BluePreferred EPO Summary of Benefits

Asbury Communities, Inc.

Services	Preferred Providers In-Network You Pay[1,2,3]
Exclusive Provider Organization (EPO)—Members must use a contracted CareFirst Preferred Provider or a BlueCard® PPO provider in order to receive benefits for covered services. Visit **carefirst.com/doctor** to locate Preferred Providers.	
ANNUAL DEDUCTIBLE[4] (Benefit period[9]) — Deductible applies to medical and prescription drug	
Individual	$500
Family[4]	$1,000
ANNUAL OUT-OF-POCKET MAXIMUM[5,6] (Benefit period[9])	
Medical[5]	$5,500 Individual/$11,000 Family
Prescription Drug[6]	Combined with in-network medical out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit)	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	Office Visits for Illness—$20 PCP/$40 Specialist
Imaging (MRA/MRS, MRI, PET & CAT scans)	$80 per visit
Lab	$20 per visit
X-ray	$40 per visit
Allergy Testing	No charge after deductible
Allergy Shots	No charge after deductible
Physical, Speech and Occupational Therapy	No charge after deductible
Chiropractic	No charge after deductible
Acupuncture Therapy	Not covered (except when aproved or authorized by Plan when used for anesthesia)
EMERGENCY CARE AND URGENT CARE	
Urgent Care Center	$60 per visit
Emergency Room—Facility Services	Deductible, then $200 per visit (waived if admitted)
Emergency Room—Physician Services	No charge after deductible
Ambulance (if medically necessary)	No charge after deductible
HOSPITALIZATION[7]—MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES	
Outpatient Facility Services	$100 copay
Outpatient Physician Services	No charge after deductible
Inpatient Facility Services	Deductible, then $300/day, max $1,500/stay
Inpatient Physician Services	No charge after deductible
HOSPITAL ALTERNATIVES	
Home Health Care (100 days of unlimited visits per benefit period)	No charge after deductible
Hospice (180 days per benefit period)	No charge after deductible
Skilled Nursing Facility[7]	No charge after deductible

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MATERNITY	
Preventive Prenatal and Postnatal Office Visits[8]	No charge*
Delivery and Facility Services	Deductible, then $300/day, max $1,500/stay
Nursery Care of Newborn	No charge after deductible
Artificial and Intrauterine Insemination	Not covered
In Vitro Fertilization Procedures (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER[7]	
Inpatient Facility Services	Deductible, then $300/day, max $1,500/stay
Inpatient Physician Services	No charge after deductible
Outpatient Facility Services	$100 copay
Outpatient Physician Services	No charge after deductible
Office Visits	$20 per visit
Medication Management	$20 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	No charge after deductible
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	Not covered
VISION	
Routine Exam (limited to 1 visit/benefit period)	Not covered
Eyeglasses and Contact Lenses	Not covered

Note: Allowed Benefit is the fee that providers in the network have agreed to accept for a particular service. The 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.

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* No deductible 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 In limited circumstances, a covered service rendered by a Non-Preferred Provider may be eligible for reimbursement based on the in-network benefit level. When this is the case, 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 an out-of-network provider may be established by law. When eligible services are rendered by Non-Preferred Providers, charges in excess of the Allowed Benefit are the member's responsibility and do not contribute to the member's out-of-pocket maximum.

4 For Family coverage: When one family member meets the individual deductible, they can start receiving benefits as indicated above. 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.

5 For Family coverage: 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.

6 Plan has an integrated medical and prescription drug out-of-pocket maximum.

7 Pre-authorization is required for inpatient hospitalization.

8 In-network preventive prenatal and postnatal office visits will be covered to the same extent as other in-network preventive office visits.

9 Benefit Period is August 1 through July 31.

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.

The benefits described are issued under the following form numbers: MD/CF/GC (R. 1/13); MD/BP/EOC (10/07); MD/GHMSI/DOL APPEAL (R. 9/11); MD/BP/DOCS (10/07); MD/CF/BP/SOB (R. 4/08); MD/CF/RX (R. 7/12); MD/CF/ATTC (R. 7/09); CFMI/51+/GC (R. 1/13); CFMI/51+/EOC (4/09); CFMI/DOL APPEAL (R. 9/11); CFMI/51+/DOCS (4/09); CFMI/51+/PPO SOB (4/09); CFMI/VISION RIDER (10/11); CFMI/51+/RX (R. 7/12); CFMI/51+/ELIG (R. 1/10) and any amendments.

Family of health care plans

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