| Benefit | BlueChoice (HMO) "Open Access" Plan | BlueChoice (HMO) Low Option "Open Access" Plan | BlueChoice Triple Option "Open Access" Plan | | |
|---|---|---|---|---|---|
| | | | Level 1 | Level 2 | Level 3 |
| **Acupuncture Services** | $15 co-pay, 24 visits per calendar year | Not covered (except when approved or authorized by plan when used for anesthesia) | $10 co-pay, 24 visits per calendar year | $15 co-pay | 80% Allowed Benefit after deductible |
| **Chiropractic Services** | $15 co-pay, 20 visits per calendar year | Office Setting – Deductible, then $40/visit; 20 visits per calendar year | $10 co-pay (limited to 20 visits per year) | $15 co-pay (unlimited visits) | 80% Allowed Benefit after deductible (unlimited visits) |
| **Dental Services as a result of an accidental injury** | No co-pay – Covered for accidental bodily injury or to correct congenital anomalies | 100% Allowed Benefit after deductible | No co-pay covered for accidental bodily injury or to correct congenital anomalies | 90% Allowed Benefit after deductible covered for accidental bodily injury or to correct congenital anomalies | 80% Allowed Benefit after deductible |
| **Diagnostic, Lab Services, X-ray** | Covered in full for x-rays and lab services (Lab Corp only)<br>Other diagnostic – $15 co-pay (eg., MRIs) | Non-routine, office setting; $40 co-pay/visit<br>(Lab Corp only for lab services) | Lab no co-pay (Lab Corp only)<br>Other diagnostic – $10 co-pay | $15 co-pay | 80% Allowed Benefit after deductible |
| **Durable Medical Equipment** | 100% Allowed Benefit | 50% Allowed Benefit after deductible | 100% Allowed Benefit | 90% Allowed Benefit after deductible | 80% Allowed Benefit after deductible |
| **Emergency Room Visits** | Medical Emergency – $85 co-pay, waived if admitted<br>Urgent Care Centers – $10 PCP co-pay/$15 Specialist co-pay | $300 co-pay after deductible (waived if admitted)<br>Urgent Care Centers – $100 co-pay after deductible | $85 co-pay (waived if admitted)<br>Urgent Care Centers – $10 co-pay | Considered under Level 1. If Benefits are not available under Level 1, benefits may be payable under the appropriate level.<br>Urgent Care Centers – $15 co-pay | 80% Allowed Benefit after deductible |
| **Family Planning/Fertility (subject to state mandate)** | Infertility Counseling & Testing – $10 co-pay Artificial Insemination – covered at 50% of the plan allowance; IVF – covered at 50% of the plan allowance (limited to 3 attempts per live birth, lifetime maximum benefit $100,000) | 50% Allowed Benefit after deductible; IVF – (limited to 3 attempts per live birth, lifetime maximum benefit $100,000) | Processed under Level 2 | 90% Allowed Benefit after deductible | 80% Allowed Benefit after deductible |
| **Hearing Exams/Hearing Aids** | Hearing exam – $10 co-pay. Aids – 100% Allowed Benefit for each ear; member may be balance billed up to total charge. Benefit once every 36 months. | Covered for minor children (up to age 18). 100% Allowed Benefit for each ear (co-pays and deductible do not apply); member may be balance billed up to total charge. | Hearing exam – $10 co-pay. Aids – 100% Allowed Benefit for each ear; member may be balance billed up to total charge. Benefit once every 36 months. | Hearing exam – $15 co-pay. 100% of Allowed Benefit every 36 months per aid per ear; member may be balance billed up to total charge. | Hearing exam – 80% of Allowed Benefit, after deductible. 100% of Allowed Benefit every 36 months per aid per ear; member may be balance billed up to total charge. |
| **Hospitalization (Inpatient)/ Surgery** | Covered in full | 30% Allowed Benefit after deductible | No co-pay | 90% Allowed Benefit after deductible | 80% Allowed Benefit after deductible |
| **Inpatient Nervous and Mental; Alcohol/Substance Abuse** | Contact CareFirst Assist for pre-authorization at 1-800-245-7013. | Contact CareFirst Assist for pre-authorization at 1-800-245-7013. 30% Allowed Benefit after deductible | Contact CareFirst Assist for pre-authorization at 1-800-245-7013.<br>No co-pay | 100% Allowed Benefit, no deductible | 80% Allowed Benefit after deductible |
| **Outpatient Nervous and Mental; Alcohol/Substance Abuse** | No pre-authorization required. Contact CareFirst Assist for provider network information at 1-800-245-7013. $10 co-pay per visit. | Office Setting – $30 co-pay after deductible | No pre-authorization required. Contact CareFirst Assist for provider network information at 1-800-245-7013.<br>$10 co-pay per visit | $10 co-pay per visit | Deductible and co-insurance apply |
