St. Mary's County Public Schools

Plan 2—July 2025

CareFirst
Family of health care plans

Product Line	HMO Plan 2	BlueChoice Triple Option Plan 2—Open Access—3 Health Care Plans in 1		
Product Name	**BlueChoice HMO Open Access**	**BlueChoice Triple Option Open Access**		
	No Referrals Required	**Level 1 No Referrals Required**	**Level 2 No Referrals Required**	**Level 3 No Referrals Required**
Services	**You Pay**	**You Pay**	**You Pay**	**You Pay**
24/7 NURSE ADVICE LINE	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.		
NETWORK	BlueChoice	BlueChoice	Preferred Provider (PPO Blue Card)	Participating/Non-Participating
PER VISIT	$5 PCP/$10 Specialist per visit	$10 PCP/$10 Specialist per visit	$15 PCP/$15 Specialist per visit	N/A
ANNUAL DEDUCTIBLE				
Individual	None	None	$200	$300
Individual & Child	None	None	$400	$600
Individual & Adult	None	None	$400	$600
Family	None	None	$400	$600
ANNUAL OUT-OF-POCKET MAXIMUM				
Medical	$2,000 Individual/$6,000 Family	$2,000 Individual/$6,000 Family	$500 Individual/$1,000 Family	$1,000 Individual/$2,000 Family
Prescription Drug	$4,600 Individual/$7,200 Family	$4,600 Individual/$7,200 Family	$4,600 Individual/$7,200 Family	$4,600 Individual/$7,200 Family
LIFETIME MAXIMUM BENEFIT	Unlimited except on fertility services	Unlimited except on fertility services		
PREVENTIVE SERVICES				
Well-Child Care				
0-24 months	$0	$0	$0	20% of CareFirst member cost
24 months-13 years (immunization visit)	$0	$0	$0	20% of CareFirst member cost
24 months-13 years (non-immunization visit)	$0	$0	$0	20% of CareFirst member cost
14-17 years	$0	$0	$0	20% of CareFirst member cost
Adult Physical Examination	$0	$0	$0	After deductible is met, 20% of CareFirst member cost
Routine GYN Visits	$0	$0	$0	After deductible is met, 20% of CareFirst member cost
Prostate Screening	$0	$0	$0	$0
Other Cancer Screening (Pap Test, Mammogram and Colorectal)	$0	$0	$0	After deductible is met, 20% of CareFirst member cost
OFFICE VISITS, LABS AND TESTING				
Office Visits for Illness	$5 PCP/$10 Specialist per visit	$10 per visit	$15 per visit	After deductible is met, 20% of CareFirst member cost
Diagnostic Services	$10 per visit	$10 per visit	$15 per visit	After deductible is met, 20% of CareFirst member cost
X-ray and Lab Tests	$0 (LabCorp)	$0 (LabCorp)	$15 per visit	After deductible is met, 20% of CareFirst member cost
Allergy Testing	$5 PCP/$10 Specialist per visit	$10 per visit	$15 per visit	After deductible is met, 20% of CareFirst member cost
Allergy Shots	$0	$0	$15 per visit	After deductible is met, 20% of CareFirst member cost
Outpatient Physical, Speech and Occupational Therapy (Office Setting)	$10 per visit (limited to 30 visits/condition/benefit period)	$10 per visit (limited to 30 visits/condition/benefit period)	$15 per visit (limited to 100 visits per year)	After deductible is met, 20% of CareFirst member cost (limited to 100 visits per year)
Outpatient Chiropractic	$10 per visit (limited to 20 visits/condition/benefit period)	$10 per visit (limited to 20 visits per year)	$15 per visit (unlimited visits)	After deductible is met, 20% of CareFirst member cost (unlimited visits)
EMERGENCY CARE AND URGENT CARE				
Physician's Office	$5 PCP/$10 Specialist per visit	$10 per visit	$15 per visit	After deductible is met, 20% of CareFirst member cost
Urgent Care Center	$10 per visit	$10 per visit	$15 per visit	After deductible is met, 20% of CareFirst member cost
Hospital Emergency Room	$75 per visit (waived if admitted)	$75 per visit (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)	$0	$0	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.

