

BlueChoice

DISTRICT OF COLUMBIA GROUPS

Summary of Benefits

SERVICES	IN-NETWORK YOU PAY
Out-of-Pocket Maximums	
• Individual	\$2,500
• Two Party/Family	\$5,000
Lifetime Maximum (per person)	None
Individual Deductible	\$500
Preventive Services and Office Visits	
Routine/Adult Health Exam	\$10 PCP/\$20 Specialist
Well-Child Care	\$10 PCP/\$20 Specialist
Mammogram (one exam per benefit period)	No Copay at approved locations
Allergy Treatment (testing and shots)	\$10 PCP/\$20 Specialist (if office visit copay paid, additional allergy copay not required)
Outpatient Chiropractic Services (limited to 20 visits per condition/calendar year)	\$20 Copay per visit, then deductible
Gynecological Visit (no copay for Pap Test)	\$10 PCP/\$20 Specialist (no Copay for Pap Smears)
X-ray & Lab Tests	No Copay, at approved locations
Maternity	
Prenatal & Postnatal	\$10 PCP/\$20 Specialist (not to exceed 10 times the copay per pregnancy)
Delivery & Hospitalization	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No Copay, after deductible
Hospitalization (365 days per year/inpatient)	
Room & Board (semi-private)	Deductible, then 20% of Allowed Benefit
Physician Services	No Copay, after deductible
Prescription Drug (inpatient)	No Copay, after deductible
Ancillary Services	No Copay, after deductible
Mental Health Care	
Outpatient Services	Visits 1-40, 25% of Allowed Benefit Visits 41+, 40% of Allowed Benefit
Inpatient Facility Services (limited to 45 days per calendar year. May substitute 2 partial hospitalization days for one full inpatient day)	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services (limited to 1 visit per day)	No Copay, after deductible

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SERVICES	IN-NETWORK YOU PAY
Substance Abuse Services	
Outpatient Services (limited to 40 visits per calendar year)	\$20 Copay per visit, then deductible
Inpatient Facility Services (limited to 30 days per calendar year. May substitute 2 partial hospitalization days for one full inpatient day)	Deductible, then 20% of Allowed Benefit
Inpatient Physician Service (1 visit per day)	No Copay, after deductible
Emergency Services	
In Plan Urgent Care Center	\$20 Copay, then deductible
Emergency Room	\$100 Copay (waived if admitted as inpatient)
Ambulance	No Copay, after deductible
Miscellaneous Services	
Skilled Nursing Facility	No Copay, after deductible
Hospice Care (inpatient facility or at-home care, limited to 180 day benefit period unless otherwise authorized)	No Copay, after deductible
Home Health Care	No Copay, after deductible
Medical Devices (including Durable Medical Equipment)	Deductible, then 25% of Allowed Benefit (limited to a total plan payment of \$7,500 per calendar year)
Vision Services	
Annual Routine Vision Examinations • Participating Vision Center (no referral required) • Limited to 1 per calendar year	\$10 Copay \$25 at Plan physician offices
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 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/SOB (R. 6/04); DC/BC/ATTC 2/02 and any amendments.