Calvert County Public Schools—Medical Benefit Options

Employees/Retirees Under 65—July 2025

CareFirst Family of health care plans

Product Line	HMO	BlueChoice Advantage		Traditional (not available to new hires after 7/1/2001)
Product Name	**BlueChoice HMO Open Access**	**BlueChoice Advantage**		**Traditional**
Services		**In-Network**	**Out-of-Network**	
NETWORK	BlueChoice	BlueChoice and Preferred Provider (PPO BlueCard)	Participating/Non-Participating	
COPAYS	$10 PCP / $10 Specialist copay	$10 PCP / $10 Specialist copay	N/A	N/A
ANNUAL DEDUCTIBLE				
Individual	None	None	$100	$100
Individual & Child	None	None	$200	$200
Individual & Adult	None	None	$200	$200
Family	None	None	$200	$300
ANNUAL OUT-OF-POCKET MAXIMUM				
Medical	$2,000 Individual / $6,000 Family	$500 Individual / $1,000 Family		$400 Individual / $800 Family
LIFETIME MAXIMUM BENEFIT	Unlimited except on fertility services	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	No charge
24 months–13 years (immunization visit)	No charge	No charge	20% of Allowed Benefit, no deductible	No charge
24 months–13 years (non-immunization visit)	No charge	No charge	20% of Allowed Benefit, no deductible	No charge
14–17 years	No charge	No charge	20% of Allowed Benefit, no deductible	No charge
Adult Physical Examination	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge
Routine GYN Visits	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge
Prostate Screening	No charge	No charge	No charge	No charge
Other Cancer Screening (Pap Test, Mammogram and Colorectal)	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge
OFFICE VISITS, LABS AND TESTING				
Office Visits for Illness	$10 copay	$10 copay	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Diagnostic Services	$10 PCP / $10 Specialist copay	$10 copay	Deductible, then 20% of Allowed Benefit	No charge
X-ray	No copay	$10 per visit	Deductible, then 20% of Allowed Benefit	No charge
Lab Tests	No copay (LabCorp)	$10 per visit (LabCorp)	$10 per visit	Deductible, then 20% of Allowed Benefit.
Allergy Testing	$10 PCP / $10 Specialist copay	No charge	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Allergy Shots	$10 PCP / $10 Specialist copay	No charge	Deductible, then 20% of Allowed Benefit	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)	No charge (Physical Therapy limited to 100 visits; after 100 visits—deductible, then 20% of Allowed Benefit) Speech and Occupational Therapy not covered.
Outpatient Chiropractic	$10 copay (limited to 20 visits/condition/benefit period)	$10 copay (unlimited visits)	Deductible, then 20% of Allowed Benefit (unlimited visits)	Deductible, then 20% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE				
Physician's Office	$10 PCP / $10 Specialist copay	No charge—Accidental Injury; $10 copay—Medical Emergency	No charge—Accidental Injury; $10 copay—Medical Emergency	No charge
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	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)	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	100% of Allowed Benefit

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Product Name	**BlueChoice HMO Open Access**	**BlueChoice Advantage**		**Traditional**
Services		**In-Network**	**Out-of-Network**	
HOSPITALIZATION				
Inpatient Facility Services	No charge (365 days)	No charge	Deductible, then 20% of Allowed Benefit	No charge (70 days)
Outpatient Facility Services	No charge	$25 copay	Deductible, then 20% of Allowed Benefit	No charge (surgery)
Inpatient Physician Services	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge (70 days)
Outpatient Physician Services	No charge	$10 copay	Deductible, then 20% of Allowed Benefit	No charge (surgery)
HOSPITAL ALTERNATIVES				
Home Health Care	No charge	No charge	No charge, no deductible	No charge (limited to 90 days; after 90 days—deductible, then 20% of Allowed Benefit)
Hospice	No charge	No charge	No charge, no deductible	No charge
Skilled Nursing Facility (limited to 365 days/benefit period)	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge (70 days)
MATERNITY				
Prenatal and Postnatal Office Visits	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge
Delivery and Facility Services	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge
Nursery Care of Newborn	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge
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	No charge
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	No charge
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	No charge (70 days)
Inpatient Physician Services	No charge	No charge	Deductible, then 20% of Allowed Benefit	No charge (70 days)
Outpatient Services (MH & SA)	$10 copay office visits	$10 copay (office)	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Partial Hospitalization	No charge	$25 copay	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Medication Management Visit	$10 copay	$10 copay	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
MISCELLANEOUS				
Durable Medical Equipment	No charge	No charge	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Acupuncture	Not covered	$10 copay	Deductible, then 20% of Allowed Benefit	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	No charge
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.	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	To age 26, end of month

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CST2800-1N (3/25)