Blue Cross and Blue Shield Benefi Comparison Chart

Asbury Communities, Inc.

	BluePreferred EPO	BluePreferred HSA		BluePreferred PPO	
Services	**Preferred Providers You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)					
Individual	$500	$3,000 (Also applies to Prescription Drugs)	$6,000 (Also applies to Prescription Drugs)	$1,000	$2,500
Family	$1,000	$6,000 (Also applies to Prescription Drugs)	$12,000 (Also applies to Prescription Drugs)	$2,000	$5,000
ANNUAL OUT-OF-POCKET LIMIT (BENEFIT PERIOD) (INCLUDES DEDUCTIBLES, COINSURANCE AND COPAYS)					
Medical	$5,500 Individual/$11,000 Family	$6,650 Individual/$13,300 Family	$9,000 Individual/$18,000 Family	$7,000 Individual/$14,000 Family	$9,000 Individual/$18,000 Family
Prescription Drug	Combined with in-network medical out-of-pocket maximum	Combined with in-network medical out-of- pocket maximum	All drug costs are subject to in-network out-of-pocket maximum	Combined with in-network medical out-of-pocket maximum	All drug costs are subject to in-network out- of-pocket maximum
LIFETIME MAXIMUM					
	None	None	None	None	None
PREVENTIVE SERVICES					
Well-Child Care (including exams & immunizations)	No charge*	No charge*	CareFirst pays 100% of Allowed Benefit	No charge*	50% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	No charge*	50% of Allowed Benefit	No charge*	Deductible, then 50% of Allowed Benefit
Breast Cancer Screening	No charge*	No charge*	CareFirst pays 100% of Allowed Benefit	No charge*	CareFirst pays 100% of Allowed Benefit
Pap Test	No charge*	No charge*	CareFirst pays 100% of Allowed Benefit	No charge*	CareFirst pays 100% of Allowed Benefit
Prostate Cancer Screening	No charge*	No charge*	CareFirst pays 100% of Allowed Benefit	No charge*	CareFirst pays 100% of Allowed Benefit
Colorectal Cancer Screening	No charge*	No charge*	CareFirst pays 100% of Allowed Benefit	No charge*	CareFirst pays 100% of Allowed Benefit
OFFICE VISITS, LABS & TESTING					
Office Visits for Illness	Office Visits for Illness—$20 PCP/$40 Specialist	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	$20 PCP/$40 Specialist per visit	Deductible, then 50% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)	$80 per visit	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Lab	$20 per visit	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
X-ray	$40 per visit	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Allergy Testing	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	100% of Allowed Benefit, no deductible, $20 PCP/$40 Specialist per visit	Deductible, then 50% of Allowed Benefit, plus $20 PCP/$40 Specialist copay per visit
Allergy Shots	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Physical, Speech and Occupational Therapy	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Chiropractic	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Acupuncture Therapy	Not covered (except when aproved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan for Anesthesia).	Not covered (except when approved or authorized by Plan for Anesthesia).	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY CARE AND URGENT CARE					
Urgent Care Center	$60 per visit	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	$75 per visit	Deductible, then 50% of Allowed Benefit
Emergency Room—Facility Services	Deductible, then $200 per visit (waived if admitted)	Deductible, then 10% of Allowed Benefit after $200 copay per visit	Deductible, then 50% of Allowed Benefit after $200 copay per visit	Deductible, then 30% of Allowed Benefit plus $200 copay per visit	In-network deductible, then 30% of Allowed Benefit plus $200 copay per visit
Emergency Room—Physician Services	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	In-network deductible, then 50% of Allowed Benefit
Ambulance (if medically necessary)	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
HOSPITALIZATION—MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES					
Outpatient Facility Services	$100 copay	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Physician Services	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Facility Services	Deductible, then $300/day, max $1,500/stay	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Physician Services	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit

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	BluePreferred EPO	BluePreferred HSA		BluePreferred PPO	
Services	**Preferred Providers You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**
HOSPITAL ALTERNATIVES					
Home Health Care (100 days of unlimited visits per benefit period)	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Hospice (180 days per benefit period)	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Skilled Nursing Facility	No charge after deductible	Deductible, then 10% of Allowed Benefit (60 days per benefit period)	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit (60 days per benefit period)	Deductible, then 50% of Allowed Benefit
MATERNITY					
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	No charge*	Deductible, then 50% of Allowed Benefit
Delivery and Facility Services	Deductible, then $300/day, max $1,500/stay	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Nursery Care of Newborn	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Artificial and Intrauterine Insemination	Not covered	Not covered	Not covered	Not covered	Not covered
In Vitro Fertilization Procedures (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	Not covered	Not covered	Not covered	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER					
Inpatient Facility Services	Deductible, then $300/day, max $1,500/stay	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Physician Services	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Facility Services	$100 copay	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Physician Services	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Office Visits	$20 per visitt	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	$20 per visit	Deductible, then 50% of Allowed Benefit
Medication Management	$20 per visit	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	$20 per visit	Deductible, then 50% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES					
Durable Medical Equipment	No charge after deductible	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	Not covered	Not covered	Not covered	Not covered	Not covered
VISION					
Routine Exam (limited to 1 visit/benefit period)	Not covered	Not covered	Not covered	Not covered	Not covered
Eyeglasses and Contact Lenses	Not covered	Not covered	Not covered	Not covered	Not covered
PRESCRIPTION DRUGS (CAREFIRST.COM/RXGROUP—FORMULARY 2)					
Deductible	Does not Apply	Subject to Deductible		Does Not Apply	
Up to a 34-day supply	Generic drugs: $5 Preferred Brand drugs: $40 Non-preferred Brand drugs: $100 Preferred Specialty drugs: $100 Non-preferred Specialty drugs: $150	Generic drugs: $5 Preferred Brand drugs: 20% up to $50 Non-preferred Brand drugs: 50% up to $100 Preferred Specialty drugs: $250 Non-preferred Specialty drugs: $500		Generic drugs: $5 Preferred Brand drugs: 20% up to $50 Non-preferred Brand drugs: 50% up to $100 Preferred Specialty drugs: $250 Non-preferred Specialty drugs: $500	
Up to a 90-day supply	Generic drugs: $15 Preferred Brand drugs: $120 Non-preferred Brand drugs: $300 Preferred Specialty drugs: 50% up to a $300 maximum Non-preferred Specialty drugs: 50% up to a $450 maximum	Generic drugs: $15 Preferred Brand drugs: 20% up to $150 Non-preferred Brand drugs: 50% up to $300 Preferred Specialty drugs: $750 Non-preferred Specialty drugs: $1,500		Generic drugs: $15 Preferred Brand drugs: 20% up to $150 Non-preferred Brand drugs: 50% up to $300 Preferred Specialty drugs: $750 Non-preferred Specialty drugs: $1,500	

*No copayment or coinsurance

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.