

# BlueChoice

DISTRICT OF COLUMBIA GROUPS

## Summary of Benefits

SERVICES	IN-NETWORK YOU PAY
<b>Maximums</b>	
Maximum Annual Copayment	
• Self-only	\$1,900
• Two-party (Subscriber & Child, Subscriber & Spouse)	\$3,000
• Family	\$5,500
Lifetime Maximum per person	Unlimited
<b>Preventive Services and Office Visits</b>	
Routine/Preventive health exam	\$20 PCP/\$30 Specialist
Well-Child Care	\$20 PCP/\$30 Specialist
Mammogram	No charge at approved locations
Allergy Treatment (testing and shots)	\$20 PCP/\$30 Specialist (if office visit copay paid, additional allergy copay not required)
Physician Office visits	\$20 PCP/\$30 Specialist
Outpatient Chiropractic Services (limited to 20 visits per condition/calendar year)	\$30 Copay per visit
Gynecological visit	\$20 PCP/\$30 Specialist (no charge Pap Smears)
<b>Maternity</b>	
Prenatal & Postnatal	\$20 PCP/\$30 Specialist (not to exceed 10 times the copay per pregnancy)
Delivery & Hospitalization	No charge
Nursery Care of Newborn	No charge
<b>Hospitalization (365 days per year/inpatient)</b>	
Room & Board (semi-private)	No charge
Physician Services	No charge
Prescription Drug (inpatient)	No charge
Ancillary Services	No charge
<b>Medical and Surgical Services</b>	
X-ray & Lab Tests (at participating facilities)	No charge
<b>Mental Health Care</b>	
Outpatient Services	Visits 1-40, 25% of Plan Allowance Visits 41+, 40% of Plan Allowance
Inpatient Facility Services (limited to 45 days per calendar year. May substitute 2 partial hospitalization days for one full inpatient day)	No charge
Inpatient Physician Services (limited to 1 visit per day)	No charge

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SERVICES	IN-NETWORK YOU PAY
<b>Substance Abuse Services</b>	
Outpatient Services (limited to 40 visits per calendar year)	\$30 Copay per visit
Inpatient Facility Services (limited to 30 days per calendar year. May substitute 2 partial hospitalization days for one full inpatient day)	No charge
Inpatient Physician Service (1 visit per day)	No charge
<b>Emergency Services</b>	
In Plan Urgent Care Center	\$30 Copay
Emergency Room	\$50 Copay (waived if admitted)
Ambulance	No charge
<b>Miscellaneous Services</b>	
Skilled Nursing Facility	No charge
Hospice Care (inpatient facility or at-home care)	No charge
Home Health Care	No charge
Medical Devices (including Durable Medical Equipment)	25% of Plan Allowance (limited to a total plan payment of \$7,500 per calendar year)
<b>Vision Services</b>	
Annual Routine Vision Examinations (additional charge for contact lens exam) • Participating Vision Center (no referral required) • Ophthalmologist (referral required) • Limited to 1 per calendar year	\$10 Copay \$25 Copay
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers

**Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Physician (PCP). To select a PCP, go to [www.carefirst.com](http://www.carefirst.com) for the most current listing of PCPs from our online provider directory. You may also call the Member Services toll free phone number on the front of your CareFirst BlueChoice ID card for assistance in selecting a PCP.**

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

Policy Form Numbers: DC/BC/GC 2/02; DC/BC/EOC 2/02; DC/BC/DOC 2/02; DC/BC-OOP/ATTB (R. 7/03); DC/BC/ATTC 2/02 and any amendments.