| **Maternity Care** | No co-pays required for prenatal services. Hospitalization covered at 100% of Allowed Benefit. | No co-pays required for pre- and postnatal services. Delivery and hospitalization – 30% Allowed Benefit after deductible | No co-pays required for prenatal services. Hospitalization covered at 100% of Allowed Benefit. | No co-pays required for prenatal services. Hospitalization covered at 90% of Allowed Benefit after deductible. | Prenatal services and hospitalization covered at 80% of Allowed Benefit after deductible. |
| **Outpatient Surgery** | $10 co-pay PCP; $15 co-pay specialist | Office Setting – $30 PCP co-pay/$40 Specialist co-pay | $10 co-pay | $15 co-pay | 80% Allowed Benefit after deductible |
| **Physical Therapy** | $15 co-pay; 30 visits/per condition/per calendar year | Office Setting – $40 co-pay; limited to 30 days/condition/ benefit period; combined with speech & occupational therapy | $10 co-pay (limited to 30 visits/per condition/per year) | $15 co-pay (limited to 100 visits per year combined between Levels 2 and 3) | 80% Allowed Benefit after deductible (limited to 100 visits per year combined between Levels 2 and 3) |
| **Prescription Drug (CVS CAREMARK)**<br>***(includes diabetic supplies)*** | **RETAIL:** $5 generic/$20 preferred brand/$35 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $75 specialty*<br>*Units 5 & 6:* $75 specialty*<br>**MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:**<br>$10 generic/$40 preferred brand/$70 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $150 specialty*<br>*Units 5 & 6:* $150 specialty*<br>** Specialty may require pre-authorization* | **RETAIL:** $500 deductible, then: $15 generic/$35 preferred brand/$60 non-preferred brand; specialty* – 50% coinsurance up to a max payment of $150 (30 days)<br>**MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:**<br>$30 generic/$70 preferred brand/$120 non-preferred brand; specialty* – 50% coinsurance up to a max payment of $300 (90 days)<br>** Specialty may require pre-authorization* | **RETAIL:** $5 generic/$20 preferred brand/$35 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $75 specialty (may require pre-authorization)<br>*Units 5 & 6:* $75 specialty (may require pre-authorization)<br>**MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:**<br>$10 generic/$40 preferred brand/$70 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $150 specialty (may require pre-authorization)<br>*Units 5 & 6:* $150 specialty (may require pre-authorization) | | |
| **Routine Physicals** | No co-pay | No co-pay | No co-pay | No co-pay | 80% Allowed Benefit, no deductible |
| **Vision Care** | $10 co-pay through Davis Vision Providers – Optometrists or Opthamologists. Limited to one examination per calendar year. Discounts on glasses and contact lenses from participating Davis Vision Providers. You may also use your CareFirst Select Vision plan. | $10 co-pay through Davis Vision Providers. Routine eye exam (limited to 1 visit/per year). Discounts on glasses and contact lenses from participating Davis Vision Providers. | $10 co-pay through Davis Vision Providers – Optometrists or Opthamologists. Limited to one examination per calendar year. Discounts on glasses and contact lenses from participating Davis Vision Providers. You may also use your CareFirst Select Vision plan. | Not Covered — refer to Level 1 benefits or the CareFirst Select Vision plan. | |
| **Well Child Care** | No co-pay | No co-pay | No co-pay | No co-pay | 80% Allowed Benefit, no deductible |
| **Additional Program Benefits** | Disease Management/Case Management • Discount program through Blue 365 • CareFirst Assist | | | | |
| **Primary Care Office Visit Co-pays/ Specialist Office Visit Co-pays** | $10 co-pay<br>$15 co-pay | $30 co-pay after deductible<br>$40 co-pay after deductible | $10 co-pay<br>$10 co-pay | $15 co-pay<br>$15 co-pay | 80% Allowed Benefit, after deductible |
| **Calendar Year Deductible** | N/A | Individual – $4,500 individual; family – $9,000 | Individual/family – $0 | Individual – $200; family – $400 | Individual – $300; family – $600 |
| **Co-insurance** | 100% | Plan pays 70%; employee pays 30% | 100% | 90% | 80% |
| **Out-of-Pocket Maximum (Medical Only)** | Individual – $2,000; family – $6,000 | Individual – $6,350; family – $12,700 | Individual – $2,000; family – $6,000 | Individual – $2,000; family – $6,000 | Individual – $2,000; family – $6,000 |
| **Out-of-Pocket Max. (Comb. Medical & Rx)** | Individual – $6,350; family – $12,700 | Individual – $6,350; family – $12,700 | Individual – $6,350; family – $12,700 | Individual – $6,350; family – $12,700 | Individual – $6,350; family – $12,700 |
| **Calendar Year Maximum** | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| **Lifetime Maximum** | Unlimited, except for fertility services | Unlimited, except for fertility services | Unlimited, except for fertility services | Unlimited, except for fertility services | Unlimited, except for fertility services |

