CareFirst Family of health care plans

Medical Benefit Options—Summary of Benefits

Actives—January 2022

Anne Arundel County Public Schools

Product Line	HMO	BlueChoice Triple Option Plan—Open Access—3 Health Care Plans in 1		
Product Name	**BlueChoice HMO Open Access**	**BlueChoice Triple Option Open Access**		
Services		**Level 1 No Referrals Required**	**Level 2 No Referrals Required**	**Level 3 No Referrals Required**
NETWORK				
Network	BlueChoice	BlueChoice	Preferred Provider (PPO Blue Card)	Participating/non-participating
COPAYS				
PCP	$10	$10	$15	N/A
Specialist	$15	$10	$15	N/A
ANNUAL DEDUCTIBLE				
Individual	None	None	$200	$300
Family	None	None	$400	$600
ANNUAL OUT-OF-POCKET MAXIMUM				
Medical	$2,000 Individual/$6,000 Family	$2,000 Individual/$6,000 Family	$2,000 Individual/$6,000 Family	$2,000 Individual/$6,000 Family
Combined Medical and Prescription Drug	$6,350 Individual/ $12,700 Family	$6,350 Individual/ $12,700 Family	$6,350 Individual/$12,700 Family	$6,350 Individual/$12,700 Family
LIFETIME MAXIMUM BENEFIT				
Lifetime Maximum Benefit	Unlimited except on fertility services	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	No charge	80% Allowed Benefit, no deductible
■ 24 months–13 years (immunization visit)	No charge	No charge	No charge	80% Allowed Benefit, no deductible
■ 24 months–13 years (non-immunization visit)	No charge	No charge	No charge	80% Allowed Benefit, no deductible
■ 14–17 years	No charge	No charge	No charge	80% Allowed Benefit, no deductible
Adult Physical Examination	No charge	No charge	No charge	80% Allowed Benefit, after deductible
Routine GYN Visits	No charge	No charge	No charge	80% Allowed Benefit, after deductible
Mammograms	No charge	No charge	No charge	80% Allowed Benefit, after deductible
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge	No charge	No charge	80% Allowed Benefit, after deductible
OFFICE VISITS, LABS AND TESTING				
Office Visits for Illness	$10 PCP / $15 Specialist copay	$10 copay	$15 copay	80% Allowed Benefit, after deductible
Diagnostic Services	$10 PCP / $15 Specialist copay	$10 copay	$15 copay	80% Allowed Benefit, after deductible
X-ray and Lab Tests	No copay (LabCorp)	No copay (LabCorp)	$15 copay	80% Allowed Benefit, after deductible
Allergy Testing	$10 PCP / $15 Specialist copay (if office visit copay paid, additional copay not required)	$10 copay	$15 copay	80% Allowed Benefit, after deductible
Allergy Shots	$10 PCP / $15 Specialist copay (if office visit copay paid, additional copay not required)	$10 copay	$15 copay	80% Allowed Benefit, after deductible
Outpatient Physical, Speech and Occupational Therapy (Office Setting)	$15 copay; (limited to 30 visits combined/condition/ benefit period)	$10 copay (limited to 30 visits combined per condition per year)	$15 copay (limited to 100 visits per year, combined between Level 2 and 3)	80% Allowed Benefit After Deductible (limited to 100 visits per year, combined between Level 2 and 3)
Outpatient Chiropractic	$15 copay; (limited to 20 visits/condition/benefit period)	$10 copay (limited to 20 visits per year)	$15 copay (unlimited visits)	80% Allowed Benefit, after deductible (unlimited visits)

