EPO BlueChoice Advantage/Exclusive BlueChoice Advantage Summary of Benefits

Eastern Shore of Maryland Educational Consortium

Services	In-Network You Pay[1,2]
	Visit carefirst.com/doctor to locate providers
24-HOUR NURSE ADVICE LINE	
Free advice from a registered nurse. Visit **carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.
ANNUAL DEDUCTIBLE (Benefit period)	
Individual	None
Family	None
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[3]	
Individual	$1,200
Family	$3,600
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit) (one per benefit period)	No charge*
Breast Cancer Screening	No charge*
Pap Test	No charge*
Prostate Cancer Screening	No charge*
Colorectal Cancer Screening	No charge*
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	$20 PCP/$30 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans)	$20 per visit
Lab	$20 per visit
X-ray	$20 per visit
Allergy Testing	No charge*
Allergy Serum	$24 per visit
Allergy Shots	No charge*
Physical, Speech, Occupational, Radiation, Chemotherapy, Renal Dialysis and Inhalation Therapy	Office—$30 per visit Outpatient Facility—$40 per visit Outpatient physician—$30 per visit
Cardiac Rehabilitation	Outpatient Facility—$40 per visit Outpatient Physician—$30 per visit
Chiropractic	$30 per visit
Acupuncture	$30 per visit
EMERGENCY SERVICES	
Urgent Care Center	$30 per visit
Emergency Room—Facility Services	$100 per visit (waived if admitted)
Emergency Room—Physician Services	$30 per visit
Ambulance (if medically necessary)	No charge*
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)	
Outpatient Facility Services	$40 per visit
Outpatient Physician Services	$30 per visit
Inpatient Facility Services	$100 per day (maximum of $300 per admit)
Inpatient Physician Services	No charge*

Services	In-Network You Pay[1,2]
HOSPITAL ALTERNATIVES	
Home Health Care	No charge*
Hospice	No charge*
Skilled Nursing Facility	No charge*
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	$100 per day (maximum of $300 per admit)
Nursery Care of Newborn	No charge*
Artificial and Intrauterine Insemination[4]	Office—$30 per visit Outpatient Facility—$40 per visit Outpatient Physician—$30 per visit
In Vitro Fertilization Procedures[4] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	Office—$30 per visit Outpatient Facility—$40 per visit Outpatient Physician—$30 per visit
MENTAL HEALTH AND SUBSTANCE USE DISORDER (Members are responsible for applicable physician and facility fees)	
Inpatient Facility Services	$100 per day (maximum of $300 per admit)
Inpatient Physician Services	No charge*
Outpatient Facility Services	$30 per visit
Outpatient Physician Services	$30 per visit
Office Visits	$20 per visit
Medication Management	$20 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	No charge*
Hearing Aids for ages 0–18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	No charge*
Adult Hearing Aids/Routine Hearing Check	Not covered
Hair Prosthesis	Coverage up to $350 maximum

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.

[1] When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

[2] In-network: When covered services are rendered by a provider in the Preferred Provider network, care is reimbursed at the in-network level. In-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueCross BlueShield (CareFirst), however, in certain circumstances, the Allowed Benefit for a Preferred Provider may be established by law.

[3] For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.

[4] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

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.