*Dependents must be added within 31 days of becoming eligible or wait until the next open enrollment period. • Dependents are covered until end of the month in which they turn 26. • This chart is for comparison purposes only. Please consult each plan benefit summary (available on-line) for full details.*

| Benefit | CareFirst/BCBS Preferred ProviderNetwork (PPN) | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Acupuncture Services** | $15 co-pay for preferred provider. | 80% of Allowed Benefit, after deductible. |
| **Chiropractic Services** | $15 co-pay in-network. Unlimited visits. | Benefit paid at 80% of Allowed Benefit after deductible |
| **Dental Services as a result of an accidental injury** | Restorative services for accidental injury to natural teeth–100% of Allowed Benefit | Restorative services for accidental injury to natural teeth–100% of Allowed Benefit |
| **Diagnostic, Lab Services, X-ray** | 100% of Allowed Benefit | 80% of Allowed Benefit after deductible |
| **Durable Medical Equipment** | 100% of Allowed Benefit | 80% of Allowed Benefit after deductible |
| **Emergency Room Visits** | $25 co-pay or if admitted 100% of Allowed Benefit. Urgent Care Centers – $15 co-pay | $25 co-pay or if admitted 100% of Allowed Benefit. Urgent Care Centers – $15 co-pay |
| **Family Planning/Fertility (subject to state mandate)** | Plan of treatment required<br>Artificial Insemination – 100% of allowed mandate, some services may require co-pay;<br>IVF – 100% of Allowed Benefit, some services may require co-pay (limited to 3 attempts per live birth, lifetime maximum benefit $100,000) | Plan of treatment required<br>Artificial Insemination – 80% of allowed benefit after deductible; IVF – 80% of Allowed Benefit after deductible (limited to 3 attempts per live birth, lifetime maximum benefit $100,000) |
| **Hearing Exams/Hearing Aids** | Hearing exam office setting – $15 co-pay. 100% of Allowed Benefit every 36 months per aid per ear. | Hearing exam – 80% of Allowed Benefit, after deductible. 100% of Allowed Benefit every 36 months per aid per ear. |
| **Hospitalization (Inpatient)/ Surgery** | 100% up to 365 days | 80% after deductible/365 days |
| **Inpatient Nervous and Mental; Alcohol/Substance Abuse** | Contact CareFirst Assist for pre-authorization at 1-800-245-7013. | |
| **Outpatient Nervous and Mental; Alcohol/Substance Abuse** | No pre-authorization required.<br>Contact CareFirst Assist for provider network information at 1-800-245-7013.<br>$15 co-pay per visit | No pre-authorization required. Contact CareFirst Assist for provider network information at 1-800-245-7013.<br>80% of Allowed Benefit after deductible. |
| **Maternity Care** | No co-pays required for prenatal services. Hospitalization covered at 100% of Allowed Benefit. | Prenatal services and hospitalization covered at 80% of Allowed Benefit after deductible. |
| **Outpatient Surgery** | 100% of Allowed Benefit | 80% of Allowed Benefit after deductible |
| **Physical Therapy** | 100 visits per year with $15 co-pay per office visit | Deductible, then 80% of Allowed Benefit for 100 visits per calendar year |
| **Prescription Drug (CVS CAREMARK)** ***(includes diabetic supplies)*** | **RETAIL:** $5 generic/$20 preferred brand/$35 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $75 specialty* \| *Units 5 & 6:* $75 specialty*<br>**MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:**<br>$10 generic/$40 preferred brand/$70 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $150 specialty* \| *Units 5 & 6:* $150 specialty*<br>** Specialty may require pre-authorization* | |
| **Routine Physicals** | No co-pay | 80% of Allowed Benefit, after deductible |
| **Vision Care** | Not included in medical benefit. See CareFirst BCBS Summary Dental and Vision Plans. | Not included in medical benefit. See CareFirst BCBS Summary Dental and Vision Plans. |
| **Well Child Care** | No co-pay | 80% of Allowed Benefit, after deductible |
| **Additional Program Benefits** | Disease Management/Case Management • Discount program through Blue 365<br>CareFirst Assist | |
| **Primary Care Office Visit Co-pays/ Specialist Office Visits Co-pays** | 100% of Allowed Benefit after $15<br>100% of Allowed Benefit after $15 | 80/20 after deductible |
| **Calendar Year Deductible** | N/A | Individual – $200; family – $400 |
| **Co-insurance** | 100% | 80/20 |
| **Out-of-Pocket Max. (Medical Only)** | Individual – $1,200; family – $2,400 | Individual – $1,200; family – $2,400 |
| **Out-of-Pocket Max. (Combined Medical & Rx)** | Individual – $6,350; family – $12,700 | Individual – $6,350; family – $12,700 |
| **Calendar Year Benefit Max.** | Unlimited | Unlimited |
| **Lifetime Maximum** | Unlimited, except for fertility services | Unlimited, except for fertility services |



