

THIS IS NOT A CONTRACT. This information highlights some of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (COC). Refer to your COC for benefit details.

SUMMARY OF COST-SHARING		Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating Providers
Deductible (per benefit period) <i>Deductible is waived for PREVENTIVE SERVICES unless otherwise noted. Deductible is combined to include medical & prescription drug benefits.</i>		\$2,000 single coverage \$4,000 family coverage	\$4,000 single coverage \$8,000 family coverage
Copayments			
• Office Visits (performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic)		\$25 copayment	30% coinsurance
• Specialist Office Visit		\$30 copayment	30% coinsurance
• Emergency Room		\$125 copayment per visit, waived if admitted	
• Urgent Care		\$50 copayment	
• Inpatient (Per Admission)		Not Applicable	30% coinsurance
• Outpatient Surgery Copayment (facility)		Not Applicable	30% coinsurance
Coinsurance		Not Applicable	30% coinsurance
Out-of-Pocket Maximum <i>Includes deductible, coinsurance and copayments for medical & prescription drug benefits.</i>		\$6,350 single coverage \$12,700 family coverage	\$4,000 single coverage \$8,000 family coverage
SUMMARY OF BENEFITS	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating Providers
PREVENTIVE CARE: Administered in accordance with Preventive Health Guidelines and PA state mandates			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full, waive deductible	30% coinsurance after deductible
• Adult Preventive Care		Covered in full, waive deductible	30% coinsurance after deductible
Immunizations		Covered in full, waive deductible	30% coinsurance, waive deductible
Mammograms			
• Screening Mammogram		One per benefit period	Covered in full, waive deductible
• Diagnostic Mammogram			Covered in full after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear		One per benefit period	Covered in full, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board			Covered in full after deductible
Acute Inpatient Rehabilitation		60 days/benefit period	Covered in full after deductible
Skilled Nursing Facility		100 days/benefit period	Covered in full after deductible
Surgery			
• Surgical Procedure & Anesthesia			Covered in full after deductible
Maternity Services and Newborn Care			Covered in full after deductible
Diagnostic Services			
• Radiology			Covered in full after deductible
• Laboratory			Covered in full after deductible
• Medical tests			Covered in full after deductible
Outpatient Surgery			Covered in full after deductible
Outpatient Therapy Services			
• Physical Medicine		Unlimited visits/benefit period	\$30 copayment
• Occupational Therapy		12 visits/benefit period	\$30 copayment
• Speech Therapy		12 visits/benefit period	\$30 copayment
• Respiratory Therapy		30 visits/benefit period	\$30 copayment
• Manipulation Therapy		Unlimited visits/benefit period	\$30 copayment
Emergency Services			Covered in full after deductible
Mental Health Care Services			Emergency room copayment applies, waived if admitted inpatient
• Inpatient Services			Covered in full after deductible
• Outpatient Services			\$30 copayment
Substance Abuse Services			
• Rehabilitation – Inpatient			Covered in full after deductible
• Rehabilitation – Outpatient			\$30 copayment
Home Health Care Services		90 visits/benefit period	Covered in full after deductible
Durable Medical Equipment (DME)			Covered in full after deductible
Prosthetic Appliances			Covered in full after deductible
Orthotic Devices			Covered in full after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. Independent licensee of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

HIGHLIGHTS	Amounts Members Are Responsible For:		
DEDUCTIBLE (Includes medical and prescription drug benefits)	Retail Pharmacy (up to a 30-day supply)	Mail Service Pharmacy (up to a 90-day supply)	Specialty Pharmacy (up to a 30-day supply)
Preventive Medications	<i>Deductible is waived for Prescription Medications listed on Capital's Preventive Medication List.</i>		
PRESCRIPTION DRUG TIER	BENEFIT		
Generic Preferred Prescription Drugs	\$5 copayment	\$10 copayment	\$3.33 copayment
Generic Non-Preferred Prescription Drugs	\$5 copayment	\$10 copayment	\$3.33 copayment
Brand Preferred Prescription Drugs	\$40 copayment	\$80 copayment	\$26.67 copayment
Brand Non-Preferred Prescription Drugs	\$60 copayment	\$120 copayment	\$40.00 copayment
Network	CVS Caremark National Pharmacy Network with Voluntary Maintenance Choice		
PRESCRIPTION DRUG TIER (Contraceptives)	BENEFIT		
Generic Prescription Drugs	\$0 copayment	\$0 copayment	Not covered
Select Brand Prescription Drugs**	\$0 copayment	\$0 copayment	Not covered
Brand Preferred Prescription Drugs	\$40 copayment	\$80 copayment	Not covered
Brand Non-Preferred Prescription Drugs	\$60 copayment	\$120 copayment	Not covered
FORMULARY SYSTEM	Open		
UTILIZATION PROGRAM	BENEFIT		
Generic Substitution Program	Restrictive Generic Substitution – In addition to the coinsurance/ copayment, the member pays the difference between the brand and generic drug price (when there is a generic alternative) <u>unless</u> the physician requests the brand be dispensed.		
Voluntary Maintenance Choice	The dispensing of maintenance covered drugs for up to a 90 day supply is available through Mail Service or at CVS Pharmacies.		
Specialty Pharmacy	For most specialty medications, coverage is available only when dispensed by Accredo Health Group, Inc.		
Quantity Level Limits (per prescription, day supply or copayment)	Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com.		
Prior Authorization and Enhanced Prior Authorization	Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com.		

Inpatient admissions as well as certain other services and equipment may require Preauthorization.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments required under any other health benefits coverage you may have.

**Select Brands include contraceptives for which there is no generic equivalent.

Participating providers and pharmacies agree to accept our allowance as payment in full—often less than their normal charge. If you visit a non-participating provider or pharmacy, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's or non-participating pharmacy's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered. Deductibles, any differences paid between brand drug and generic drug prices, and any balances paid to non-participating pharmacies are not applied to the out-of-pocket maximum. In certain situations a facility fee may be associated with an outpatient visit to a professional provider. Members should consult with the provider of the services to determine whether a facility fee may apply to that provider. An additional cost sharing amount may apply to the facility fee.

On behalf of Capital BlueCross, CVS/Caremark assists in the administration of our prescription drug program. CVS/Caremark is an independent pharmacy benefit manager. Accredo Health Group, Inc. is the exclusive vendor for specialty prescription drugs. On behalf of Capital BlueCross, Accredo Health Group, Inc. assists in the delivery of specialty medications directly to our Members. Accredo Health Group, Inc. is an independent company.

For more information or to locate a participating provider, visit www.capbluecross.com.
Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size >51.