

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

Retirees Under 65—July 2026

Product Name	BlueChoice HMO Open Access		BlueChoice Advantage	
	You Pay		In-Network You Pay	Out-of-Network You Pay
<b>SERVICES</b>				
<b>NETWORK</b>	BlueChoice		BlueChoice and Preferred Provider (PPO Blue Card)	Participating/Non-Participating
<b>PER VISITS</b>	\$10 PCP / \$20 Specialist per visit		\$20 PCP / \$20 Specialist	N/A
<b>CALENDAR YEAR DEDUCTIBLE</b>				
Individual	\$0		\$250	\$500
Individual & Child	\$0		\$500	\$1,000
Individual & Adult	\$0		\$500	\$1,000
Family	\$0		\$500	\$1,000
<b>CALENDAR YEAR OUT-OF-POCKET LIMIT</b>				
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
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited except on fertility services		Unlimited except on fertility services	
<b>PREVENTIVE SERVICES</b>				
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
<b>OFFICE VISITS, LALLOED BENEFITS AND TESTING</b>				
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 calendar year)		\$20 per visit—Physical, Speech and Occupational Therapy (limited to 100 visits per therapy/per calendar year)	After deductible is met, 20% of CareFirst member cost (limited to 100 visits per therapy/per calendar year)
Outpatient Chiropractic	\$20 per visit; (limited to 20 visits per condition/per calendar year)		\$20 per visit (unlimited visits)	After deductible is met, 20% of CareFirst member cost (unlimited visits)
<b>EMERGENCY CARE AND URGENT CARE</b>				
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

Product Name	BlueChoice HMO Open Access		BlueChoice Advantage	
	You Pay		In-Network You Pay	Out-of-Network You Pay
<b>HOSPITALIZATION</b>				
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	
<b>HOSPITAL ALTERNATIVES</b>				
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	
<b>MATERNITY</b>				
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	
<b>MENTAL HEALTH (MH) AND SUBSTANCE USE DISORDER (SUD)—SUBJECT TO FEDERAL MANDATE</b>				
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	
<b>MISCELLANEOUS</b>				
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	
<b>VISION</b>	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.	
<b>PRESCRIPTION DRUGS</b>	\$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	
<b>DEPENDENT AGE LIMIT</b>	To age 26, end of month		To age 26, end of month	



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