Anne Arundel County Public Schools
*Division of Human Resources • Office of Benefits*

# 2020
# Medical Plans Comparison Chart
## *Active Employees*

*Our goal...to educate all employees so they can make an informed healthcare decision.*

CareFirst BlueCross BlueShield
From the CareFirst BlueCross BlueShield family of health care plans.

CVS CAREMARK

| Benefit | BlueChoice (HMO) "Open Access" Plan | BlueChoice (HMO) Low Option "Open Access" Plan | BlueChoice Triple Option "Open Access" Plan | | |
|---|---|---|---|---|---|
| | | | Level 1 | Level 2 | Level 3 |
| **Acupuncture Services** | $15 co-pay, 24 visits per calendar year | Not covered (except when approved or authorized by plan when used for anesthesia) | $10 co-pay, 24 visits per calendar year | $15 co-pay | 80% Allowed Benefit after deductible |
| **Chiropractic Services** | $15 co-pay, 20 visits per calendar year | Office Setting – Deductible, then $40/visit; 20 visits per calendar year | $10 co-pay (limited to 20 visits per year) | $15 co-pay (unlimited visits) | 80% Allowed Benefit after deductible (unlimited visits) |
| **Dental Services as a result of an accidental injury** | No co-pay – Covered for accidental bodily injury or to correct congenital anomalies | 100% Allowed Benefit after deductible | No co-pay covered for accidental bodily injury or to correct congenital anomalies | 90% Allowed Benefit after deductible covered for accidental bodily injury or to correct congenital anomalies | 80% Allowed Benefit after deductible |
| **Diagnostic, Lab Services, X-ray** | Covered in full for x-rays and lab services (Lab Corp only)<br>Other diagnostic – $15 co-pay (eg., MRIs) | Non-routine, office setting; $40 co-pay/visit<br>(Lab Corp only for lab services) | Lab no co-pay (Lab Corp only)<br>Other diagnostic – $10 co-pay | $15 co-pay | 80% Allowed Benefit after deductible |
| **Durable Medical Equipment** | 100% Allowed Benefit | 50% Allowed Benefit after deductible | 100% Allowed Benefit | 90% Allowed Benefit after deductible | 80% Allowed Benefit after deductible |
| **Emergency Room Visits** | Medical Emergency – $85 co-pay, waived if admitted<br>Urgent Care Centers – $10 PCP co-pay/$15 Specialist co-pay | $300 co-pay after deductible (waived if admitted)<br>Urgent Care Centers – $100 co-pay after deductible | $85 co-pay (waived if admitted)<br>Urgent Care Centers – $10 co-pay | Considered under Level 1. If Benefits are not available under Level 1, benefits may be payable under the appropriate level.<br>Urgent Care Centers – $15 co-pay | 80% Allowed Benefit after deductible |
| **Family Planning/Fertility (subject to state mandate)** | Infertility Counseling & Testing – $10 co-pay Artificial Insemination – covered at 50% of the plan allowance; IVF – covered at 50% of the plan allowance (limited to 3 attempts per live birth, lifetime maximum benefit $100,000) | 50% Allowed Benefit after deductible; IVF – (limited to 3 attempts per live birth, lifetime maximum benefit $100,000) | Processed under Level 2 | 90% Allowed Benefit after deductible | 80% Allowed Benefit after deductible |
