deductible <sup>11</sup>	\$500 copay after deductible	No charge after deductible <sup>11</sup>	No charge after deductible <sup>11</sup>	\$500 copay after deductible11	deductible	\$250 copay, no deductible <sup>11</sup>	\$250 copay, no deductible	\$250 copay, no deductible <sup>11</sup>	\$250 copay, no deductible	\$350 copay after deductible	\$350 copay after deductible <sup>11</sup>	\$150 copay <sup>11</sup>	\$150 copay	No charge after ded
Members are responsible for															
ooth facility and physician charges) Non-Hospital /	20% coinsurance after	20% coinsurance after	No charge after deductible	No charge after deductible	\$300 copay after deductible	\$300 copay after deductible	20% coinsurance after	20% coinsurance after	\$600 copay, no deductible	\$600 copay, no deductible	\$300 copay no deductible	\$300 copay, no deductible	\$250 copay	\$250 copay	No charge after ded
Outpatient Surgery Surgical Center (facility charge)	deductible 20% coinsurance after	deductible 20% coinsurance after				30% coinsurance after	deductible 20% coinsurance after	deductible 20% coinsurance after				1			
Hospital  Non-Hospital /	deductible <sup>11</sup> 20% coinsurance after	deductible 20% coinsurance after	No charge after deductible"	No charge after deductible <sup>11</sup>	\$450 copay after deductible**	deductible	deductible <sup>11</sup> 20% coinsurance after	deductible 20% coinsurance after	\$600 copay, no deductible <sup>11</sup>	\$600 copay, no deductible		\$400 copay after deductible <sup>11</sup>	\$250 copay <sup>11</sup>	\$250 copay	No charge after ded
Outpatient Surgery Surgical Center	deductible	deductible	No charge after deductible	No charge after deductible	\$40 copay after deductible	\$40 copay after deductible	deductible	deductible	No separate physician charge; combined with the	No separate physician charge; combined with the	\$30 copay, no deductible	\$30 copay, no deductible	No separate physician charge; combined with the	No separate physician charge; combined with the	No charge after de
physician charge) Hospital	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	No charge after deductible <sup>11</sup>	No charge after deductible <sup>11</sup>	\$40 copay after deductible <sup>11</sup>	\$40 copay after deductible	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	facility charge	facility charge	\$30 copay after deductible	\$30 copay after deductible <sup>11</sup>	facility charge	facility charge	No charge after ded
NPATIENT HOSPITAL SERVICES  Including all inpatient surgery, labor & delivery, mental lealth related visits (Members are responsible for both															
ospital and physician charges)	20% coinsurance after	20% coinsurance after					20% coinsurance after	20% coinsurance after	No separate physician	No separate physician			No separate physician	No separate physician	
npatient Services (physician charge)	deductible	deductible	No charge after deductible	No charge after deductible	\$40 copay after deductible	\$40 copay after deductible	deductible	deductible	charge; combined with the facility charge	charge; combined with the facility charge	\$30 copay after deductible	\$30 copay after deductible	charge; combined with the facility charge	charge; combined with the facility charge	No charge after de
npatient Services (hospital charge)	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after deductible	No charge after deductible <sup>11</sup>	No charge after deductible <sup>11</sup>	\$500 copay/day after deductible (up to a copay	30% coinsurance after	20% coinsurance after deductible <sup>11</sup>	20% coinsurance after	\$600 copay/day after deductible (up to a copay	\$600 copay/day after deductible (up to a copay	\$450 copay/day after deductible (up to a copay	\$450 copay/day after deductible (up to a copay	\$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 ded
MATERNITY OFFICE VISITS <sup>6</sup>	deductible	deductible			maximum of \$2,500) <sup>11</sup>	deductible	deductible	deductible	maximum of \$3,000)11	maximum of \$3,000)	maximum of \$2,250)	maximum of \$2,250) <sup>11</sup>	copay maximum or \$1,230)	copay maximum of \$1,230)	
