Calvert County Public Schools—Medical Benefit Options

Medicare Eligible/Retirees Over 65—January 2027

CareFirst Family of health care plans

Product Line	HMO	BlueChoice Advantage	
Product Name	**BlueChoice HMO Open Access 65+**	**BlueChoice Advantage 65+**	
Services		**In-Network**	**Out-of-Network**
NETWORK	BlueChoice	Preferred Provider (PPO BlueCard)	Participating/Non-Participating
COPAYS	$10 PCP / $10 Specialist copay	$10 PCP / $10 Specialist copay	N/A
ANNUAL DEDUCTIBLE			
Individual	None	None	$100
Individual & Child	None	None	$200
Individual & Adult	None	None	$200
Family	None	None	$200
ANNUAL OUT-OF-POCKET MAXIMUM			
Medical	$2,000 Individual / $6,000 Family	$500 Individual / $1,000 Family	
LIFETIME MAXIMUM BENEFIT	Unlimited except on fertility services	Unlimited except on fertility services	
PREVENTIVE SERVICES			
Well-Child Care			
0–24 months	No charge	No charge	20% of Allowed Benefit, no deductible
24 months–13 years (immunization visit)	No charge	No charge	20% of Allowed Benefit, no deductible
24 months–13 years (non-immunization visit)	No charge	No charge	20% of Allowed Benefit, no deductible
14–17 years	No charge	No charge	20% of Allowed Benefit, no deductible
Adult Physical Examination	No charge	No charge	Deductible, then 20% of Allowed Benefit
Routine GYN Visits	No charge	No charge	Deductible, then 20% of Allowed Benefit
Prostate Screening	No charge	No charge	No charge
Other Cancer Screening (Pap Test, Mammogram and Colorectal)	No charge	No charge	Deductible, then 20% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING			
Office Visits for Illness	$10 copay	$10 copay	Deductible, then 20% of Allowed Benefit
Diagnostic Services	$10 PCP / $10 Specialist copay	$10 copay	Deductible, then 20% of Allowed Benefit
Lab Tests	No copay (LabCorp)	$10 copay (LabCorp)	$10 copay
X-ray	No copay	$10 copay	Deductible, then 20% of Allowed Benefit
Allergy Testing	$10 PCP / $10 Specialist copay	No charge	Deductible, then 20% of Allowed Benefit
Allergy Shots	$10 PCP / $10 Specialist copay	No charge	Deductible, then 20% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy (Office Setting)	$10 copay (limited to 100 visits/condition/benefit period)	No charge (limited to 100 visits/condition/benefit period combined in- and out-of-network)	Deductible, then 20% of Allowed Benefit (limited to 100 visits/condition/benefit period combined in- and out-of-network)
Outpatient Chiropractic	$10 copay (limited to 20 visits/condition/benefit period)	$10 copay (unlimited visits)	Deductible, then 20% of Allowed Benefit (unlimited visits)
EMERGENCY CARE AND URGENT CARE			
Physician's Office	$10 PCP / $10 Specialist copay	Accidental Injury—No charge; Medical Emergency—$10 copay	Accidental Injury—No charge; Medical Emergency—$10 copay
Urgent Care Center	Accidental Injury—No charge; Medical Emergency—$15 copay	Accidental Injury—No charge; Medical Emergency—$15 copay	Accidental Injury—No charge; Medical Emergency—$15 copay
Hospital Emergency Room	Accidental Injury—No charge; Medical Emergency—$75 copay (waived if admitted)	Accidental Injury—No charge; Medical Emergency—$75 copay (waived if admitted)	Accidental Injury—No charge; Medical Emergency—$75 copay (waived if admitted)
Ambulance (if medically necessary)	100% of Allowed Benefit	100% of Allowed Benefit	100% of Allowed Benefit

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Product Name	**BlueChoice HMO Open Access 65+**	**BlueChoice Advantage 65+**	
Services		**In-Network**	**Out-of-Network**
HOSPITALIZATION			
Inpatient Facility Services	No charge (365 days)	No charge	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge	$25 copay	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge	No charge	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge	$10 copay	Deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES			
Home Health Care	No charge	No charge	No charge, no deductible
Hospice	No charge	No charge	No charge, no deductible
Skilled Nursing Facility (limited to 365 days/benefit period)	No charge	No charge	Deductible, then 20% of Allowed Benefit
MATERNITY			
Prenatal and Postnatal Office Visits	No charge	No charge	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge	No charge	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge	No charge	Deductible, then 20% of Allowed Benefit
Artificial Insemination—Subject to State Mandate (limited to 6 attempts per live birth)	50% of Allowed Benefit	No charge after copay	Deductible, then 20% of Allowed Benefit
InVitro Fertilization Procedures—Subject to State Mandate (limited to 3 attempts per live birth & $100,000 lifetime max)	50% of Allowed Benefit	No charge after copay	Deductible, then 20% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER (MHSUD)—SUBJECT TO FEDERAL MANDATE			
Inpatient Facility Services (requires Pre-authorization)	No charge	No charge	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge	No charge	Deductible, then 20% of Allowed Benefit
Outpatient Services (MH & SA)	$10 copay office visits	$10 copay (office)	Deductible, then 20% of Allowed Benefit
Partial Hospitalization	No charge	$25 copay	Deductible, then 20% of Allowed Benefit
Medication Management Visit	$10 copay	$10 copay	Deductible, then 20% of Allowed Benefit
MISCELLANEOUS			
Durable Medical Equipment	No charge	No charge	Deductible, then 20% of Allowed Benefit
Acupuncture	Not covered	$10 copay	Deductible, then 20% of Allowed Benefit
Transplants—Major Organ (travel & lodging limited to 70 days per transplant)	No charge	No charge	No charge, no deductible
Hearing Aids for Children and Adults (limited to one hearing aid/per ear every 36 months)	100% of Allowed Benefit per aid/per ear; member may be balanced billed up to the total charge.	100% of Allowed Benefit per aid/per ear; member may be balanced billed up to the total charge	100% of Allowed Benefit per aid/per ear; member may be balanced billed up to the total charge
PRESCRIPTION DRUGS			
Prescription Drugs: Formulary 2	$8 Generic; $15 Formulary Brand; $30 Non-formulary Brand—30 day supply Mandatory generics or pay difference in cost plus copay Voluntary Maintenance Choice: 1 copay for 90-day maintenance supply at CVS retail or CVS Mail Order; all other retail pharmacies will be 2 copays for 90-day maintenance supply		
DEPENDENT AGE LIMIT	To age 26, end of month	To age 26, end of month	To age 26, end of month

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