BlueChoice HMO Summary of Benefits

Marymount University

Services	In-Network You Pay[1]
	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)[2]	
Individual	None
Family	None
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[3]	
Medical[4]	$3,500 Individual/$6,000 Family
Prescription Drug[4]	Combined with in-network medical out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*
Breast Cancer Screening	No charge*
Pap Test	No charge*
Prostate Cancer Screening	No charge*
Colorectal Cancer Screening	No charge*
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	$25 PCP/ $40 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans)[6]	No charge*
Lab[6]	No charge*
X-ray[6]	No charge*
Allergy Testing	No charge*
Allergy Shots	$5 per visit
Physical, Speech and Occupational Therapy (limited to 30 visits/injury/benefit period)	$40 per visit
Chiropractic (limited to 20 visits/benefit period)	$40 per visit
Acupuncture (limited to 20 visits/benefit period)	Not covered (except when approved or authorized by Plan when used for anesthesia)

Services	In-Network You Pay[1]
EMERGENCY SERVICES	
Urgent Care Center	$40 per visit
Emergency Room—Facility Services	$150 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*
Ambulance (if medically necessary)	No charge*
HOSPITALIZATION—(Members are responsible for applicable physician and facility fees)	
Outpatient Facility Services	$200 per visit
Outpatient Physician Services	$25 PCP/$40 Specialist per visit
Inpatient Facility Services	$400 per admission
Inpatient Physician Services	No charge* PCP/$40 Specialist per visit
HOSPITAL ALTERNATIVES	
Home Health Care	No charge*
Hospice	No charge*
Skilled Nursing Facility	No charge*
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	$400 per admission
Nursery Care of Newborn	No charge*
Artificial and Intrauterine Insemination[7]	$200 Facility fee per visit
In Vitro Fertilization Procedures[7]	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)	
Inpatient Facility Services	$400 per admission
Inpatient Physician Services	$25 per visit
Outpatient Facility Services	$200 per visit
Outpatient Physician Services	$25 per visit
Office Visits	$25 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	25% 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
VISION	
Routine Exam (limited to 1 visit/benefit period)	$10 per visit
Eyeglasses and Contact Lenses	Discounts from participating vision centers

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 For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.

3 For family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum includes deductibles, copays and coinsurance.

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

5 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.

6 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.

7 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.

Reminder: To enroll in HMO, HMO Referral and Plus plans, members must live or work within the CareFirst service area of Maryland, Washington, D.C. or Northern Virginia.

Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Provider (PCP). To select a PCP, go to www.carefirst.com/findadoc for the most current listing of PCPs from our online provider directory. You may also call the Member Services number on the back of your CareFirst ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider directory.

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/HMO/EOC (1/24); VA/CFBC/DOL APPEAL (R. 1/24); VA/CFBC/LG/HMO/DOCS (1/25); VA/CFBC/LG/HMO/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 BlueChoice

Exclusions and Limitations

10.1 Coverage is Not Provided For**:**

A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst BlueChoice.

B. Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst BlueChoice.

C. The cost of services that:

1. Are furnished without charge; or

2. Are normally furnished without charge to persons without health insurance coverage; or

3. Would have been furnished without charge if the Member was not covered under the Evidence of Coverage or under any health insurance.

D. Services that are not described as covered in the Evidence of Coverage or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a Primary Care Physician and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.

E. Except for Emergency Services, Urgent Care and follow-up care after emergency surgery, benefits will not be provided for any service(s) provided to a Member by Non-Contracting Physicians or Non-Contracting Providers, unless written prior authorization is specifically obtained from CareFirst BlueChoice.

F. 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.

G. Except for treatment for Accidental Injury or benefits for Oral Surgery as described above, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.

H. Benefits will not be provided for cosmetic surgery (except as specifically provided for reconstructive breast surgery and reconstructive surgery as listed above) or other services primarily intended to correct, change or improve appearances.

I. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).

J. 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. Benefits for prescription drugs may be available through a rider purchased by the Group and attached to the Evidence of Coverage.

K. 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. 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.

L. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.

M. All assisted reproductive technologies (except artificial insemination and intrauterine insemination), including 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.

N. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; and use of passive or patient-activated exercise equipment.

O. Treatment for obesity except for the surgical treatment of Morbid Obesity.

P. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty.

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

R. 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.

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

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

U. 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.

V. Coverage under this Description of Covered Services 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.

W. Private duty nursing.

X. Non-medical, health care provider services, including, but not limited to:
1. Telephone consultations, failure to keep a scheduled visit, completion of forms, 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 Description of Covered Services are available for Covered Services rendered to the Member by a health care provider.
Y. Educational therapies intended to improve academic performance.
Z. Vocational rehabilitation and employment counseling.
AA. 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.
BB. 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).
CC. 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.
DD. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
EE. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in the Transplants section of this Description of Covered Services).
FF. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
GG. Services required solely for administrative purposes, for example: employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
10.2 Infertility Services. Coverage for Artificial Insemination (and intrauterine insemination) does not include the following:
A. Any costs associated with freezing, storage or thawing of sperm for future attempts or other use.
B. Any charges associated with donor sperm.
C. Infertility services that include the use of any surrogate or gestational carrier service.
D. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures, with or without reversal.
E. All self-administered fertility drugs.
10.3 Organ and Tissue Transplants. Benefits will not be provided for the following:
A. Non-human organs and their implantation.
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.
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 this Description of Covered Services.
10.4 Inpatient Hospital Services. Coverage is not provided for the following:
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, phone rentals, guest trays and laundry charges.
C. Except for covered Emergency Services and Childbirth (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.
D. Private duty nursing.
10.5 Home Health Services. Coverage is not provided for:
A. Private duty nursing.
B. Custodial Care.
C. Services in the Member's home if it is outside the Service Area.
10.6 Hospice Benefits. Coverage is not provided for:
A. Services, visits, medical equipment or supplies that are not included in the CareFirst BlueChoice-approved plan of treatment.
B. Services in the Member's home if it is outside the Service Area.
C. Financial and legal counseling.
D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
E. Chemotherapy or radiation therapy, unless used for symptom control.
F. 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.
G. Reimbursement for volunteer services.
H. Custodial Care, domestic or housekeeping services.
I Meals on Wheels or similar food service arrangements.
J. Rental or purchase of renal dialysis equipment and supplies.
K. Private duty nursing.
10.7 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. Mental retardation, after diagnosis.
D. Psychoanalysis.
10.8 Inpatient Mental Health and Substance. The following services are excluded:
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.
10.9 Emergency Services and Urgent Care. Benefits will not be provided for:
A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).

B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.
C. Charges for emergency and Urgent Care services received from a Non-Contracting Provider after the Member could reasonably be expected to travel to the nearest Contracting Provider.
D. Charges for services when the claims filing and notice procedures stated in Section 7 of this Description of Covered Services have not been followed by the Member.
E. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the emergency or Urgent Care facility outside of the Service Area unless CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care.
F. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.
G. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency Services as defined in Section 7 of this Description of Covered Services.

10.10 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 P, 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 a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.