EPO (Exclusive Preferred Option) Summary of Benefits

Eastern Shore of Maryland Educational Consortium

Services	In-Network You Pay[1,2]
	Visit carefirst.com/doctor to locate providers
24/7 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 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—$20 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	$20 per visit
Acupuncture	$20 per visit
EMERGENCY SERVICES	
Urgent Care Center	$20 per visit
Emergency Room—Facility Services	$40 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	No charge*
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	No charge*
Nursery Care of Newborn	No charge*
Artificial and Intrauterine Insemination[4]	Office—$20 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—$20 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	No charge*
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