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 deductible	No charge, no deductible	No charge no deductible	No charge, no deductible	No charge, no ded
IENTAL HEALTH & SUBSTANCE ABUSE <sup>7</sup>	No sharge, no deddelizite	The charge, the deductions	The diffuse, the deductible	The sharge, no deduction	no charge, no deductible	no charge, no deductible	no charge, no deduction	no diaise, no deductible	no enarge, no deddenare	ite diaige, no deduction	The charge, no accusting	no enarge, no deduction	no onarge, no deduction	no charge, no deductible	no enarge, no des
office Visits	\$50 copay, no deductible	\$50 copay, no deductible	No charge after deductible	No charge after deductible	\$30 copay after deductible	\$30 copay after deductible	\$25 copay, no deductible	\$25 copay, no deductible	\$25 copay, no deductible	\$25 copay, no deductible	No charge, no deductible	No charge, no deductible	\$20 copay	\$20 copay	Visits 1–3: No ch no deductibl
	, , , , , , , , , , , , , , , , , , , ,		0	0	, ,	. ,			, ,,	, ,	0, 111111111	0,7,7,7,7,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,			Visits 4+: No ch after deductib
RESCRIPTION DRUGS <sup>8</sup>			No concrete days	No concrete days	No concrete drug	No congrete drive									No consents d
rescription Drug Deductible	\$250 per person (Tiers 2–4)	\$250 per person (Tiers 2-4)	No separate drug deductible; Must meet medical deductible first	\$250 per person (Tiers 2–4)	\$250 per person (Tiers 2-4)	No drug deductible	No drug deductible	\$250 per person (Tier 2-4)	\$150 per person (Tiers 2–4)	No drug deductible	No drug deductible	No separate di deductible; Must medical deductibl			
eneric Drugs (Tier 1)	\$25 copay, no deductible	\$25 copay, no deductible			\$10 copay after deductible	\$10 copay after deductible	\$15 copay, no deductible	\$15 copay, no deductible	\$15 copay, no deductible	\$15 copay, no deductible	No charge, no deductible	No charge, no deductible	\$5 copay	\$5 copay	
referred Brand Drugs (Tier 2) <sup>9</sup>	50% coinsurance after deductible	50% coinsurance after deductible	No charge often de destil	No charge often de destill	\$75 copay after deductible	\$50 copay after deductible	\$50 copay after deductible	\$50 copay after deductible	\$50 copay, no deductible	\$50 copay, no deductible	\$50 copay after deductible	\$50 copay after deductible	\$15 copay	\$15 copay	No charge of the d
on-Preferred Brand Drugs (Tier 3)10	50% coinsurance after deductible	50% coinsurance after deductible	NO charge after deductible	No charge after deductible	\$150 copay after deductible	\$70 copay after deductible	\$70 copay after deductible	\$70 copay after deductible	\$70 copay, no deductible	\$70 copay, no deductible	\$70 copay after deductible	\$70 copay after deductible	\$25 copay	\$25 copay	No charge after ded
pecialty Drugs (Tier 4)	50% coinsurance after deductible	50% coinsurance after deductible			\$150 copay after deductible	\$150 copay after deductible	20% coinsurance after deductible	20% coinsurance after	20% coinsurance,	20% coinsurance,	\$150 copay after deductible	\$150 copay after deductible	\$100 copay	\$100 copay	
OUT-OF-NETWORK	deductible	Out-of-Network				Out-of-Network	deductible	deductible Out-of-Network	no deductible	no deductible Out-of-Network	Out-of-Network			Out-of-Network	
Deductible	N/A	Individual: \$9,000	NI/A	NI/A	NI/A	Individual: \$3,200	N/A	Individual: \$4,000	N/A	Individual: \$1,000	Individual: \$1,500	N/A	N/A	Individual: \$1,000	N1/A
	N/A	Family: \$18,000 Individual: \$13,700	N/A	N/A	N/A	Family: \$6,400 Individual: \$9,000	, 	Family: \$8,000 Individual: 12,500	, '	Family: \$2,000 Individual: \$7,000	Family: \$3,000 Individual: \$8,000	·	<u>'</u>	Family: \$2,000 Individual: \$4,000	N/A
Out-of-Pocket Maximum	N/A	Family: \$27,400	N/A	N/A	N/A	Family: \$18,000	N/A	Family: \$25,000	N/A	Family: \$14,000	Family: \$16,000	N/A	N/A	Family: \$8,000	N/A

