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

Retirees Under 65—July 2025

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
Mammograms	$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 (Pap Test and Colorectal)	$0 per visit	$0 per visit	After deductible is met, 20% of CareFirst member cost
OFFICE VISITS, LALLOWED BENEFITS 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	$0 (LabCorp)	$0 (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

Product Name	BlueChoice HMO Open Access	BlueChoice Advantage	
Services	**You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**
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
HOSPITALIZATION			
Inpatient Facility Services	$0 per visit	After deductible is met, $0	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 per visit	$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 per visit	$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 per visit	$0	After deductible is met, 20% of CareFirst member cost
Nursery Care of Newborn	$0 per visit	$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 per visit	After deductible is met, $0	After deductible is met, 20% of CareFirst member cost
Inpatient Physician Services	$0 per visit	$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; member may be balanced billed up to the total charge
VISION	BlueVision Plus is an option for both the HMO and BlueChoice Advantage plans.	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	

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CST5247-1N (4/24)