CareFirst

Pharmacy Program Summary of Benefits

Eastern Shore of Maryland Educational Consortium

Formulary 2 ■ 3-Tier ■ $8/30/45 ■ Specialty $30/$45

Plan Feature	Amount You Pay	Description
Deductible	See medical summary of benefits for annual deductible amount	If you meet your deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any deductible are noted below.
Out-of-Pocket Maximum	$5,100 Individual $10,200 Family	If you reach your out-of-pocket maximum, CareFirst or CareFirst BlueChoice will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Preventive Drugs (up to a 34-day supply)	$0	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List.*
Oral Chemotherapy Drugs and Diabetic Supplies (up to a 34-day supply)	$0	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	$8	Generic drug are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	$30	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	$45	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Maintenance Drugs (up to a 100-day supply)	**Retail Copays** Generic: $16 Preferred Brand: $60 Non-Preferred Brand: $90 **Mail Order Copays** Generic: $16 Preferred Brand: $60 Non-Preferred Brand: $90	Maintenance generic, preferred brand and non-preferred brand drugs up to a 100-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Maintenance preferred and non-preferred specialty drugs up to a 100-day supply **must be filled through Exclusive Specialty Pharmacy Network** and you pay a copay.
2023 Enhanced Diabetic Benefits	Plans effective in 2023 will cover preferred brand insulin at $0 copay (no deductible) and non-preferred brand insulin at $35 copay (no deductible) for a one-month supply. Diabetic supplies will not be subject to deductible.	
Restricted Generic Substitution	If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay or coinsurance. Also, if your prescription is written for a brand-name drug and DAW (dispense as written) is noted by your doctor, you will only pay the copay or coinsurance.	

Visit carefirst.com/rx *for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.*

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Policy Form Numbers: MD/CFBC/RX (R. 1/18) • CFMI/RX (R. 1/18) • CFMI/Matrix/PRESC DRUG (R. 1/18) • MD/CF/RX (R. 1/18)

CareFirst
Family of health care plans

Preferred Dental

Effective 1/1/2023

CareFirst BlueCross BlueShield (CareFirst) offers Preferred (PPO) Dental coverage, which allows you the freedom to see any dentist you choose.

Advantages of the plan

- **Freedom of choice, freedom to save**—With Preferred Dental coverage, you can see any dentist you choose. However, this plan also gives you the option to reduce your out-of-pocket expenses by visiting a dentist who participates in our Preferred Provider network. It's your choice!
- **Comprehensive coverage**—Benefits include regular preventive care, X-rays, dental surgery and more. A summary of your benefits is available on the following page.
- **Nationwide access to participating dentists**—You have access to one of the nation's largest dental networks, with more than 95,000 participating dentists throughout the United States. Preferred Dental gives you coverage for the dental services you need, whenever and wherever you need them.

Three options for care

- **Option 1**—By choosing a dentist in the Preferred Provider Network, you incur the lowest out-of-pocket costs. These dentists accept CareFirst's allowed benefit as payment in full, which means no balance billing for you.
- **Option 2**—You can receive out-of-network coverage from a dentist who participates with CareFirst, but not through the Preferred Provider Network. Similar to Option 1, there is no balance billing. You are responsible for out-of-network deductibles and coinsurance, and also have the convenience of your provider being reimbursed directly.
- **Option 3**—You can receive out-of-network coverage from a dentist who has no relationship with CareFirst. With this option, you may experience higher out-of-pocket costs since you pay your provider directly. You can be balance billed and must pay your deductible and coinsurance as well.

Frequently asked questions

How do I find a preferred dentist?

You can access an online directory 24 hours a day at **carefirst.com/doctor**. Click on *Dental* and then select *Preferred Dental.*

How much will I have to pay for dental services?

The chart on the following page gives you an overview of many of the covered services along with the percentage of what you will pay for each class of services, both in- and out-of-network.

Is there a lot of paperwork?

There is no paperwork when you see a participating dentist, you are free from filing claims. However, if you use a non-participating dentist, you may be required to pay all costs at the time of care, and then submit a claim form in order to be reimbursed for covered services.

Who can I call with questions about my dental plan?

Call Dental Customer Service toll free at: 866-891-2802 between 8:30 a.m. and 5 p.m. ET, Monday–Friday.