# Know before you go: Your health, your money, your decision





non-emergency care.





Health Maintenance Organization (HMO) plans underwritten by CareFirst BlueChoice, Inc.
 Preferred Provider Organization (PPO) plans underwritten by Group Hospitalization and Medical Services, Inc.

For family coverage only – For BlueChoice HMO HSA Silver \$1,350 and Blue Cross Blue Shield Preferred 1600, a Multi-State Plan: The family deductible must be met before full benefits will be available to any member on the policy. Once the family deductible has been met, full benefits will become available to everyone covered. All other plans: 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..

<sup>4</sup> 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.

<sup>5</sup> For HMO plans: For in-network benefits, members must use LabCorp for laboratory services and freestanding facilities for diagnostic services and X-rays.

<sup>6</sup> For non-routine obstetrical care or complications of pregnancy, cost-sharing may apply.

7 For HMO plans: To receive in-network coverage, mental health and substance abuse coverage must be performed by Magellan behavioral health providers.

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.

<sup>11</sup> Prior authorization required.

To view participating pharmacies and find out how drugs are covered (e.g. generic vs. non-preferred brand) please visit **www.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 **www.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.

#### 2016 D.C. POLICY FORM NUMBERS

#### BlueChoice HMO HSA Bronze \$6,000

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10); DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO HSA/BRZ 6000 (1/16)

#### BlueChoice HMO HSA Bronze \$6,550

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10) DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO HSA/BRZ 6550 (1/16)

#### BlueChoice HMO HSA Silver \$1,350 (Base Plan)

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10); DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO HSA/SIL 1350 (1/16)

#### BlueChoice HMO HSA Silver \$1,350 (73)

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10); DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO HSA/SIL 1350 73 (1/16)

#### BlueChoice HMO HSA Silver \$1,350 (87)

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10); DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO HSA/SIL 1350 87(1/16)

# BlueChoice HMO HSA Silver \$1,350 (94)

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10); DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO HSA/SIL 1350 94 (1/16)

# BlueChoice HMO Young Adult \$6,850

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10); DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO/YA SOB (1/16)

# BlueChoice HMO Standard Gold \$500

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14) DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10) DC/CFBC/EXC/2016
AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO STD/GOLD 500 (1/16)

# BlueChoice HMO Standard Platinum \$0

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10); DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO STD/PLAT 0 (1/16)

# BlueChoice HMO Standard Silver \$2,000 (Base Plan)

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14) DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10) DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO STD/SIL 2000 (1/16)

#### BlueChoice HMO Standard Silver (94)

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14) DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10) DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO STD/SIL 2000 94 (1/16)

#### BlueChoice HMO Standard Silver (87)

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14) DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10); DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO STD/SIL 2000 87(1/16)

#### BlueChoice HMO Standard Silver (73)

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14) DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10); DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO STD/SIL 2000 73 (1/16)

#### BlueChoice HMO Standard Bronze \$4,500

DC/CFBC/EXC/HMO/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14) DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10); DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HMO STD/BRZ

# HealthyBlue HMO Gold \$1,000

DC/CFBC/EXC/HB IN/IEA (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/EXC/NATAMER (1/14); DC/CFBC/DOL APPEAL (R. 1/16); DC/CFBC/MEM/BLCRD (1/12); DC/CFBC/PT PROTECT (9/10) DC/CFBC/EXC/2016 AMEND (1/16); DC/CFBC/DB/INCENT (1/16); DC/CFBC/EXC/HB HMO/GOLD 1000 (1/16)

# Blue Cross Blue Shield Preferred \$750, a Multi-State Plan

DC/CF/EXC/MSP/BP/IEA (1/14); DC/CF/MSP/APPEAL (R. 1/16); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/EXC/NATAMER (1/14); DC/CF/MSP/EXCLUSION (1/14); DC/CF/MEM/BLCRD (1/12) DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10) DC/CF/EXC/2016 AMEND (1/16); DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP/MSP PPO 750 (1/16)

# Blue Cross Blue Shield Preferred \$1,600, a Multi-State Plan (Base Plan)

DC/CF/EXC/MSP/BP/IEA (1/14); DC/CF/MSP/APPEAL (R. 1/16); DC/CF/SHOP/EXC/DOCS (1/14) DC/CF/EXC/NATAMER (1/14); DC/CF/MSP/EXCLUSION (1/14); DC/CF/MEM/BLCRD (1/12) DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10) DC/CF/EXC/2016 AMEND (1/16); DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP HSA/SIL 1600 (1/16)

# Blue Cross Blue Shield Preferred \$1,600, a Multi-State Plan (73)

DC/CF/EXC/MSP/BP/IEA (1/14); DC/CF/MSP/APPEAL (R. 1/16); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/EXC/NATAMER (1/14); DC/CF/MSP/EXCLUSION (1/14); DC/CF/MEM/BLCRD (1/12); DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10) DC/CF/EXC/2016 AMEND (1/16); DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP HSA/ SIL 1600 73 (1/16)

# Blue Cross Blue Shield Preferred \$1,600, a Multi-State Plan (87)

DC/CF/EXC/MSP/BP/IEA (1/14); DC/CF/MSP/APPEAL (R. 1/16); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/EXC/NATAMER (1/14); DC/CF/MSP/EXCLUSION (1/14); DC/CF/MEM/BLCRD (1/12) DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10) DC/CF/EXC/2016 AMEND (1/16); DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP HSA/ SIL 1600 87 (1/16)

