EASTERN SHORE OF MARYLAND EDUCATIONAL CONSORTIUM
EPO MEDICAL BENEFITS

The Preferred Provider Network gives you access to a quality network of practitioners and hospitals within Maryland. The BlueCard® PPO program provides access to a national network.

- No need to enroll with a primary care physician
- No permission required to see an in-network specialist

In Network benefits are provided when you use Preferred Providers. In-network providers must render all services.

IN-NETWORK	OUT-OF-NETWORK
• You choose a network practitioner, specialist or hospital • You have low out-of-pocket costs • You are responsible for per visit copayments	BENEFITS ARE NOT COVERED OUT-OF-NETWORK, YOU MUST USE AN IN-NETWORK PROVIDER.

If an in-network specialist is not available to provide services, the in-network physician may refer you to an out-of-network specialist. In-network benefits will apply if the referring in-network physician reports the referral and receives approval through the Referral Service Unit. Whenever in-network benefits are applied to an out-of-network, non-participating provider, you will be responsible for any balance remaining after Plan payment.

- To find participating Preferred Providers in Maryland Call the Preferred Provider Hotline 1-800-235-5160 or reach us on the World Wide Web at: http://www.carefirst.com
- To find participating BlueCard PPO healthcare providers outside of Maryland, Call BlueCard Access at: 1-800-810-BLUE (2583) OR Reach us on the World Wide Web at: http://provider.bcbs.com/

	EPO IN-NETWORK	EPO OUT-OF-NETWORK **(OON)
TYPE OF SERVICE	**PLAN PAYMENT**	**PLAN PAYMENT**
BENEFIT PERIOD	CALENDAR YEAR	
DEDUCTIBLE	NOT APPLICABLE	NO BENEFIT OON
ANNUAL OUT-OF-POCKET MAXIMUM: Plan has a separate max for medical and drug expenses which accumulate independently		
➢ **Medical**	$1,200 individual $3,600 family	NO BENEFIT OON
➢ **Prescription Drug**	$5,400 Individual $9600 Family	NO BENEFIT OON
LIFETIME MAXIMUM	UNLIMITED	NO BENEFIT OON
Copayments for certain services	➢ Office Visit $20 per visit ➢ Hospital Facility $40 per visit ➢ Practitioner (at the hospital) $30 per visit	NO BENEFIT OON
TYPE OF SERVICE	**PLAN PAYMENT**	**PLAN PAYMENT**
HOSPITAL INPATIENT PREADMISSION REVIEW/APPROVAL REQUIRED ➢ Semi-private room or intensive care unit ➢ Operating room/special treatment room ➢ All medically necessary services ➢ Includes Medical, Surgical, Maternity, Physical Rehab, Psychiatric and Substance Abuse Admissions	100% of "AB"	NO BENEFIT OON
➢ Extended Care Facility Benefits (when used as an alternative to acute inpatient days)	100% of "AB"	NO BENEFIT OON

"AB"= ALLOWED BENEFIT **** Non-Participating providers can bill you up to total charges.**

Certain outpatient services require approval to begin or continue outpatient treatment including outpatient rehabilitative services; private duty nursing; home health care; hospice services; artificial insemination and invitro fertilization.