| **Hearing Exams/Hearing Aids** | Hearing exam – $10 co-pay. Aids – 100% Allowed Benefit for each ear; member may be balance billed up to total charge. Benefit once every 36 months. | Covered for minor children (up to age 18). 100% Allowed Benefit for each ear (co-pays and deductible do not apply); member may be balance billed up to total charge. | Hearing exam – $10 co-pay. Aids – 100% Allowed Benefit for each ear; member may be balance billed up to total charge. Benefit once every 36 months. | Hearing exam – $15 co-pay. 100% of Allowed Benefit every 36 months per aid per ear; member may be balance billed up to total charge. | Hearing exam – 80% of Allowed Benefit, after deductible. 100% of Allowed Benefit every 36 months per aid per ear; member may be balance billed up to total charge. |
| **Hospitalization (Inpatient)/ Surgery** | Covered in full | 30% Allowed Benefit after deductible | No co-pay | 90% Allowed Benefit after deductible | 80% Allowed Benefit after deductible |
| **Inpatient Nervous and Mental; Alcohol/Substance Abuse** | Contact CareFirst Assist for pre-authorization at 1-800-245-7013. | Contact CareFirst Assist for pre-authorization at 1-800-245-7013. 30% Allowed Benefit after deductible | Contact CareFirst Assist for pre-authorization at 1-800-245-7013.<br>No co-pay | 100% Allowed Benefit, no deductible | 80% Allowed Benefit after deductible |
| **Outpatient Nervous and Mental; Alcohol/Substance Abuse** | No pre-authorization required. Contact CareFirst Assist for provider network information at 1-800-245-7013. $10 co-pay per visit. | Office Setting – $30 co-pay after deductible | No pre-authorization required. Contact CareFirst Assist for provider network information at 1-800-245-7013.<br>$10 co-pay per visit | $10 co-pay per visit | Deductible and co-insurance apply |
| **Maternity Care** | No co-pays required for prenatal services. Hospitalization covered at 100% of Allowed Benefit. | No co-pays required for pre- and postnatal services. Delivery and hospitalization – 30% Allowed Benefit after deductible | No co-pays required for prenatal services. Hospitalization covered at 100% of Allowed Benefit. | No co-pays required for prenatal services. Hospitalization covered at 90% of Allowed Benefit after deductible. | Prenatal services and hospitalization covered at 80% of Allowed Benefit after deductible. |
| **Outpatient Surgery** | $10 co-pay PCP; $15 co-pay specialist | Office Setting – $30 PCP co-pay/$40 Specialist co-pay | $10 co-pay | $15 co-pay | 80% Allowed Benefit after deductible |
| **Physical Therapy** | $15 co-pay; 30 visits/per condition/per calendar year | Office Setting – $40 co-pay; limited to 30 days/condition/ benefit period; combined with speech & occupational therapy | $10 co-pay (limited to 30 visits/per condition/per year) | $15 co-pay (limited to 100 visits per year combined between Levels 2 and 3) | 80% Allowed Benefit after deductible (limited to 100 visits per year combined between Levels 2 and 3) |
| **Prescription Drug (CVS CAREMARK)**<br>***(includes diabetic supplies)*** | **RETAIL:** $5 generic/$20 preferred brand/$35 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $75 specialty*<br>*Units 5 & 6:* $75 specialty*<br>**MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:**<br>$10 generic/$40 preferred brand/$70 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $150 specialty*<br>*Units 5 & 6:* $150 specialty*<br>** Specialty may require pre-authorization* | **RETAIL:** $500 deductible, then: $15 generic/$35 