

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

**Marymount University, Inc**  
**BlueChoice Advantage HSA**

**Coverage Period:** 01/01/2025 – 12/31/2025  
**Coverage for:** Individual | **Plan Type:** POS-HSA



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

**This is only a summary.** For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can see the Glossary at [www.carefirst.com/sbcg](http://www.carefirst.com/sbcg) or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit [www.carefirst.com](http://www.carefirst.com).

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In-Network: \$1,650 individual/\$3,300 family; Out-of-Network: \$3,300 individual/\$6,600 family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family member(s) on the <a href="#">plan</a> , each family member may need to meet their own individual <a href="#">deductible</a> , OR all family members may combine to meet the overall family <a href="#">deductible</a> before the <a href="#">plan</a> begins to pay, depending upon plan coverage. Please refer to your contract for further details.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, all In-Network preventive care services.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Prescription drug and medical combined.	You must pay all the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Medical and Prescription Drug combined: In-Network: \$3,500 individual/\$7,000 family; Out-of-Network: \$7,000 individual/\$14,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a <a href="#">plan</a> year for covered services. If you have other family member(s) on the <a href="#">plan</a> , each family member may need to meet their own <a href="#">out-of-pocket limits</a> , OR all family members may combine to meet the overall family <a href="#">out-of-pocket limit</a> , depending upon <a href="#">plan</a> coverage. Please refer to your contract for further details.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.carefirst.com">www.carefirst.com</a> or call 855-258-6518 for a list of Network providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	<a href="#">Specialist</a> visit	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	20% of Allowed Benefit	Some services may have limitations or exclusions based on your contract
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab Tests: Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Lab Tests: Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	In-Network Lab Test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://www.carefirst.com/rxgroup">prescription drug coverage</a> is available at <a href="https://www.carefirst.com/rxgroup">www.carefirst.com/rxgroup</a>	Generic drugs	Deductible, then 20% of Allowed Benefit up to a minimum of \$10 and maximum of \$20	Not Covered	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 34-day supply; Up to 90-day supply of maintenance drugs is 2 copays; <b>Specialty Drugs:</b> Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
	Preferred brand drugs	Deductible, then 20% of Allowed Benefit up to a minimum of \$25 and maximum of \$50	Not Covered	
	Non-preferred brand drugs	Deductible, then 20% of Allowed Benefit up to a minimum of \$40 and maximum of \$80	Not Covered	
	Preferred <a href="#">Specialty drugs</a>	Deductible, then 20% of Allowed Benefit up to a minimum of \$10 and maximum of \$20/minimum of \$25 and maximum of \$50/minimum of \$40 and maximum of \$80; Deductible, then 50% of Allowed Benefit up to \$100	Not Covered	
	Non-preferred <a href="#">Specialty drugs</a>	Deductible, then 20% of Allowed Benefit up to a minimum of \$10 and maximum of \$20/minimum of \$25 and maximum of \$50/minimum of \$40 and maximum of \$80; Deductible, then 50% of Allowed Benefit up to \$100	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Deductible, then 20% of Allowed Benefit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply
	<a href="#">Emergency medical transportation</a>	Deductible, then 20% of Allowed Benefit	Paid As In-Network	None
	<a href="#">Urgent care</a>	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to unexpected, urgently required services
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit & Hospital Facility: Deductible, then 20% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 40% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
<b>If you are pregnant</b>	Office visits	No Charge	Deductible, then 40% of Allowed Benefit	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Additional professional charges may apply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required Benefits are limited to 90 days per benefit period. Renews when care not received for 60 consecutive days
	<a href="#">Rehabilitation services</a>	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	<a href="#">Habilitation services</a>	Provider & Hospital Facility: Not Covered	Provider & Hospital Facility: Not Covered	None
	<a href="#">Skilled nursing care</a>	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required Benefits are limited to 60 days per benefit period
	<a href="#">Durable medical equipment</a>	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	<a href="#">Hospice services</a>	Inpatient and Outpatient Facility: Deductible, then 20% of Allowed Benefit	Inpatient and Outpatient Facility: Deductible, then 40% of Allowed Benefit	Prior authorization is required Hospice Maximum: Benefits are limited to 180 lifetime days inpatient/outpatient combined. 180 days inpatient per lifetime Bereavement: Services must be rendered within 90 days following the death of a covered Member Family Counseling: Applies to the 180-day Hospice Maximum Respite Care: Benefits are limited to 3 period of 48 hours in 180-day period
<b>If your child needs dental or eye care</b>	Children's eye exam	\$10 copay per visit	Plan pays \$33; Member pays balance	Benefits are limited to 1 visit per benefit period
	Children's glasses	Discount programs available to all Members	Not Covered	Benefits are limited to 1 set of glasses/lenses per benefit period
	Children's dental check-up	Not Covered	Not Covered	None

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Long-term care</li><li>• </li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Abortion</li><li>• Bariatric surgery</li><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Coverage provided outside the US. See <a href="http://www.carefirst.com">www.carefirst.com</a></li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Non-emergency care when travelling outside the US</li><li>• Routine eye care</li></ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565.

**Does this plan provide Minimum Essential Coverage? Yes**  
[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**  
If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**  
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.  
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.  
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518.  
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-258-6518.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,650
■ <a href="#">Specialist</a> Coinsurance	20%
■ Hospital (facility) Coinsurance	20%
■ Other Coinsurance	20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,650
Copayments	\$0
Coinsurance	\$1,670
What isn't covered	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$3,330</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,650
■ <a href="#">Specialist</a> Coinsurance	20%
■ Hospital (facility) Coinsurance	20%
■ Other Coinsurance	20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,650
Copayments	\$305
Coinsurance	\$695
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,650</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,650
■ <a href="#">Specialist</a> Coinsurance	20%
■ Hospital (facility) Coinsurance	20%
■ Other Coinsurance	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,650
Copayments	\$10
Coinsurance	\$228
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,888</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.