

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 | \$2,000 out-of-pocket limit \$4,000 out-of-pocket limit \$4,000 out-of-pocket limit |
| Annual Deductible ³ <ul style="list-style-type: none"> • Single Coverage • Two-Party/Family | No deductible No deductible | \$300 \$600 |
| Lifetime Maximum Per Person | Unlimited | \$1,000,000 |
| Preventive Services and Office Visits | | |
| Well Child | \$20 PCP/\$30 Specialist | 20% of Plan Allowance* |
| Mammograms | No charge at approved locations | Amounts in excess of Plan Allowance |
| Allergy Treatment (testing and shots) | \$20 PCP/\$30 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 | \$20 PCP/\$30 Specialist | Deductible, then 20% of Plan Allowance |
| Outpatient Chiropractic Services | \$30 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 | \$20 PCP/\$30 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 | \$30 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 | \$30 Specialist Copay (limited to 30 days per condition per calendar year) | Deductible, then 20% of Plan Allowance |
| Emergency Services² | | |
| Urgent Care Center | \$30 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.