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Services	You Pay	You Pay	You Pay	You Pay
HOSPITALIZATION				
Inpatient Facility Services	$0	$0	After deductible is met, 10% of CareFirst member cost	After deductible is met, 20% of CareFirst member cost
Outpatient Facility Services	$0	$0	After deductible is met, 10% of CareFirst member cost	After deductible is met, 20% of CareFirst member cost
Inpatient Physician Services	$0	$0	After deductible is met, 10% of CareFirst member cost	After deductible is met, 20% of CareFirst member cost
Outpatient Physician Services	$10 per visit	$10 per visit	$15 per visit	After deductible is met, 20% of CareFirst member cost
HOSPITAL ALTERNATIVES				
Home Health Care	$0	$0	$0	$0
Hospice	$0	$0	$0	$0
Skilled Nursing Facility (limited to 365 days/benefit period)	$0	$0	After deductible is met, 10% of CareFirst member cost	After deductible is met, 20% of CareFirst member cost
MATERNITY				
Prenatal and Postnatal Office Visits	$0	$0	$0	After deductible is met, 20% of CareFirst member cost
Delivery and Facility Services	$0	$0	After deductible is met, 10% of CareFirst member cost	After deductible is met, 20% of CareFirst member cost
Nursery Care of Newborn	$0	$0	After deductible is met, 10% of CareFirst member cost	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	50% of CareFirst member cost	After deductible is met, 10% of CareFirst member cost	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	50% of CareFirst member cost	After deductible is met, 10% of CareFirst member cost	After deductible is met, 20% of CareFirst member cost
MENTAL HEALTH (MH) AND SUBSTANCE USE DISORDER (SUD)—SUBJECT TO FEDERAL MANDATE		**BLUECHOICE NETWORK**	**PREFERRED PROVIDER NETWORK**	**PARTICIPATING/NON-PARTICIPATING**
Inpatient Facility Services (requires Pre-authorization)	$0	$0	$0	After deductible is met, 20% of CareFirst member cost
Inpatient Physician Services	$0	$0	$0	After deductible is met, 20% of CareFirst member cost
Outpatient Services (MH & SUD) (office)	$5 per visit (office)	$10 per visit	$10 per visit	After deductible is met, 20% of CareFirst member cost
Partial Hospitalization	$0	$0	$0	After deductible is met, 20% of CareFirst member cost
Medication Management Visit	$5 per visit	$10 per visit	$10 per visit	After deductible is met, 20% of CareFirst member cost
MISCELLANEOUS				
Durable Medical Equipment	$0	$0	After deductible is met, 10% of CareFirst member cost	After deductible is met, 20% of CareFirst member cost
Acupuncture	Not covered	Not covered	$15 per visit	After deductible is met, 20% of CareFirst member cost
Hearing Aids (limited to once/36 months)	$0 per aid/per ear (children and adults) ; member may be balanced billed up to the total charge	$0 per aid/per ear (children and adults) ; member may be balanced billed up to the total charge	$0 per aid/ per ear (children and adults) ; member may be balanced billed up to the total charge	$0 per aid/ per ear (children and adults) ; member may be balanced billed up to the total charge
Outpatient Surgery (office)	$10 per visit	$10 per visit	$15 per visit	After deductible is met, 20% of CareFirst member cost
Chemotherapy/Radiation Therapy (office)	$10 per visit	$10 per visit	$15 per visit	After deductible is met, 20% of CareFirst member cost
Renal Dialysis	$0	$0	$15 per visit	After deductible is met, 20% of CareFirst member cost
Cardiac Rehab (subject to Medical Policy review)	$0	$0	$0	After deductible is met, 20% of CareFirst member cost
PRESCRIPTION DRUGS	$10 Generic/$15 Brand for non-maintenance: mail order included, $10 Generic/$15 Brand for maintenance 90 day supply for mail order or CVS retail pharmacy, $20 Generic/$30 Brand for maintenance 90 day supply at all other retail pharmacies—Formulary 2	$10 Generic/$15 Brand for non-maintenance: mail order included, $10 Generic/$15 Brand for maintenance 90 day supply for mail order or CVS retail pharmacy, $20 Generic/$30 Brand for maintenance 90 day supply at all other retail pharmacies—Formulary 2		
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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