BlueChoice Advantage HSA Summary of Benefits

Marymount University

Integrated Deductible

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Visit www.carefirst.com/doctor to locate providers and facilities	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
WELLBEING PROGRAM		
Visit **www.carefirst.com/wellbeing** for more information.	You have access to a comprehensive wellbeing program as part of your medical plan.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$1,650	$3,300
Family	$3,300	$6,600
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$3,500 Individual/$7,000 Family	$7,000 Individual/$14,000 Family
Prescription Drug[6]	Combined with in-network medical out-of-pocket maximum	All drug costs are subject to in-network out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	20% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	20% of Allowed Benefit
Breast Cancer Screening	No charge*	20% of Allowed Benefit
Pap Test	No charge*	20% of Allowed Benefit
Prostate Cancer Screening	No charge*	20% of Allowed Benefit
Colorectal Cancer Screening	No charge*	20% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)[8]	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Lab[8]	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
X-ray[8]	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Allergy Testing	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Allergy Shots	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Physical, Speech and Occupational Therapy[9] (limited to 30 visits/injury/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Chiropractic (limited to 20 visits/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Acupuncture (limited to 20 visits/benefit period)	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)

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EMERGENCY SERVICES		
Urgent Care Center	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Emergency Room—Facility Services	Deductible, then 20% of Allowed Benefit (waived if admitted)	In-network deductible then 40% of Allowed Benefit (waived if admitted)
Emergency Room—Physician Services	No charge* after deductible	No charge* after in-network deductible
Ambulance (if medically necessary)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
HOSPITALIZATION—(Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Hospice	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Artificial and Intrauterine Insemination[10]	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
In Vitro Fertilization Procedures[10]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Office Visits	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing-impaired ear, up to $1,500, every 24 months)	Not covered	Not covered
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per exam	Total charge minus $33 Allowed Benefit
Eyeglasses and Contact Lenses	Discounts from participating vision centers	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.

* No copayment or coinsurance.

1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

2 In-network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level.

3 Out-of-network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

4 For family coverage only: The family deductible must be met before any member starts receiving benefits. The deductible may be met by one member or any combination of members.

5 For family coverage only: The family out-of-pocket maximum must be met before any member's services will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum may be met by one member or any combination of members.

6 Plan has integrated medical and prescription drug out-of-pocket maximum.

7 CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross Blue Shield products or services and is providing in person and telehealth services to CareFirst members. Atlas Health, LLC is a corporate affiliate within the CareFirst, Inc. corporate umbrella of companies.

8 Members accessing laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) must use LabCorp as their Lab Test facility and a non-hospital/freestanding facility for X-rays and specialty Imaging for In-Network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered Out-of-Network. Members accessing laboratory, X-rays, and specialty Imaging services outside of Maryland, D.C. or Northern Virginia, may use any participating BlueCard PPO facility and receive in-network benefits.

9 Visit Limitation does not apply to children ages 2-10 when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.

10 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

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.

The benefits described are issued under form numbers: VA/CFBC/GC (R. 1/24); VA/CFBC/LG/POS/EOC (1/24); VA/CFBC/DOL APPEAL (R. 1/24); VA/CFBC/LG/POS/DOCS (1/25); VA/CFBC/LG/POS/SOB (1/25); VA/CFBC/RX3 (R. 1/25); VA/CFBC/LG/SELECT PROV (1/25); VA/CFBC/LG/INCENT (R. 1/25); VA/CFBC/ATTC (R. 1/10) and any amendments.

CareFirst

Family of health care plans

Exclusions

Coverage is not provided for:

A. Any services, tests, procedures, or supplies which CareFirst BlueChoice determines are not necessary for the prevention, diagnosis, or treatment of the Member's illness, injury, or condition. Although a service or supply may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.

B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in CareFirst BlueChoice's judgment, is Experimental/Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for clinical trials.

C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under this Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.

D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that do not meet all other conditions and criteria for coverage as determined by CareFirst BlueChoice.

E. Routine, palliative or Cosmetic foot care (except for conditions determined by CareFirst BlueChoice to be Medically Necessary) including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

F. Any type of dental care (except treatment of accidental bodily injuries or oral surgery, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess and periodontal disease, removal of teeth, orthodontics, replacement of teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. All other procedures involving the teeth or areas and structures surrounding and/or supporting the teeth, including surgically altering the mandible or maxillae (orthognathic surgery) for Cosmetic purposes or for correction of malocclusion unrelated to a documented functional impairment are excluded.

G. Benefits will not be provided for Cosmetic surgery (except as specifically provided for Reconstructive Breast Surgery and Reconstructive Surgery and services for cleft lip or cleft palate or both, as listed above) or other services primarily intended to correct, change or improve appearances.

H. Treatment rendered by a health care provider who is a member of the Member's family (parents, Spouse, domestic partner, brothers, sisters, and children).

I. Any Prescription Drugs obtained and self-administered by the Member for outpatient use unless the Prescription Drug is specifically covered under the Evidence of Coverage. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility except as otherwise provided in this Description of Covered Services. Benefits for Prescription Drugs may be available through a rider attached to the Evidence of Coverage.