Summary of Benefits

Eastern Shore Educational Consortium

(Talbot Board of Education—Only Active Employees are Eligible)

Services		In-network You Pay (Preferred Dental Provider)	Out-of-network You Pay (Traditional Dental or Non-Participating Dental Provider)
DEDUCTIBLE APPLIES TO ALL BASIC AND MAJOR SERVICES **There is a separate deductible for in-and out-of-network services**		$25 Individual $75 Family	$25 Individual $75 Family
ANNUAL MAXIMUM APPLIES TO ALL SERVICES EXCEPT ORTHODONTIC		Plan pays $1,500 per member	
PREVENTIVE AND DIAGNOSTIC SERVICES			
▪ Oral Exams (two per benefit period) ▪ Prophylaxis (two cleanings per benefit period) ▪ Bitewing X-rays ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months)	▪ Fluoride treatments (two per benefit period per member, until the end of the year the member reaches the age 19) ▪ Sealants on permanent molars (once per tooth per 36 months per member, until the end of the year the member reaches the age 19) ▪ Space maintainers (once per 60 months) ▪ Palliative emergency treatment	100% of Allowed Benefit[1]	100% of Allowed Benefit[1]
BASIC SERVICES			
▪ Direct placement fillings using approved materials (one filling per surface per 12 months)	▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment) ▪ Simple extractions	80% of Allowed Benefit after deductible[1]	80% of Allowed Benefit after deductible[1]
MAJOR SERVICES—SURGICAL			
▪ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy)	▪ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section) ▪ General anesthesia rendered for a covered dental service	80% of Allowed Benefit after deductible[1]	80% of Allowed Benefit after deductible[1]
MAJOR SERVICES—RESTORATIVE			
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges, crowns, inlays and onlays (once per 60 months) ▪ Denture adjustments and relining (limits apply for regular and immediate dentures)	▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance) ▪ Dental implants, subject to medical necessity review (once per 60 months)	50% of Allowed Benefit after deductible[1]	50% of Allowed Benefit after deductible[1]
ORTHODONTIC SERVICES			
▪ Benefits for orthodontic services may be available for covered members under age 19 who meet treatment criteria.		50% of Allowed Benefit[1]	50% of Allowed Benefit[1]
▪ Orthodontic Lifetime Maximum		Plan pays $1,500 per member	

[1] NOTE: CareFirst payments are based on the CareFirst Allowed Benefit. Participating and Preferred Dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.

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

CareFirst
Family of health care plans

BlueVision Plus

A plan for healthy eyes, healthy lives

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueCross BlueShield and CareFirst BlueChoice, through the Davis Vision, Inc. national network of providers.

How the plan works

How do I find a provider?

To find a provider, go to **carefirst.com** and utilize the *Find a Provider* feature or call Davis Vision at **800-783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

How do I receive care from a network provider?

Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueCross BlueShield or CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

What if I go out-of-network?

Staying in-network gives you the best benefit, but BlueVision Plus does offer an out-of-network allowance schedule as well. In this case, you may see any provider you wish, but you will be responsible for all payments up-front. You will also be responsible for filing the claim with Davis Vision for reimbursement and paying any balances over the allowed benefit to the non-participating provider. You can find the claim form by going to **carefirst.com**, locate *For Members*, then click on *Forms, Vision, Davis Vision*.

Can I get contacts and eyeglasses in the same benefit period?

With BlueVision Plus, the benefit covers one pair of eyeglasses or a supply of contact lenses per benefit period.

Mail order replacement contact lenses

DavisVisionContacts.com offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses, easy, convenient purchasing online and quick shipping direct to your door.

Need more information? Visit carefirst.com or call 800-783-5602.

