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) Other diagnostic – $15 co-pay (eg., MRIs)	Non-routine, office setting; $40 co-pay/visit (Lab Corp only for lab services)	Lab no co-pay (Lab Corp only) 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 Urgent Care Centers – $10 PCP co-pay/$15 Specialist co-pay	$300 co-pay after deductible (waived if admitted) Urgent Care Centers – $100 co-pay after deductible	$85 co-pay (waived if admitted) 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. 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. 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. $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) ***(includes diabetic supplies)***	**RETAIL:** $5 generic/$20 preferred brand/$35 non-preferred brand *Units 1–4:* 50% coinsurance up to a max of $75 specialty* *Units 5 & 6:* $75 specialty* **MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:** $10 generic/$40 preferred brand/$70 non-preferred brand *Units 1–4:* 50% coinsurance up to a max of $150 specialty* *Units 5 & 6:* $150 specialty* ** 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) **MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:** $30 generic/$70 preferred brand/$120 non-preferred brand; specialty* – 50% coinsurance up to a max payment of $300 (90 days) ** Specialty may require pre-authorization*	**RETAIL:** $5 generic/$20 preferred brand/$35 non-preferred brand *Units 1–4:* 50% coinsurance up to a max of $75 specialty (may require pre-authorization) *Units 5 & 6:* $75 specialty (may require pre-authorization) **MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:** $10 generic/$40 preferred brand/$70 non-preferred brand *Units 1–4:* 50% coinsurance up to a max of $150 specialty (may require pre-authorization) *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 $15 co-pay	$30 co-pay after deductible $40 co-pay after deductible	$10 co-pay $10 co-pay	$15 co-pay $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 Artificial Insemination – 100% of allowed mandate, some services may require co-pay; 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 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. Contact CareFirst Assist for provider network information at 1-800-245-7013. $15 co-pay per visit	No pre-authorization required. Contact CareFirst Assist for provider network information at 1-800-245-7013. 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 *Units 1–4:* 50% coinsurance up to a max of $75 specialty* | *Units 5 & 6:* $75 specialty* **MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE:** $10 generic/$40 preferred brand/$70 non-preferred brand *Units 1–4:* 50% coinsurance up to a max of $150 specialty* | *Units 5 & 6:* $150 specialty* ** 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 CareFirst Assist	
Primary Care Office Visit Co-pays/ Specialist Office Visits Co-pays	100% of Allowed Benefit after $15 100% 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