

# 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, LALLOWED 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   |

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|   | 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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