Commissioners of St. Mary's County—Medical Benefit Options

Medicare Eligibles/Retirees 65+—July 2024

CareFirst Family of health care plans

Product Name	BlueChoice HMO Open Access	BlueChoice Advantage	
Services	**You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**
NETWORK	BlueChoice	BlueChoice and Preferred Provider (PPO Blue Card)	Participating/Non-Participating
PER VISITS	$10 PCP / $20 Specialist per visit	$20 PCP / $20 Specialist	N/A
ANNUAL DEDUCTIBLE			
Individual	$0	$250	$500
Individual & Child	$0	$500	$1,000
Individual & Adult	$0	$500	$1,000
Family	$0	$500	$1,000
ANNUAL OUT-OF-POCKET LIMIT			
Medical	$2,000 Individual / $6,000 Family	$1,000 Individual / $2,000 Family	$1,000 Individual / $2,000 Family
Prescription Drug	$4,600 Individual / $7,200 Family	$5,600 Individual / $11,200 Family	$5,600 Individual / $11,200 Family
LIFETIME MAXIMUM BENEFIT	Unlimited except on fertility services	Unlimited except on fertility services	
PREVENTIVE SERVICES			
Well-Child Care			
0–24 months	$0 per visit	$0 per visit	20% of CareFirst member cost
24 months–13 years (immunization visit)	$0 per visit	$0 per visit	20% of CareFirst member cost
24 months–13 years (non-immunization visit)	$0 per visit	$0 per visit	20% of CareFirst member cost
14–17 years	$0 per visit	$0 per visit	20% of CareFirst member cost
Adult Physical Examination	$0 per visit	$0 per visit	After deductible is met, 20% of CareFirst member cost
Routine GYN Visits	$0 per visit	$0 per visit	After deductible is met, 20% of CareFirst member cost
Prostate Screening	$0 per visit	$0 per visit	$0 per visit
Other Cancer Screening (Mammogram, Pap Test and Colorectal)	$0 per visit	$0 per visit	After deductible is met, 20% of CareFirst member cost
OFFICE VISITS, LABS AND TESTING			
Office Visits for Illness	$10 PCP / $20 Specialist per visit	$20 per visit	After deductible is met, 20% of CareFirst member cost
Diagnostic Services	$10 PCP / $20 Specialist per visit	$20 per visit	After deductible is met, 20% of CareFirst member cost
X-ray and Lab Tests	No per visit (LabCorp)	$0 per visit (LabCorp)	After deductible is met, 20% of CareFirst member cost
Allergy Testing	$10 PCP / $20 Specialist per visit	$20 per visit	After deductible is met, 20% of CareFirst member cost
Allergy Shots	$10 PCP / $20 Specialist per visit	$0 per visit	After deductible is met, 20% of CareFirst member cost
Allergy Serum	$10 PCP / $20 Specialist per visit	$20 per visit	After deductible is met, 20% of CareFirst member cost
Outpatient Physical, Speech and Occupational Therapy (Office Setting)	$20 per visit; (limited to 100 visits per therapy/per year)	$20 per visit—Physical, Speech and Occupational Therapy (limited to 100 visits per therapy/per year)	After deductible is met, 20% of CareFirst member cost (limited to 100 visits per therapy/per year)
Outpatient Chiropractic	$20 per visit; (limited to 20 visits per condition/per year)	$20 per visit (unlimited visits)	After deductible is met, 20% of CareFirst member cost (unlimited visits)
EMERGENCY CARE AND URGENT CARE			
Physician's Office	$10 PCP / $20 Specialist per visit	$20 per visit	$20 per visit
Urgent Care Center	$20 per visit	$20 per visit	$20 per visit
Hospital Emergency Room	$75 per visit (waived if admitted)	$100 per visit (waived if admitted)	$100 per visit (waived if admitted)
Ambulance (if medically necessary)	$0 per visit	$0 per visit	$0 per visit

