Smithsonian Institution Health Care Plan Options

Summary of Benefits

	BlueChoice HMO *Open Access*	BlueChoice Opt-Out Plus POS *Open Access*		BluePreferred PPO	
SERVICES	**In-Network You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**	**Preferred Provider In-Network You Pay**	**Non-Preferred Providers Out-of-Network You Pay**
ANNUAL DEDUCTIBLE (Calendar year)					
Individual Family	None None	None None	$300 $600	$250 $500	$500 $1,000
ANNUAL OUT-OF-POCKET LIMIT (Calendar year)					
Medical	$1,900 Individual/$3,000 Two party/ $5,500 Family	$2,000 Individual/$3,200 Two party/ $6,000 Family	$2,000 Individual/$4,000 Two party/ $4,000 Family	$1,500 Individual/$3,000 Family	$3,000 Individual/$6,000 Family
Prescription Drug	$3,500 Individual/$7,000 Family	$3,500 Individual/$7,000 Family	All drug costs are subject to in-network out-of-pocket maximum	$4,500 Individual/$9,000 Family	All drug costs are subject to in-network out-of-pocket maximum
LIFETIME MAXIMUM	None	None	None	None	None
PREVENTIVE SERVICES					
Well-Child Care 0–24 months 24 months–13 years (immunization visit) 24 months–13 years (non-immunization visit) 14–17 years	 No charge No charge No charge No charge	 No charge No charge No charge No charge	 20% of Allowed Benefit 20% of Allowed Benefit 20% of Allowed Benefit 20% of Allowed Benefit	 No charge No charge No charge No charge	 Plan pays 100% of Allowed Benefit Plan pays 100% of Allowed Benefit Plan pays 100% of Allowed Benefit Plan pays 100% of Allowed Benefit
Adult Physical Examination	No charge	No charge	Not covered	No charge	Deductible, then 30% of Allowed Benefit
Routine GYN Visits	No charge	No charge	20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Mammograms	No charge	No charge	Plan pays 100% of Allowed Benefit	No charge	30% Allowed Benefit
Cancer Screening Prostate and Colorectal Pap Test	No charge No charge	No charge No charge	Plan pays 100% of Allowed Benefit Plan pays 100% of Allowed Benefit	No charge No charge	Deductible, then 30% of Allowed Benefit 30% of Allowed Benefit
OFFICE VISITS, LABS & TESTING					
Office Visits for Illness	$15 PCP/$25 Specialist per visit	$15 PCP/$25 Specialist per visit	Deductible, then 20% of Allowed Benefit	$20 per visit	Deductible, then 30% of Allowed Benefit
Diagnostic Services	$15 PCP/$25 Specialist per visit	$15 PCP/$25 Specialist per visit	Deductible, then 20% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
X-ray and Lab Tests	No charge	No charge	Deductible, then 20% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Allergy Testing	$15 PCP/$25 Specialist per visit	$15 PCP/$25 Specialist per visit	Deductible, then 20% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Allergy Shots	$15 PCP/$25 Specialist per visit	$15 PCP/$25 Specialist per visit	Deductible, then 20% of Allowed Benefit	$5 per visit	Deductible, then 30% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy	$25 per visit (limited to 30 visits/condition/ benefit period)	$25 per visit (limited to 30 visits/condition/ benefit period)	Deductible, then 20% of Allowed Benefit	$20 per visit (limited to 30 visits/condition/ benefit period)	Deductible, then 30% of Allowed Benefit
Outpatient Chiropractic	$25 per visit (limited to 20 visits/benefit period)	$25 per visit (limited to 20 visits/benefit period)	Deductible, then 20% of Allowed Benefit	$20 per visit (limited to 20 visits/benefit period)	Deductible, then 30% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE					
Physician's Office	$15 PCP/$25 Specialist per visit	$15 PCP/$25 Specialist per visit	Deductible, then 20% of Allowed Benefit	$20 per visit	Deductible, then 30% of Allowed Benefit
Urgent Care Center	$25 per visit	$25 per visit	Paid as in-network	$20 per visit	Paid as in-network
Hospital Emergency Room	$100 per visit (waived if admitted)	$100 per visit (waived if admitted)	Paid as in-network	$100 per visit (copay waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	No charge	No charge	Deductible, then 20% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
HOSPITALIZATION					
Inpatient Facility Services	No charge after $200 per admission copay	No charge after $200 per admission copay	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	$15 PCP/$25 Specialist per visit	$15 PCP/$25 Specialist per visit	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Outpatient Surgical Professional Services	$15 PCP/$25 Specialist per visit	$15 PCP/$25 Specialist per visit	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit

SERVICES	BlueChoice HMO *Open Access*	BlueChoice Opt-Out Plus POS *Open Access*		BluePreferred PPO	
	In-Network You Pay	In-Network You Pay	Out-Of-Network You Pay	Preferred Provider In-Network You Pay	Non-Preferred Providers Out-Of-Network You Pay
HOSPITAL ALTERNATIVES					
Home Health Care	No charge	No charge	Deductible, then 20% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hospice	No charge	No charge	Deductible, then 20% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Skilled Nursing Facility	No charge	No charge	Deductible, then 20% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MATERNITY					
Prenatal and Postnatal Office Visits	No charge	No charge	No charge	No charge	No charge
Delivery and Facility Services	No charge after $200 per admission copay	No charge after $200 per admission copay	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Nursery Care of Newborn	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Initial Office Consulation(s) for Infertility Services/Procedures	$15 PCP/$25 Specialist per visit	$25 Specialist per visit	Deductible, then 20% of Allowed Benefit	$20 per visit	Deductible, then 30% of Allowed Benefit
Artificial Insemination	$25 per visit	$25 per visit	Not covered	Not covered	Not covered
In Vitro Fertilization Procedures	Not covered	Not covered	Not covered	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE					
Inpatient Facility Services	No charge after $200 per admission copay	No charge after $200 per admission copay	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Outpatient Services	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Office Visits for Mental Health and Substance Abuse	$15 per visit	$15 per visit	Deductible, then 20% of Allowed Benefit	$20 per visit	Deductible, then 30% of Allowed Benefit
Partial Hospitalization	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge	Deductible, then 30% of Allowed Benefit
Medication Management Visit	$15 per visit	$15 per visit	Deductible, then 20% of Allowed Benefit	$20 per visit	Deductible, then 30% of Allowed Benefit
MISCELLANEOUS					
Durable Medical Equipment	25% of Allowed Benefit	25% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by the Plan when used for anesthesia)	Not covered (except when approved or authorized by the Plan when used for anesthesia)	Not covered (except when approved or authorized by the Plan when used for anesthesia)	Only when Plan approved for anesthesia	Only when Plan approved for anesthesia
Transplants	Covered as stated in Evidence of Coverage	Covered as stated in Evidence of Coverage	Covered as stated in Evidence of Coverage	Covered as stated in Evidence of Coverage	Covered as stated in Evidence of Coverage
Hearing Aids for ages 0–18	25% of Allowed Benefit	25% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
VISION					
Routine Exam (limited to 1 visit/benefit period)	$10 per visit	$10 per visit	Not covered	$10 per visit at participating vision provider	Plan pays $33
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Discounts from participating Vision Centers	Not covered	Discounts from participating Vision Centers	Not covered

Not all services and procedures are covered by your benefits contract. This list is a summary and is not intended to itemize every procedure not covered by CareFirst BlueCross BlueShield. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Prescription Drugs (no annual maximum)

Annual Deductible $100 Individual/$200 Family

	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug	Self-administered Injectibles
Retail	$10 copay	$30 copay	$55 copay	50% to a maximum of $75
Maintenance drugs	$20 copay	$60 copay	$110 copay	50% to a maximum of $150

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