Summary of Benefits

Eastern Shore of Maryland Education Consortium

(12-month benefit period)

In-network	You Pay
EYE EXAMINATIONS	
Routine Eye Examination with dilation (per benefit period)	No copay
FRAMES	
Davis Vision Frame Collection	$20 copay for Fashion and Designer frames $40 copay for Premier frames
Non-Collection Frame	Plan pays up to $100, you pay balance plus $20 frame copay
SPECTACLE LENSES	
Basic Single Vision (including lenticular lenses)	$20 copay
Basic Bifocal	$20 copay
Basic Trifocal	$20 copay
CONTACT LENSES *(initial supply)*	
Medically Necessary Contacts	No copay with prior approval
Davis Vision Contact Lens Collection	$40 copay
Other Single Vision Contact Lenses	Plan pays $97, you pay balance
Other Bifocal Contact Lenses	Plan pays $127, you pay balance
LENS OPTIONS[1] *(add to spectacle lens prices above)*	
Standard Progressive Lenses	$50
Premium Progressive Lenses (Varilux®, etc.)	$90
Ultra Progressive Lenses (digital)	$140
Polarized Lenses	$75
High Index Lenses	$55
Blended Segment Lenses	$20
Polycarbonate Lenses for children, monocular and high prescription	No copay
Polycarbonate Lenses for all other patients	$30
Transition Lenses	$65
Intermediate Vision Lenses	$30
Photochromic Lenses	$20
Scratch-Resistant Coating	$20
Standard Anti-Reflective (AR) Coating	$35
Premium AR Coating	$48
Ultra AR Coating	$60
Ultraviolet (UV) Coating	$12
Tinting	No copay
Plastic Photosensitive Lenses	$65
Oversized Lenses	No copay

In-network	You Pay
CONTACT LENSES[1] *(mail order)*	
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices
Laser Vision Correction[1]	Up to 40%–50% off the national average price of traditional LASIK

Out-of-network	You Pay
Routine Eye Examination with dilation (per benefit period)	Plan pays $36, you pay balance
Frames	Plan pays $30, you pay balance
Single Lenses	Plan pays $42, you pay balance
Bifocal Lenses	Plan pays $67, you pay balance
Trifocal Lenses	Plan pays $90, you pay balance
Lenticular (post-cataract) Eyeglass Lenses	Plan pays $157, you pay balance
Medically Necessary Contacts	Plan pays $80, you pay balance
Elective Contact Lenses	Plan pays $71, you pay balance
Elective Bifocal Contact Lenses	Plan pays $97, you pay balance

[1] These services or supplies are not considered covered benefits under the Plan. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.

Exclusions

The following services are excluded from coverage:

1. Diagnostic services, except as listed in *What's Covered* under the Evidence of Coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
4. Services or supplies not specifically approved by the Vision Care Designee where required in *What's Covered* under the Evidence of Coverage.
5. Orthoptics, vision training and low vision aids.
6. Replacement, within the same benefit period of frames, lenses or contact lenses that were lost.
7. Non-prescription glasses, sunglasses or contact lenses.
8. Vision Care services for cosmetic use.

Benefits issued under policy form numbers: Non-rider/Freestanding: MD: MD/CF/GC (R, 10/07) • MD/CF/EOC/D-V (10/08) • MD/CF/DOCS-V (9/04) • MD/CF/SOB-V (R, 1/06) • MD/CF/ELIG (R, 1/08) • CFMI/51+/GC (R, 7/10) • CFMI/EOC/D-V (7/09) • CFMI/VISION DOCS (7/09) • CFMI/VISION SOB (7/09) • CFMI/ELIG/D-V (7/09) and any amendments.

DC: DC/CF/GC (R, 1/09) • DC/CF/COC-V (9/04) • DC/CF/DOCS-V (9/04) • DC/CF/SOB-V (R, 1/06) • DC/CF/ELIG (9/04) • VA: VA/CF/GC (R, 1/09) • VA/CF/COC-V (9/04) • VA/CF/DOCS-V (9/04) • VA/CF/SOB-V (R, 1/06) • VA/CF/ELIG (9/04) • as amended

Ridered: CFMI/51+/VISION (4/09) • MD/BCOO/VISION (R, 1/06) • MD/CF/VISION (R, 1/06) • DC/BCOO/VISION (R, 1/06) • DC/CF/VISION(R, 1/06) • VA/BCOO/VISION (R, 1/06) • VA/CF/VISION (R, 1/06).

CareFirst
Family of health care plans