#### Blue Cross Blue Shield Preferred \$1,600, a Multi-State Plan (94)

DC/CF/EXC/MSP/BP/IEA (1/14); DC/CF/MSP/APPEAL (R. 1/16); DC/CF/SHOP/EXC/DOCS (1/14) DC/CF/EXC/NATAMER (1/14); DC/CF/MSP/EXCLUSION (1/14); DC/CF/MEM/BLCRD (1/12) DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15 DC/CF/PT PROTECT (9/10); DC/CF/EXC/2016 AMEND (1/16); DC/CF/DB/INCENT (1/16) DC/CF/EXC/BP HSA/ SIL 1600 94 (1/16)

#### BluePreferred PPO Standard Bronze \$4,500

DC/CF/EXC/BP/IEA (1/14); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/EXC/NATAMER (1/14) DC/GHMSI/DOL APPEAL (R. 1/16); DC/CF/MEM/BLCRD (1/12); DC/CF/ANCILLARY AMEND (10/12) DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10); DC/CF/EXC/2016 AMEND (1/16) DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP STD/BRZ 4500 (1/16)

#### BluePreferred PPO Standard Silver \$2,000 (Base Plan)

DC/CF/EXC/BP/IEA (1/14); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/EXC/NATAMER (1/14); DC/GHMSI/DOL APPEAL (R. 1/16); DC/CF/MEM/BLCRD (1/12); DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10); DC/CF/EXC/2016 AMEND (1/16); DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP STD/SIL 2000 (1/16); DC/CF/EXC/BP STD/PLAT 0 (1/16)

#### BluePreferred PPO Standard Silver \$2,000 (73)

DC/CF/EXC/BP/IEA (1/14); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/EXC/NATAMER (1/14) DC/GHMSI/DOL APPEAL (R. 1/16); DC/CF/MEM/BLCRD (1/12); DC/CF/ANCILLARY AMEND (10/12) DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10); DC/CF/EXC/2016 AMEND (1/16) DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP STD/SIL 2000 73 (1/16)

# BluePreferred PPO Standard Silver \$2,000 (87)

DC/CF/EXC/BP/IEA (1/14); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/EXC/NATAMER (1/14); DC/GHMSI/DOL APPEAL (R. 1/16); DC/CF/MEM/BLCRD (1/12); DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10); DC/CF/EXC/2016 AMEND (1/16); DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP STD/SIL 2000 87 (1/16)

# BluePreferred PPO Standard Silver \$2,000 (94)

DC/CF/EXC/BP/IEA (1/14); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/EXC/NATAMER (1/14); DC/GHMSI/DOL APPEAL (R. 1/16); DC/CF/MEM/BLCRD (1/12); DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10); DC/CF/EXC/2016 AMEND (1/16); DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP STD/SIL 2000 94 (1/16)

# BluePreferred PPO Standard Gold \$500

DC/CF/EXC/BP/IEA (1/14); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/EXC/NATAMER (1/14); DC/GHMSI/DOL APPEAL (R. 1/16); DC/CF/MEM/BLCRD (1/12); DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10); DC/CF/EXC/2016 AMEND (1/16); DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP STD/GOLD 500 (1/16)

# BluePreferred PPO Standard Platinum \$0

DC/CF/EXC/BP/IEA (1/14); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/EXC/NATAMER (1/14); DC/GHMSI/DOL APPEAL (R. 1/16); DC/CF/MEM/BLCRD (1/12); DC/CF/ANCILLARY AMEND (10/12); DC/GHMSI/HEALTH GUARANTEE 1/15; DC/CF/PT PROTECT (9/10); DC/CF/EXC/2016 AMEND (1/16); DC/CF/DB/INCENT (1/16); DC/CF/EXC/BP STD/PLAT 0 (1/16)

# BlueDental Preferred HIGH Option:

DC/CF/DB/DENTAL/IEA (1/14); DC/CF/DB/PREF DENT DOCS-SOB (R. 1/15); DC/CF/DB/2015 DENTAL AMEND (REV 1/15); DC/CF/DB/2016 DENTAL AMEND (1/16); DC/GHMSI/DOL APPEAL (R. 11/11); and any amendments

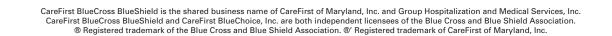
# BlueDental Preferred LOW Option:

DC/CF/DB/DENTAL/IEA (1/14); DC/CF/DB/PREF DENT DOCS-SOB LOW (1/15); DC/CF/DB/2015 DENTAL AMEND (REV 1/15); DC/CF/DB/2016 DENTAL AMEND (1/16); DC/GHMSI/DOL APPEAL (R. 11/11); and any amendments

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.





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