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TYPE OF SERVICE	EPO IN-NETWORK PLAN PAYMENT	EPO OUT-OF-NETWORK ** (OON) PLAN PAYMENT
OUTPATIENT SURGERY		
➢ Outpatient Facility Services	100% of "AB" after $40 copay	NO BENEFIT OON
➢ Physician Care in Outpatient Department	100% of "AB" after $30 copay	NO BENEFIT OON
➢ Practitioner in Office	100% of "AB" after $20 copay	NO BENEFIT OON
PHYSICIAN SERVICES		
➢ Office visits, home visits, second surgical opinion	100% of "AB" after $20 copay	NO BENEFIT OON
➢ Inpatient Care/Physical Rehabilitation	100% of "AB"	NO BENEFIT OON
➢ Surgeon, In-Hospital visits	100% of "AB"	NO BENEFIT OON
➢ Assistant Surgeon, Anesthesiologist	100% of "AB"	Paid at in-network benefit**
MATERNITY (Outpatient)		
➢ Physician and medical services	100% of "AB"	NO BENEFIT OON
➢ Invitro Fertilization IVF benefits are limited three attempts per live birth; and, a lifetime maximum benefit of $100,000. Pre Approval Required	100% of "AB"	NO BENEFIT OON
➢ Artificial Insemination Pre Approval Required	100% of "AB"	NO BENEFIT OON
URGENT CARE **Emergency accident, trauma & medical emergency.**		
➢ Outpatient Facility Services	100% of "AB" after $40 copay	NO BENEFIT OON
➢ Practitioner in Outpatient Facility	100% of "AB" after $30 copay	NO BENEFIT OON
➢ Practitioner in Office	100% of "AB" after $20 copay	NO BENEFIT OON
HOSPITAL OUTPATIENT NON-SURGICAL		
➢ Outpatient Facility Services	100% of "AB" after $40 copay	NO BENEFIT OON
➢ Physician Care in Outpatient Department	100% of "AB" after $30 copay	NO BENEFIT OON
OUTPATIENT DIAGNOSTIC - LAB		
➢ Physician Office/Independent Lab	100% of "AB" after $20 copay	NO BENEFIT OON
➢ Outpatient (Facility)	100% of "AB" after $20 copay	Paid at in-network benefit **
➢ Outpatient Professional Component billing – charge for "reading"	100% of the "AB	Paid at in-network benefit **
Mammogram Screening ***GUIDELINES APPLY***	Paid the same as diagnostic	Paid the same as diagnostic
WELL CARE		
➢ Adult Routine Physical Exam	100% of "AB" after appropriate copay	NO BENEFIT OON
➢ Routine GYN Exam	100% of "AB" after appropriate copay	NO BENEFIT OON
➢ Well Child Visits guidelines apply	100% of "AB" after appropriate copay	NO BENEFIT OON
RADIATION THERAPY, CHEMOTHERAPY & RENAL DIALYSIS		
➢ Facility Billed	$40 member copay	NO BENEFIT OON
➢ Practitioner in Facility	$30 member copay	NO BENEFIT OON
➢ Practitioner in Office	$20 member copay	NO BENEFIT OON
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	Unlimited visits	
➢ Facility Billed	$40 member copay	NO BENEFIT OON
➢ Practitioner in Facility	$30 member copay	
➢ Practitioner in Office	$20 member copay	NO BENEFIT OON

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RESPIRATORY & INHALATION THERAPY		
➢ Facility Billed ➢ Practitioner in Facility	$40 member copay $30 member copay	NO BENEFIT OON
➢ Practitioner in Office	$20 member copay	NO BENEFIT OON
OUTPATIENT CARDIAC REHAB: limited to JCAH approved program following inpatient admission		
➢ Facility Billed ➢ Practitioner in Facility	$40 member copay $30 member copay	NO BENEFIT OON
OUTPATIENT PSYCHIATRIC & SUBSTANCE ABUSE.	Paid the same as Outpatient Medical Services	NO BENEFIT OON
TRANSPLANTS		
ORGAN & TISSUE TRANSPLANTS: All medically necessary non-experimental transplants. Prior Authorization Required ✦ **Organ transplant procurement** ✦ **Organ transplant travel: $150 per day up to $10,000 maximum**	Benefits are available to the same extent as benefits provided for other illnesses	NO BENEFIT OON
OTHER SERVICES		
➢ **CHIROPRACTIC SERVICES**	Unlimited visits 100% of "AB" after appropriate copay	NO BENEFIT OON
➢ **DURABLE MEDICAL EQUIPMENT, PROSTHESES, MEDICAL & OSTOMY SUPPLIES (guidelines apply)**	100% of "AB"	NO BENEFIT OON
➢ **ORTHOTICS AND BRACES**	100% of "AB"	NO BENEFIT OON
➢ **ACUPUNCTURE (guidelines apply)**	Unlimited visits 100% of "AB" after appropriate copay	NO BENEFIT OON
➢ **TREATMENT OF TMJ SYNDROME**	guidelines apply, 100% of "AB" after appropriate copay	NO BENEFIT OON
OTHER SERVICES		
➢ **WHOLE BLOOD, if not replaced**	100% of "AB"	NO BENEFIT OON
➢ **ALLERGY SERUM**	**100% of "AB" after $24 copay**	**NO BENEFIT OON**
➢ **ALLERGY TESTING & INJECTIONS**	100% of "AB" after appropriate copay	NO BENEFIT OON
➢ **AMBULANCE – ground, air if medically necessary**	100% of "AB"	100% of “AB” no deductible
➢ **HOME CARE & HOSPICE SERVICES - Agency services, guidelines apply**	100% of "AB"	NO BENEFIT OON
➢ **Hair Prosthesis (guidelines apply)**	100% of “AB”, no deductible up to a $350 maximum	
➢ **Adult Hearing Aids/Routine Hearing Checks**	Not Covered	
➢ **Child Hearing Aids/Routine Hearing Checks (guidelines apply)**	100% of “AB”, no deductible every 36 months	NO BENEFIT OON

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