preferred brand/$60 non-preferred brand; specialty* – 50% coinsurance up to a max payment of $150 (30 days)<br>**MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:**<br>$30 generic/$70 preferred brand/$120 non-preferred brand; specialty* – 50% coinsurance up to a max payment of $300 (90 days)<br>** Specialty may require pre-authorization* | **RETAIL:** $5 generic/$20 preferred brand/$35 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $75 specialty (may require pre-authorization)<br>*Units 5 & 6:* $75 specialty (may require pre-authorization)<br>**MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:**<br>$10 generic/$40 preferred brand/$70 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $150 specialty (may require pre-authorization)<br>*Units 5 & 6:* $150 specialty (may require pre-authorization) | | |
| **Routine Physicals** | No co-pay | No co-pay | No co-pay | No co-pay | 80% Allowed Benefit, no deductible |
| **Vision Care** | $10 co-pay through Davis Vision Providers – Optometrists or Opthamologists. Limited to one examination per calendar year. Discounts on glasses and contact lenses from participating Davis Vision Providers. You may also use your CareFirst Select Vision plan. | $10 co-pay through Davis Vision Providers. Routine eye exam (limited to 1 visit/per year). Discounts on glasses and contact lenses from participating Davis Vision Providers. | $10 co-pay through Davis Vision Providers – Optometrists or Opthamologists. Limited to one examination per calendar year. Discounts on glasses and contact lenses from participating Davis Vision Providers. You may also use your CareFirst Select Vision plan. | Not Covered — refer to Level 1 benefits or the CareFirst Select Vision plan. | |
| **Well Child Care** | No co-pay | No co-pay | No co-pay | No co-pay | 80% Allowed Benefit, no deductible |
| **Additional Program Benefits** | Disease Management/Case Management • Discount program through Blue 365 • CareFirst Assist | | | | |
| **Primary Care Office Visit Co-pays/ Specialist Office Visit Co-pays** | $10 co-pay<br>$15 co-pay | $30 co-pay after deductible<br>$40 co-pay after deductible | $10 co-pay<br>$10 co-pay | $15 co-pay<br>$15 co-pay | 80% Allowed Benefit, after deductible |
| **Calendar Year Deductible** | N/A | Individual – $4,500 individual; family – $9,000 | Individual/family – $0 | Individual – $200; family – $400 | Individual – $300; family – $600 |
| **Co-insurance** | 100% | Plan pays 70%; employee pays 30% | 100% | 90% | 80% |
| **Out-of-Pocket Maximum (Medical Only)** | Individual – $2,000; family – $6,000 | Individual – $6,350; family – $12,700 | Individual – $2,000; family – $6,000 | Individual – $2,000; family – $6,000 | Individual – $2,000; family – $6,000 |
| **Out-of-Pocket Max. (Comb. Medical & Rx)** | Individual – $6,350; family – $12,700 | Individual – $6,350; family – $12,700 | Individual – $6,350; family – $12,700 | Individual – $6,350; family – $12,700 | Individual – $6,350; family – $12,700 |
| **Calendar Year Maximum** | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| **Lifetime Maximum** | Unlimited, except for fertility services | Unlimited, except for fertility services | Unlimited, except for fertility services | Unlimited, except for fertility services | Unlimited, except for fertility services |

