

BlueChoice Opt-Out *Plus* • Open Access

No referrals required for specialists

EPISCOPAL DIOCESE OF WASHINGTON

SUMMARY OF SERVICES	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY ¹
Annual Deductible and Maximums		
• Single Coverage • Family Aggregate	\$2,750 maximum annual copay \$7,500 maximum annual copay	\$3,000 \$6,000
Lifetime Maximum Per Person	Unlimited	\$1,000,000
Annual Out-of-Network deductible ³ • Single Coverage • Two-Party/Family	Not applicable Not applicable	\$500 \$1000
Preventive Services and Office Visits		
Office Visit for Illness	\$15 PCP/ \$25 Specialist	Deductible then, 20% of Plan Allowance
Well child	\$15 PCP/ \$25 Specialist	20% of Plan Allowance*
Pap test	No charge	No Charge
Mammograms	No charge at approved locations	No Charge
Infertility counseling, testing and Artificial Insemination	\$15 PCP/ \$25 Specialist	Deductible then, 20% of Plan Allowance (Artificial Insemination not covered)
Laboratory tests and X-rays	No charge at approved locations	Deductible then, 20% of Plan Allowance
Allergy Shots or Testing	\$15 PCP/ \$25 Specialist (if office visit copay paid, additional allergy copay not required)	Deductible then, 20% of Plan Allowance
Outpatient Chiropractic Services (limited to 20 visits per calendar year)	\$25 Specialist	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	\$15 PCP/ \$25 Specialist	Deductible then, 20% of Plan Allowance
Outpatient Facility Services including Outpatient Surgery	No charge	Deductible then, 20% of Plan Allowance
Emergency Services ²		
Urgent Care Center	\$25 Copay at participating facilities	Paid as in-network if true emergency
Emergency room or Non-participating Urgent Care Center	\$25 Copay (waived if admitted)	Paid as in-network if true emergency
Ambulance	No charge	Paid as in-network if true emergency

Note: Upon enrollment in 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 BlueChoice ID card for assistance in selecting a PCP.

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.

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.

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Maternity Services		
Prenatal and postnatal care	\$15 PCP/ \$25 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
Physical Rehabilitation		
Inpatient Services (limited to 90 days/calendar year)	No charge	Deductible then, 20% of Plan Allowance
Inpatient Physical Therapist Services	No charge	Deductible then, 20% of Plan Allowance
Outpatient Services	\$25 copay	Deductible then, 20% of Plan Allowance
Mental Health/Alcohol and Substance Abuse		
Inpatient Hospitalization for Mental Illness (may substitute 2 partial hospitalization days for 1 full day)	20% of Plan Allowance (limited to 30 days per calendar year)	Deductible then, 20% of Plan Allowance (limited to 45 days per calendar year)
Inpatient Hospitalization for Substance Abuse	20% of Plan Allowance (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 1–20: \$25 Copay (combined visits)	Visits 1–40: Deductible, then 25% of Plan Allowance Visits 41+: Deductible, then 40% of Plan Allowance
• Alcohol & Drug Abuse		Deductible then, 20% of Plan Allowance (limited to 30 visits per calendar year)
Inpatient Medical Detoxification	No charge	Deductible then, 20% of Plan Allowance
Additional Medical 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)	Not covered	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

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 BEN 8/96; DC/CCH/ATTB 6/01; 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.