2021 Summary of Benefits

Washington Gas Life, Under 65 Retirees

Services	Preferred Providers In-network You Pay[1]	Non-Preferred Providers Out-of-network You Pay[2]
	Visit carefirst.com/doctor to locate providers	
ANNUAL DEDUCTIBLE AND ANNUAL OUT-OF-POCKET MAXIMUMS		
Deductible ▪ Individual ▪ Family[3]	 $100 $200	 $500 $1,000
Out-of-Pocket Limit ▪ Individual ▪ Family[4]	 $1,500 $3,000	 $3,000 $6,000
Lifetime Maximum Per Person	Unlimited	Unlimited
PREVENTIVE SERVICES AND OFFICE VISITS		
Routine Adult Physical Exam	No charge	30% of Allowed Benefit
Well-Child Care (including immunizations)	No charge	Plan pays 100% of Allowed Benefit
Cancer Screenings (Prostate-PSA/DRE, Pap Test, Mammogram*)	No charge	Plan pays 100% of Allowed Benefit
Office Visits	$10 Copay	Deductible, then 30% of Allowed Benefit
Allergy Shots	$5 Copay	Deductible, then 30% of Allowed Benefit
Allergy Testing	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Therapy	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Laboratory Tests and X-Rays	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Acupuncture (Limited to $1,000 per year)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Chiropractic Care	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MATERNITY SERVICES		
Prenatal & Postnatal Care	No charge	Deductible, then 30% of Allowed Benefit
Delivery and Hospitalization	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Physician Visit	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Diagnostic Services & Lab Tests	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Infertility Treatment (lifetime maximum of $20,000)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
EMERGENCY SERVICES		
Urgent Care Center	$10 Copay	Deductible, then 30% of Allowed Benefit
Emergency Room (copay waived if admitted; copay applies to outpatient observation)	$100 Copay, then Deductible and 20% of Allowed Benefit	Paid as in-network for bona fide medical emergencies
Physician's Office	$10 Copay	Deductible, then 30% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 visits per episode of care)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hospice	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days per calendar year)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
HOSPITALIZATION (INCLUDES SEMI-PRIVATE ROOM ONLY)		
Inpatient Medical Facility	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Medical Facility	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Medical Physician	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit

2021 Summary of Benefits

Services	Preferred Providers In-network You Pay[1]	Non-Preferred Providers Out-of-network You Pay[2]
MEDICAL AND SURGICAL SERVICES		
Outpatient Specialty Physician (office visit)	$10 copay	Deductible, then 30% of Allowed Benefit
Outpatient Surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Diagnostic Tests, X-ray, Anesthesia, Lab Tests and Other Related Services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MISCELLANEOUS SERVICES		
Ambulance (if medically necessary)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Medical Devices (including Durable Medical Equipment)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hearing Aids5 (limited to $1,000 per hearing aid every three years)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER		
(Benefits will be provided at the same level as for Preventive Services and Office Visits, Hospitalization and Emergency Care for covered services rendered in connection with the diagnoses: schizophrenia, schizoaffective disorder, attention deficit hyperactivity disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, autism, panic disorder and drug and alcohol addiction.)		
Inpatient Hospitalization (Must be authorized in advance under Utilization Management requirements.)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Partial Hospitalization	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Visits	$10 copay	Deductible, then 30% of Allowed Benefit
Custodial Care	Not covered	Not covered
Prescription Drug Card	Provided through Washington Gas' Caremark Rx Program	
DENTAL SERVICES		
Provided through CareFirst BCBS	Maximum of $1,000	
VISION SERVICES (PROVIDED THROUGH BLUEVISION)		
Annual Routine Vision Exams	$10 copay	Total charge minus $33
Eyeglasses and Contact Lenses	Discounts available from Participating Providers	Not covered

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* One baseline mammogram between the ages of 35-39. One screening once every 12 months beginning at age 40+.

[1] In-network: When you have care rendered by a provider in the Preferred Provider network. In-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueCross BlueShield (CareFirst), however, in certain circumstances, an allowance may be established by law.

[2] Out-of-network: When you have care rendered by a provider not in the Preferred Provider network, care is reimbursed as out-of-network. Out-of-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Participating Providers have agreed to accept as payment of covered services. These payments are established by CareFirst, however, in certain circumstances, an allowance may be established by law. When services are rendered by Non-Participating Providers, charges in excess of the Allowed Benefit are the member's responsibility.

[3] The Family deductible may be met by combining the eligible expenses of all eligible family members. An individual family member cannot contribute more than the Individual deductible toward meeting the Family deductible.

[4] The Family out-of-pocket maximum may be met by combining the eligible expenses of all eligible family members. An individual family member cannot contribute more than the Individual out-of-pocket maximum toward meeting the Family out-of-pocket maximum.

[5] Note: Hearing Aids will be covered to a maximum of $1,000 per ear every 36 months.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

CareFirst
Family of health care plans

CST5003-1P (10/20)