

BlueChoice Opt-Out Plus

Summary of Benefits

DISTRICT OF COLUMBIA

SUMMARY OF SERVICES	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY ¹
Annual Deductible and Maximums		
<ul style="list-style-type: none"> • Single Coverage • Two-Party (Subscriber & Child, Subscriber & Spouse)⁴ • Family 	\$2,000 maximum annual copay \$3,200 maximum annual copay \$6,000 maximum annual copay	\$2,500 out-of-pocket limit \$5,000 out-of-pocket limit \$5,000 out-of-pocket limit
Annual Deductible ³ <ul style="list-style-type: none"> • Single Coverage • Two-Party/Family 	No deductible No deductible	\$500 \$1,000
Lifetime Maximum Per Person	Unlimited	\$1,000,000
Preventive Services and Office Visits		
Well Child	\$10 PCP/\$20 Specialist	20% of Plan Allowance*
Mammograms	No charge at approved locations	Amounts in excess of Plan Allowance
Allergy Treatment (testing and shots)	\$10 PCP/\$20 Specialist (if office visit copay paid, additional allergy copay not required)	Deductible, then 20% of Plan Allowance
Pap Test	No charge	Amounts in excess of Plan Allowance
Office Visit for Illness	\$10 PCP/\$20 Specialist	Deductible, then 20% of Plan Allowance
Outpatient Chiropractic Services	\$20 Specialist (limited to 20 visits per calendar year)	Deductible, then 20% of Plan Allowance
Laboratory Tests and X-rays	No charge at approved locations	Deductible, then 20% of Plan Allowance
Maternity Services		
Prenatal and Postnatal Care	\$10 PCP/\$20 Specialist (up to 10 times the copay per pregnancy)	Deductible, then 20% of Plan Allowance
Hospital Services	No charge	Deductible, then 20% of Plan Allowance
Hospital Services		
Inpatient Physician Services	No charge	Deductible, then 20% of Plan Allowance
Inpatient Facility Services	No charge	Deductible, then 20% of Plan Allowance
Outpatient Physician Services	No charge	Deductible, then 20% of Plan Allowance

(Continued next side)

¹ All Out-of-Network services except those marked with an asterisk (*) are subject to a deductible. The member is responsible for Out-of-Network charges that exceed the Plan Allowance unless the services are rendered by a CareFirst BlueCross BlueShield Participating Provider. Out-of-Network coinsurances are based on a percentage of the CareFirst BlueCross BlueShield Plan Allowance.

² Must contact CareFirst BlueChoice within 48 hours or by the end of the first business day following the rendering of care, whichever is later.

³ The family or two-party deductible will be met when two covered family members each meet the individual deductible.

⁴ The family or two-party Out-of-Network Out-of-Pocket Maximum will be met when two covered family members each meet the individual Out-of-Network Out-of-Pocket Maximum.

SUMMARY OF SERVICES	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY ¹
Mental Health/Alcohol and Substance Abuse		
Inpatient Hospitalization for Mental Illness (may substitute 2 partial hospitalization days for 1 full day)	No charge (limited to 45 days per calendar year)	Deductible, then 20% of Plan Allowance (limited to 45 days per calendar year)
Inpatient Hospitalization for Substance Abuse	No charge (limited to 30 days per calendar year)	Deductible, then 20% of Plan Allowance (limited to 30 days per calendar year)
Outpatient Visits		
• Mental Illness	Visits 1–40: 25% of Allowed Benefit Visits 41+: 40% of Allowed Benefit	Visits 1-40: Deductible, then 25% of Plan Allowance Visits 41+: Deductible, then 40% of Plan Allowance
• Alcohol & Drug Abuse	\$20 Copay (limited to 40 visits per calendar year)	Deductible, then 20% of Plan Allowance (limited to 30 visits per calendar year)
Physical Rehabilitation		
Inpatient Facility Services	No charge	Deductible, then 20% of Plan Allowance
Inpatient Physical Therapist Services	No charge	Deductible, then 20% of Plan Allowance
Outpatient Services	\$20 Specialist Copay (limited to 30 days per condition per calendar year)	Deductible, then 20% of Plan Allowance
Emergency Services²		
Urgent Care Center	\$20 Copay at participating facilities	Deductible, then 20% of Plan Allowance
Emergency Room or Non-Participating Urgent Care Center	\$50 Copay (waived if admitted)	Deductible, then 20% of Plan Allowance
Ambulance	No charge	Deductible, then 20% of Plan Allowance
Miscellaneous Services		
Home Health Care	No charge	Deductible, then 20% of Plan Allowance
Skilled Nursing Facility	No charge	Deductible, then 20% of Plan Allowance
Hospice Care	No charge	Deductible, then 20% of Plan Allowance
Medical Devices (including Durable Medical Equipment)	25% of Allowed Benefit (limited to a Plan payment of \$7,500 per calendar year)	Deductible, then 20% of Plan Allowance
Vision Services		
Annual Routine Vision Exams (additional charge for contact lens exams)		
• Participating Vision Center (no referral required)	\$10 Copay	Not covered
• Ophthalmologist (referral required)	\$25 Copay	Not covered
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

Note: Upon enrollment in CareFirst BlueChoice Opt-Out Plus, you must 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/CCH/CC GC 8/95; DC/CCH/CC GPS 8/95; DC/CCH/CC COC 8/96; DC/CCH/CC DOCS 8/96; DC/BC-OOP/SOB (R. 6/04); DC/CCH NCA GC 9/96; DC/CCH/NCA COC 8/96; DC/DOCS 8/96; CMM/DC-9/96; DC/CCH/NCA ELIG 6/97 and any amendments.

Medical **4**
Option

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