J. All non-Prescription Drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services or the Prescription Drug Benefits Rider attached to this Evidence of Coverage. Over-the-Counter means any item or supply, as determined by CareFirst BlueChoice, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

K. Voluntary sterilization of male Members and services to reverse voluntary, surgically induced infertility, such as a reversal of sterilization, for all Members.

L. All assisted reproductive technologies, including artificial insemination and intrauterine insemination, in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.

M. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; exercise programs; and use of passive or patient-activated exercise equipment other than Medically Necessary and approved Cardiac Rehabilitation and pulmonary rehabilitation programs.

N. Treatment for obesity, weight reduction, dietary control or commercial weight loss programs. This exclusion does not apply to:

1. Surgical treatment for morbid obesity;
2. Well child care visits for obesity evaluation and management;
3. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
4. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
5. Office visits for the treatment of childhood obesity; and
6. Professional Nutritional Counseling and Medical Nutrition Therapy.

O. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy or any other form of refractive keratoplasty.

P. Services furnished as a result of a referral prohibited by law.

Q. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst BlueChoice.

R. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.

S. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia

T. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may

have therapeutic value or be provided by a health care provider.
U. Coverage under this Evidence of Coverage does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
2. From any federal, state, county or municipal facility or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that Benefits are payable by the federal, state, county or municipal facility or other government agency and provided at no charge to the Member, but excluding Medicare benefits and Medicaid benefits.
   Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.

V. Private duty nursing.
W. Non-medical, health care provider services, including, but not limited to:

1. Telephone consultations, except as provided for telemedicine services in Section 1.1.AA, failure to keep a scheduled visit, completion of forms (except for forms that may be required by CareFirst BlueChoice), copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.
2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a health care provider.

X. Educational therapies intended to improve academic performance.
Y. Vocational rehabilitation and employment counseling.
Z. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact lenses may be available through a rider purchased by the group and attached to the Evidence of Coverage. This exclusion does not apply to evidence-informed preventive care and screenings, including oral and vision care, provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents.
AA. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).
BB. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
CC. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, drug therapy, and psychiatric treatment.
DD. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in Section 1.3, Organ and Tissue Transplants.
EE. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
FF. Services required solely for administrative purposes, for example: employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
Autism Spectrum Disorder. Coverage is not provided for:
A. Services delivered through school services.
Organ and Tissue Transplants. Coverage is not provided for:
A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary, non-experimental skin grafts that are covered under the Evidence of Coverage.
B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice that are not for the recipient Member and a companion (or two (2) companions if the Member is under age eighteen (18)).
D. Services for a Member who is an organ donor when the recipient is not a Member.
E. Benefits will not be provided for donor search services.
F. Any service, supply or device related to a transplant that is not listed as a benefit in the Evidence of Coverage.
Inpatient Hospital Services. Coverage is not provided for:
A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
B. Non-medical items and convenience items, such as television and phone rentals, guest trays and laundry charges.
C. Except for covered Emergency Services and Maternity Care (including interhospital transfers for mothers and newborns as stated in Section 2), a hospital admission or any portion of a hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage. See Utilization Management Non-Compliance provision in the Schedule of Benefits for exclusion of services or limitation of benefits, if any, for failure to comply with Utilization Management requirements.
D. Private duty nursing.
E. Admissions to a facility that is a convalescent home, convalescent rest or nursing facilities, facilities primarily affording custodial, educational or rehabilitative care, or facilities for the aged, drug addicts or alcoholics.
Home Health Services. Coverage is not provided for:
A. Private duty nursing.
B. Custodial Care.
Hospice Benefits. Coverage is not provided for:
A. Services, visits, medical equipment or supplies that are not included in CareFirst BlueChoice approved plan of treatment.
B. Financial and legal counseling.
C. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
D. Chemotherapy or radiation therapy, unless used for symptom control.
E. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.
F. Reimbursement for volunteer services.
G. Custodial Care, domestic or housekeeping services.
H. Meals on Wheels or similar food service arrangements.
I. Rental or purchase of renal dialysis equipment and supplies.
J. Private duty nursing.
Outpatient Mental Health and Substance Use Disorder. Coverage is not provided for:

A. Psychological testing, unless Medically Necessary, as determined by CareFirst BlueChoice, and appropriate within the scope of Covered Services.
B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
C. Intellectual disability, after diagnosis.
D. Psychoanalysis.

Inpatient Mental Health and Substance Use Disorder. Coverage is not provided for:
A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
B. Custodial Care.
C. Observation or isolation.

Emergency Services and Urgent Care. Benefits for Emergency Services and Urgent Care will not be provided for:
A. Charges for services when the claims filing and notice procedures stated in Section 7 of the Evidence of Coverage have not been followed by the Member.
B. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by the Member's treating physician.

Medical Devices and Supplies. Coverage is not provided for:
A. Convenience items.
B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g., chair or dresser.
C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, e.g., exercycle or other physical fitness equipment.
D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g., parallel bars.
E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids, except for Hearing Aids for minors, as described in Section N, Hearing Aids for Minors, of this amendment. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.
H. Medical equipment/supplies of an expendable nature, except those specifically listed as Covered Medical Supplies in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.
I. Tinnitus maskers; purchase, examination, or fitting of hearing aids, except as described in the Hearing Aids for Minors section.
J. Related charges for handling, delivery, mailing and shipping, and taxes for Durable Medical Equipment.