BlueChoice HMO

MARYMOUNT UNIVERSITY
Summary of Benefits

Services	In-Network You Pay[1]
	Visit www.carefirst.com/findadoc to locate providers
24/7 FIRSTHELP NURSE ADVICE LINE	
Free advice from a registered nurse	When your doctor is not available, call FirstHelp to speak with a registered nurse about your health questions and treatment options. Call 800-535-9700.
ANNUAL DEDUCTIBLE (Benefit period)[2]	
Individual	None
Family	None
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[3]	
Medical[4]	$3,300 Individual/$4,600 Family
Prescription Drug[4]	Combined with in-network medical out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
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/$35 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans)[5]	$25 PCP/$35 Specialist
Lab[5]	No charge*
X-ray[5]	No charge*
Allergy Testing	No charge*
Allergy Shots	$5 per visit
Physical, Speech and Occupational Therapy[6] (limited to 30 visits/condition/benefit period)	$35 per visit
Chiropractic (limited to 20 visits/benefit period)	$35 per visit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES	
Urgent Care Center	$35 per visit
Emergency Room—Facility Services	$100 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*
Ambulance (if medically necessary)	No charge*

Services	In-Network You Pay[1]
HOSPITALIZATION **(Members are responsible for applicable physician and facility fees)**	
Outpatient Facility Services	$150 per visit
Outpatient Physician Services	$25 PCP/ $35 Specialist
Inpatient Facility Services	$300 per admission
Inpatient Physician Services	$25 PCP/ $35 Specialist
HOSPITAL ALTERNATIVES	
Home Health Care	No charge*
Hospice	No charge*
Skilled Nursing Facility (limited to 100 days/benefit period)	No charge*
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	$300 per admission
Nursery Care of Newborn	No charge*
Artificial and Intrauterine Insemination[7] (limited to 6 attempts per live birth)	$35 per visit
In Vitro Fertilization Procedures[7]	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE **(Members are responsible for applicable physician and facility fees)**	
Inpatient Facility Services	$300 per admission
Inpatient Physician Services	$25 PCP/ $35 Specialist
Outpatient Facility Services	$150 per visit
Outpatient Physician Services	$25 PCP/ $35 Specialist
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.