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Services	**You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**
HOSPITALIZATION			
Inpatient Facility Services	$0	$0 after deductible	After deductible is met, 20% of CareFirst member cost
Outpatient Facility Services	$0 per visit	$35 per visit	After deductible is met, 20% of CareFirst member cost
Inpatient Physician Services	$0	$0	After deductible is met, 20% of CareFirst member cost
Outpatient Physician Services	$0 per visit	$25 per visit	After deductible is met, 20% of CareFirst member cost
HOSPITAL ALTERNATIVES			
Home Health Care	$0 per visit	$0 per visit	20% of CareFirst member cost
Hospice	$0 per visit	$0 per visit	20% of CareFirst member cost
Skilled Nursing Facility (limited to 365 days/benefit period)	$0	$0	After deductible is met, 20% of CareFirst member cost
MATERNITY			
Prenatal and Postnatal Office Visits	$0 per visit	$0 per visit	After deductible is met, 20% of CareFirst member cost
Delivery and Facility Services	$0	$0	After deductible is met, 20% of CareFirst member cost
Nursery Care of Newborn	$0	$0	After deductible is met, 20% of CareFirst member cost
Artificial Insemination—Subject to State Mandate (limited to 6 attempts per live birth)	50% of CareFirst member cost	$20 per visit (office)	After deductible is met, 20% of CareFirst member cost
InVitro Fertilization Procedures—Subject to State Mandate (limited to 3 attempts per live birth & $100,000 lifetime max)	50% of CareFirst member cost	$20 per visit (office)	After deductible is met, 20% of CareFirst member cost
MENTAL HEALTH (MH) AND SUBSTANCE USE DISORDER (SUD)—SUBJECT TO FEDERAL MANDATE			
Inpatient Facility Services (requires Pre-authorization)	$0	$0 after deductible	After deductible is met, 20% of CareFirst member cost
Inpatient Physician Services	$0	$0	After deductible is met, 20% of CareFirst member cost
Outpatient Services (MH & SA)	$10 per visit	$20 per visit (office)	After deductible is met, 20% of CareFirst member cost
Partial Hospitalization	$0 per visit	$35 per visit	After deductible is met, 20% of CareFirst member cost
Medication Management Visit	$10 per visit	$20 per visit	After deductible is met, 20% of CareFirst member cost
MISCELLANEOUS			
Durable Medical Equipment	$0 per visit	$0 per visit	After deductible is met, 20% of CareFirst member cost
Acupuncture	Not covered	$20 per visit	After deductible is met, 20% of CareFirst member cost
Transplants—Major Organ	$0 per visit. Travel & Lodging limited to 90 days per transplant	$0 per visit. Travel & Lodging limited to 90 days per transplant	
Hearing Aids for Children and Adults (limited to one hearing aid/ per ear every 36 months)	$0 per aid/per ear; member may be balanced billed up to the total charge	$0 per aid/per ear; member may be balanced billed up to the total charge	$0 per aid/ per ear (children); 20% CareFirst member cost per aid/ per ear (adults); member may be balanced billed up to the total charge
VISION*	BlueVision Plus is an option for both the HMO and BlueChoice Advantage plans.		
PRESCRIPTION DRUGS	$10 Generic / $20 Preferred Brand / $35 Non-preferred Brand / 50% up to $75 max. Preferred Specialty / 50% up to $150 max. Non-preferred Specialty; Mail Order included—Formulary 2	$10 Generic / $20 Preferred Brand / $35 Non-preferred Brand / 50% up to $75 max. Preferred Specialty / 50% up to $150 max. Non-preferred Specialty; Mail Order included—Formulary 2	
DEPENDENT AGE LIMIT	To age 26, end of month	To age 26, end of month	

