BlueChoice HMO Summary of Benefits

Marymount University
HMO Plan

Services	In-network You Pay[1,2]
	Visit carefirst.com/marymount to locate providers
24-HOUR NURSE ADVICE LINE	
Free advice from a registered nurse. Visit **carefirst.com/marymount** 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.
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*
OFFIE VISITS, LABS AND TESTING	
Office Visits for Illness (Members are responsible for applicable physician and facility fees)	$25 PCP/$40 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans)	No charge*
Lab	No charge*
X-ray	No charge*
Allergy Testing	No charge*
Allergy Shots	$5 per visit
Physical, Speech and Occupational Therapy[5] (limited to 30 visits/condition/benefit period)	$40 per visit
Chiropractic (limited to 20 visits/benefit period)	$40 per visit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)
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

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Services	In-network You Pay[1,2]
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[6] (limited to 6 attempts per live birth)	$200 Facility fee per visit
In Vitro Fertilization Procedures[6]	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
Medication Management	$25 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	25% of Allowed Benefit
Hearing Aids	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.
[4] Plan has an integrated medical and prescription drug out-of-pocket maximum.
[5] Visit Limitation does not apply to children ages 2-10 when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.
[6] 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.

These benefits are issued under policy form numbers: VA/CFBC/GC (R. 1/13), VA/CFBC/DOCS (R. 1/09), VA/CFBC/EOC (R. 1/09), VA/BC-OOP/SOB (R. 1/09), VA/CFBC/ATTC (R. 1/10), VA/CFBC/DOL APPEAL (R. 7/12), VA/CFBC/RX3 (R. 1/15), and any amendments.

CareFirst
Family of health care plans