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EMERGENCY CARE AND URGENT CARE				
Physician's Office	$10 PCP / $15 Specialist copay	$10 copay	$15 copay	80% Allowed Benefit, after deductible
Urgent Care Center	$10 PCP / $15 Specialist copay	$10 copay	$15 copay	80% Allowed Benefit, after deductible
Hospital Emergency Room	$85 copay (waived if admitted)	$85 copay (waived if admitted)	Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level	Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level.
Ambulance (if medically necessary)	100% of Allowed Benefit	100% of Allowed Benefit	Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level	Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level.
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)				
Inpatient Facility Services	No charge	No charge	90% of Allowed Benefit, after deductible	80% of Allowed Benefit, after deductible
Outpatient Facility Services	No charge	No charge	90% of Allowed Benefit, after deductible	80% of Allowed Benefit, after deductible
Inpatient Physician Services	No charge	No charge	90% of Allowed Benefit, after deductible	80% of Allowed Benefit, after deductible
Outpatient Physician Services	$10 PCP / $15 Specialist copay	$10 copay	$15 copay	80% of Allowed Benefit, after deductible
HOSPITAL ALTERNATIVES				
Home Health Care	No charge	No charge	100% of Allowed Benefit	100% of Allowed Benefit
Hospice	No charge	No charge	100% of Allowed Benefit	100% of Allowed Benefit
Skilled Nursing Facility (limited to 365 days/benefit period)	No charge	No charge	90% of Allowed Benefit, after deductible	80% of Allowed Benefit, after deductible
MATERNITY				
Preventive Prenatal and Postnatal Office Visits	No charge	No charge	No charge	80% of Allowed Benefit, after deductible
Delivery and Facility Services	No charge	No charge	90% of Allowed Benefit, after deductible	80% of Allowed Benefit, after deductible
Nursery Care of Newborn	No charge	No charge	90% of Allowed Benefit, after deductible	80% of Allowed Benefit, after deductible
Artificial Insemination—Subject to State Mandate (limited to 6 attempts per live birth)	50% of the Allowed Benefit	Not covered under Level 1	90% of Allowed Benefit, after deductible (OP Facility) $15 copay (OP Facility Practitioner or Office)	80% of Allowed Benefit, after deductible
InVitro Fertilization Procedures— Subject to State Mandate (limited to 3 attempts per live birth & $100,000 lifetime max)	50% of the Allowed Benefit	Not covered under Level 1	90% of Allowed Benefit, after deductible (OP Facility) $15 copay (OP Facility Practitioner or Office)	80% of Allowed Benefit, after deductible
MENTAL HEALTH (MH) AND SUBSTANCE USE DISORDER (SUD)—Subject to federal mandate				
Inpatient Facility Services (requires Pre-authorization)	No charge	No charge	90% Allowed Benefit, after deductible	80% of Allowed Benefit, after deductible
Inpatient Physician Services	No charge	No charge	90% Allowed Benefit, after deductible	80% of Allowed Benefit, after deductible
Outpatient Services (MH & SUD)	$10 copay (office)	$10 copay	$10 copay	80% of Allowed Benefit, after deductible
Partial Hospitalization	No charge	No charge	100% of Allowed Benefit	80% of Allowed Benefit, after deductible
Medication Management Visit	$10 copay	$10 copay	$10 copay	80% of Allowed Benefit, after deductible
MISCELLANEOUS				
Durable Medical Equipment	No charge	No charge	90% of Allowed Benefit, after deductible	80% of Allowed Benefit, after deductible
Diabetic Supplies	Covered under Prescription Drug plan	Covered under Prescription Drug plan	Covered under Prescription Drug plan	Covered under Prescription Drug plan
Acupuncture	$15 copay (limited to 24 visits/benefit period)	$10 copay (limited to 24 visits/benefit period)	$15 copay	80% of Allowed Benefit, after 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	100% of Allowed Benefit per aid/per ear; member may be balanced billed up to the total charge
Outpatient Surgery (office)	$10 PCP / $15 Specialist copay	$10 copay	$15 copay	80% of Allowed Benefit, after deductible
Chemotherapy/Radiation Therapy (office)	$15 copay	$10 copay	$15 copay	80% of Allowed Benefit, after deductible
Renal Dialysis	No charge	No charge	$15 copay	80% of Allowed Benefit, after deductible
Cardiac Rehab (subject to Medical Policy review)	No charge	No charge	100% of Allowed Benefit	80% of Allowed Benefit, after deductible
DEPENDENT AGE LIMIT				
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

Note: Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

** No copayment or coinsurance.

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