



The Maryland School for the Blind

2025-2026 HEALTH BENEFITS

MEDICAL Please see your benefit summary for full details on your benefits.

Effective September 1, 2025, three comprehensive medical plans will be offered through CareFirst. Each plan includes both in- and out-of-network benefits; however, services received outside the BlueChoice Advantage 2.0 network may be subject to balance billing. None of the plans require a primary care physician designation or referrals.

SUMMARY OF SERVICES	1 HSA BLUECHOICE ADVANTAGE 2.0 \$1,650		2 HRA BLUECHOICE ADVANTAGE 2.0 \$3,000		3 BLUECHOICE ADVANTAGE 2.0 \$750	
	<i>In-Network</i>	<i>Out-of-Network*</i>	<i>In-Network</i>	<i>Out-of-Network*</i>	<i>In-Network</i>	<i>Out-of-Network*</i>
Plan Year Deductible (Ded.) (Ind. / Family)	\$1,650 / \$3,300	\$3,300 / \$6,600	\$3,000 / \$6,000	\$6,000 / \$12,000	\$750 / \$1,500	\$1,500 / \$3,000
Plan Year Out-of-Pocket Max.	\$3,500 / \$7,000	\$7,000 / \$14,000	\$5,000 / \$10,000	\$10,000 / \$20,000	\$3,500 / \$7,000	\$7,000 / \$14,000
Co-Insurance (Plan pays / You pay)	90% / 10%	70% / 30%	90% / 10%	70% / 30%	90% / 10%	70% / 30%
Employer Funding	HSA Eligible		All Coverage Tiers: \$3,000 HRA Funding		None	
Physician / Specialist Visits	Ded., then Co-Ins.	Ded., then Co-Ins.*	Ded., then \$45 / \$60 Copay	Ded., then Co-Ins.*	\$50 / \$70 Copay	Ded., then Co-Ins.*
Emergency Room ¹	Ded., then Co-Ins.	In-Network Ded., then 10% Co-Ins.*	Ded., then Co-Ins.	In-Network Ded., then 10% Co-Ins.*	Ded., then Co-Ins.	In-Network Ded., then 10% Co-Ins.*
Urgent Care	Ded., then Co-Ins.	Ded., then Co-Ins.*	Ded., then Co-Ins.	Ded., then Co-Ins.*	\$50 Copay	\$150 Copay*
Referral Required	No	No	No	No	No	No
PCP Required	No	No	No	No	No	No
PRESCRIPTION DRUGS Generic / Preferred / Non-Preferred / Preferred Specialty / Non-Preferred Specialty						
Retail Pharmacy (34-day supply)	Ded., then \$15 / \$35 / \$60 / 50% up to \$100 / 50% up to \$150	Ded., then \$15 / \$35 / \$60* ²	Ded., then \$15 / \$35 / \$60 / 50% up to \$100 / 50% up to \$150	Ded., then \$15 / \$35 / \$60* ²	\$15 / \$35 / \$60 / 50% up to \$100 / 50% up to \$150	\$15 / \$35 / \$60* ²
Mail Order (90-day supply)	Ded., then \$30 / \$70 / \$120 / 50% up to \$200 / 50% up to \$300	Ded., then \$30 / \$70 / \$120* ²	Ded., then \$30 / \$70 / \$120 / 50% up to \$200 / 50% up to \$300	Ded., then \$30 / \$70 / \$120* ²	\$30 / \$70 / \$120 / 50% up to \$200 / 50% up to \$300	\$30 / \$70 / \$120* ²

Please note: This is a brief description of the program. Actual benefit payments are made in accordance with the insurance contract and plan documents.

*Coverage is based on the Allowed Benefit, which is the amount established for payment of covered In-Network services. The Allowed Benefit will generally be lower than the amount charged. You are responsible for copayments, coinsurance, and all charges that exceed the Allowed Benefit for services received Out-of-Network. This is called balance billing.

¹Waived if admitted.

²Specialty Drugs must be filled through CareFirst's Exclusive Specialty Pharmacy Network.

DENTAL Please see your benefit summary for full details on your benefits.

DHMO PLAN THROUGH CIGNA

The DHMO plan operates on a fixed fee schedule, with most preventive services covered at little to no cost, and other services requiring set copayments. There are no deductibles or annual maximums.

Each covered family member must select a Primary Care Dentist (PCD) from the list of participating DHMO providers. Your PCD will deliver routine dental care and coordinate referrals to in-network specialists when needed. You must utilize an In-network provider, as out-of-network services are not covered.

Before enrolling and selecting your PCD, it is recommended that you contact the provider's office directly to confirm they are participating and accepting new patients.

PPO PLAN THROUGH CIGNA

The PPO plan allows you the freedom to seek care both in- and out-of-network. Please note that if you do receive care out-of-network, you will pay more out-of-pocket and will be subject to balance billing.

BENEFITS	1 CIGNA DHMO	2 CIGNA PPO	
	In-Network	In-Network	Out-of-Network
Annual Deductible (Ind. / Family)	None	\$25 / \$75	\$50 / \$150
Annual Maximum	N/A	\$1,500 (Combined In and Out-of-Network)	
Orthodontia Lifetime Maximum	See Fee Schedule	\$1,500 (Combined In and Out-of-Network)	
COVERED SERVICES	YOU PAY	YOU PAY AFTER DEDUCTIBLE	
Preventive Services	See Fee Schedule	No Charge (Deductible does not apply)	20% of Allowed Benefit (Deductible does not apply)
Basic Services	See Fee Schedule	20%	40% of Allowed Benefit
Major Services	See Fee Schedule	50%	65% of Allowed Benefit
Orthodontia Services (Children and Adults)	See Fee Schedule	50%	65% of Allowed Benefit

VISION Please see your benefit summary for full details on your benefits.

The voluntary vision plan through EyeMed (utilizing the Insight network) covers one eye exam per plan year. You can choose either eyeglass lenses with frames or contact lenses instead of glasses. To receive the highest level of benefits, you must use in-network providers. **Benefits renew each plan year on September 1.**

BENEFITS	1 EYEMED VISION	
	In-Network	Out-of-Network Reimbursed up to:
Eye Exams	\$10 copay	\$45
Contact Lens Fit / Follow-up	Up to \$40	Not Covered
Lens Copay (Single Vision, Bifocals, Trifocals)	\$25 copay	\$40-\$80
Standard Progressives	\$90 copay	\$60
Premium Progressives	\$110 - \$135 Copay	\$60
Frames	\$130 allowance Plus 20% off balance over \$130	\$104
Elective Contact Lenses	\$110 allowance	\$110

Please note for Medical, Dental, and Vision plans: Dependent children may be covered up to age 26.

Please refer to your Paylocity bSwift Benefits Portal to view all plan documents for further details.