Product Line	Standard Group Over 65	
Services	**Medicare Covers**	**Standard Group Over 65**
Part A Hospital Deductible	60 days of inpatient hospital care, except for a $1,632 deductible.	Pays the first $1,632 of the inpatient hospital bill for the first 60 days of hospitalization.
Inpatient Days 61–90	30 additional days of hospital inpatient care, except for a $408 per day copay.	Pays the $408 per day copay for days 61–90 of inpatient hospitalization.
Lifetime Reserve Days	60 additional "lifetime reserve" days of inpatient hospital care, except for a $816 per day copay.	Pays $816 per day copay when the 60 "lifetime reserve" days are used.
Skilled Nursing Facility	100 days of inpatient care in a skilled nursing facility, except for the $204 per day copay for days 21–100.	Pays the $204 per day copay for days 21–100 in a skilled nursing facility.
Inpatient Medical/Surgery	80% of the Medicare-approved amount for in-hospital surgery and medical care, after the annual $240 deductible has been met.	Pays the $240 deductible and 20% of the Medicare-approved amount for in-hospital surgery and medical care.
Outpatient Surgery	80% of the Medicare-approved amount for outpatient hospital visits and surgery, for medical conditions after the annual $240 deductible has been met.	Pays the $240 deductible and 20% of the Medicare-approved amount for outpatient hospital visits and surgery, for a medical condition.*
Emergency Services	80% of the Medicare-approved amount for minor surgery and emergency first aid provided in a physician's office or hospital outpatient department, after the annual $240 deductible has been met.	Pays the $240 deductible and 20% of the Medicare-approved amount for physician services for surgery and emergency first aid provided in a physician's office or hospital outpatient department.*
Diagnostic Services	Covers clinical laboratory services at 100% of the Medicare-approved amount. 80% of the Medicare-approved amount for diagnostic X-rays or pathology examinations provided in a physician's office or hospital outpatient department, after the $240 deductible has been met.	Medicare covers in full. **For outpatient minor surgery or accidental injury:** Pays the $240 deductible and 20% of the Medicare-approved amount if provided by a Medicare participating physician or hospital outpatient department* **For all other cases:** Covered by Major Medical.
Radiation/Chemotherapy Services	80% of the Medicare-approved amount for radiation/chemotherapy services provided in an office or hospital outpatient department, after the $240 deductible has been met.	Pays the $240 deductible and 20% of the Medicare-approved amount for radiation/chemotherapy services provided in an office or hospital outpatient department.
Diabetic Self-Management	80% of the Medicare-approved amount for blood glucose monitors, testing strips, lancet devices, after the $240 annual deductible has been met.	Pays 80% of Medicare Part B deductible and coinsurance.
PREVENTIVE SERVICES		
Annual Physical	One Annual Wellness visit every 12 months. There is no coinsurance, copay or deductible.	Covered by Medicare
Routine GYN	No coinsurance, copay or deductible for Pap Smears, Pelvic and clinical breast exams. Covered once every 2 years. Covered once a year for women at high risk.	100% of the Allowed Benefit the year Medicare does not pay
Prostate Cancer Screening Exam	80% of the Medicare-approved amount for digital rectal exam for men age 50 and older after the $240 annual deductible has been met. 100% for the PSA test; 80% for other related services. Covered once a year.	Pays 100% of Medicare Part B deductible and coinsurance.
Colorectal Cancer Screening Procedures	No coinsurance, copay or deductible for screening colonoscopy or screening flexible sigmoidoscopy.	Covered by Medicare
Mammography Screening	No coinsurance, copay or deductible. One baseline between ages 35–39. Once every 12 months for age 40 and older.	Covered by Medicare
Bone Mass Measurement	No coinsurance, copay or deductible. Once every 24 months for persons at high risk for osteoporosis.	Covered by Medicare

*Benefits limited to minor surgery or services provided within 72 hours of an accident or injury.

In addition to the Standard Group Over 65 Benefits, the Retirees of Commissioners of St. Mary's County, Metropolitan Commission and Library also have:

- Major Medical Benefits to reimburse subscribers for out-of-pocket expenses not covered by Medicare, such as balances on office visits and durable medical equipment. Major Medical benefits are then reimbursed at 80% of allowed benefit up to $500 out-of-pocket maximum. Reimbursement is then 100% of allowed benefit for the remaining calendar year.
- Prescription Drug Card Program—Generic $10 / Preferred Brand $20 / Non-Preferred Brand $35 / Preferred Specialty 50% up to $75 max. / Non-preferred Specialty 50% up to $150 max. / Mail Order included—Formulary 2
  The prescription annual out-of-pocket maximum is $6,100

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