*Dependents must be added within 31 days of becoming eligible or wait until the next open enrollment period. • Dependents are covered until end of the month in which they turn 26. • This chart is for comparison purposes only. Please consult each plan benefit summary (available on-line) for full details.*

| Benefit | CareFirst/BCBS Preferred ProviderNetwork (PPN) | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Acupuncture Services** | $15 co-pay for preferred provider. | 80% of Allowed Benefit, after deductible. |
| **Chiropractic Services** | $15 co-pay in-network. Unlimited visits. | Benefit paid at 80% of Allowed Benefit after deductible |
| **Dental Services as a result of an accidental injury** | Restorative services for accidental injury to natural teeth–100% of Allowed Benefit | Restorative services for accidental injury to natural teeth–100% of Allowed Benefit |
| **Diagnostic, Lab Services, X-ray** | 100% of Allowed Benefit | 80% of Allowed Benefit after deductible |
| **Durable Medical Equipment** | 100% of Allowed Benefit | 80% of Allowed Benefit after deductible |
| **Emergency Room Visits** | $25 co-pay or if admitted 100% of Allowed Benefit. Urgent Care Centers – $15 co-pay | $25 co-pay or if admitted 100% of Allowed Benefit. Urgent Care Centers – $15 co-pay |
| **Family Planning/Fertility (subject to state mandate)** | Plan of treatment required<br>Artificial Insemination – 100% of allowed mandate, some services may require co-pay;<br>IVF – 100% of Allowed Benefit, some services may require co-pay (limited to 3 attempts per live birth, lifetime maximum benefit $100,000) | Plan of treatment required<br>Artificial Insemination – 80% of allowed benefit after deductible; IVF – 80% of Allowed Benefit after deductible (limited to 3 attempts per live birth, lifetime maximum benefit $100,000) |
| **Hearing Exams/Hearing Aids** | Hearing exam office setting – $15 co-pay. 100% of Allowed Benefit every 36 months per aid per ear. | Hearing exam – 80% of Allowed Benefit, after deductible. 100% of Allowed Benefit every 36 months per aid per ear. |
| **Hospitalization (Inpatient)/ Surgery** | 100% up to 365 days | 80% after deductible/365 days |
| **Inpatient Nervous and Mental; Alcohol/Substance Abuse** | Contact CareFirst Assist for pre-authorization at 1-800-245-7013. | |
| **Outpatient Nervous and Mental; Alcohol/Substance Abuse** | No pre-authorization required.<br>Contact CareFirst Assist for provider network information at 1-800-245-7013.<br>$15 co-pay per visit | No pre-authorization required. Contact CareFirst Assist for provider network information at 1-800-245-7013.<br>80% of Allowed Benefit after deductible. |
| **Maternity Care** | No co-pays required for prenatal services. Hospitalization covered at 100% of Allowed Benefit. | Prenatal services and hospitalization covered at 80% of Allowed Benefit after deductible. |
| **Outpatient Surgery** | 100% of Allowed Benefit | 80% of Allowed Benefit after deductible |
| **Physical Therapy** | 100 visits per year with $15 co-pay per office visit | Deductible, then 80% of Allowed Benefit for 100 visits per calendar year |
| **Prescription Drug (CVS CAREMARK)** ***(includes diabetic supplies)*** | **RETAIL:** $5 generic/$20 preferred brand/$35 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $75 specialty* \| *Units 5 & 6:* $75 specialty*<br>**MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:**<br>$10 generic/$40 preferred brand/$70 non-preferred brand<br>*Units 1–4:* 50% coinsurance up to a max of $150 specialty* \| *Units 5 & 6:* $150 specialty*<br>** Specialty may require pre-authorization* | |
| **Routine Physicals** | No co-pay | 80% of Allowed Benefit, after deductible |
| **Vision Care** | Not included in medical benefit. See CareFirst BCBS Summary Dental and Vision Plans. | Not included in medical benefit. See CareFirst BCBS Summary Dental and Vision Plans. |
| **Well Child Care** | No co-pay | 80% of Allowed Benefit, after deductible |
| **Additional Program Benefits** | Disease Management/Case Management • Discount program through Blue 365<br>CareFirst Assist | |
| **Primary Care Office Visit Co-pays/ Specialist Office Visits Co-pays** | 100% of Allowed Benefit after $15<br>100% of Allowed Benefit after $15 | 80/20 after deductible |
| **Calendar Year Deductible** | N/A | Individual – $200; family – $400 |
| **Co-insurance** | 100% | 80/20 |
| **Out-of-Pocket Max. (Medical Only)** | Individual – $1,200; family – $2,400 | Individual – $1,200; family – $2,400 |
| **Out-of-Pocket Max. (Combined Medical & Rx)** | Individual – $6,350; family – $12,700 | Individual – $6,350; family – $12,700 |
| **Calendar Year Benefit Max.** | Unlimited | Unlimited |
| **Lifetime Maximum** | Unlimited, except for fertility services | Unlimited, except for fertility services |



Anne Arundel County Public Schools
*Division of Human Resources • Office of Benefits*

# 2021
# Medical Plans Comparison Chart
## *Active Employees*

*Our goal...to educate all employees so they can make an informed healthcare decision.*

CareFirst BlueCross BlueShield
From the CareFirst BlueCross BlueShield family of health care plans.

CVS CAREMARK