

**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)		\$250 per member \$500 per family	\$1,000 per member \$2,000 per family
Copayments			
<ul style="list-style-type: none"> <li>Office Visits (performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic)</li> </ul>		\$20 copayment per visit	Coinsurance applies
<ul style="list-style-type: none"> <li>Specialist Office Visit</li> </ul>		\$30 copayment per visit	Coinsurance applies
<ul style="list-style-type: none"> <li>Emergency Room</li> </ul>		\$100 copayment per visit, waived if admitted	
<ul style="list-style-type: none"> <li>Urgent Care</li> </ul>		\$50 copayment per visit	Coinsurance applies
<ul style="list-style-type: none"> <li>Inpatient (Per Admission)</li> </ul>		Not Applicable	Coinsurance applies
<ul style="list-style-type: none"> <li>Outpatient Surgery Copayment (facility)</li> </ul>		Not Applicable	Coinsurance applies
Coinsurance		Not Applicable	20% coinsurance
Out-of-Pocket Maximum (includes Deductible, Copayments and Coinsurance for Medical (including ER), and Prescription Drug for Participating Providers only).		\$7,350 per member \$14,700 per family	\$7,350 per member \$14,700 per family
SUMMARY OF BENEFITS		Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating Providers
Limits and Maximums			
<b>PREVENTIVE CARE:</b> Administered in accordance with Preventive Health Guidelines and PA state mandates			
Preventive Care Services			
<ul style="list-style-type: none"> <li>Pediatric Preventive Care</li> </ul>		Covered in full, waive deductible	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Adult Preventive Care</li> </ul>		Covered in full, waive deductible	20% coinsurance after deductible
Immunizations		Covered in full, waive deductible	20% coinsurance, waive deductible
Mammograms			
<ul style="list-style-type: none"> <li>Screening Mammogram</li> </ul>		One per benefit period Covered in full, waive deductible	20% coinsurance, waive deductible
<ul style="list-style-type: none"> <li>Diagnostic Mammogram</li> </ul>		Covered in full after deductible	20% coinsurance after deductible
Gynecological Services			
<ul style="list-style-type: none"> <li>Screening Gynecological Exam &amp; Pap Smear</li> </ul>		One per benefit period Covered in full, waive deductible	20% coinsurance, waive deductible
<b>BENEFITS LISTED BELOW APPLY ONLY AFTER AFTER BENEFIT PERIOD DEDUCTIBLE IS MET</b>			
Acute Care Hospital Room & Board		Covered in full after deductible	50% coinsurance after deductible
Acute Inpatient Rehabilitation		60 days/benefit period Covered in full after deductible	50% coinsurance after deductible
Skilled Nursing Facility		100 days/benefit period Covered in full after deductible	50% coinsurance after deductible
Surgery			
<ul style="list-style-type: none"> <li>Surgical Procedure &amp; Anesthesia</li> </ul>		Covered in full after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care		Covered in full after deductible	20% coinsurance after deductible
Diagnostic Services			
<ul style="list-style-type: none"> <li>Radiology</li> </ul>		Covered in full after deductible	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Laboratory</li> </ul>		Covered in full after deductible	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Medical tests</li> </ul>		Covered in full after deductible	20% coinsurance after deductible
Outpatient Surgery		Covered in full after deductible	20% coinsurance after deductible
Outpatient Therapy Services			
<ul style="list-style-type: none"> <li>Physical Medicine</li> </ul>		Copayment applies	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Occupational Therapy</li> </ul>		30 visits/benefit period Copayment applies	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Speech Therapy</li> </ul>		30 visits/benefit period Copayment applies	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Respiratory Therapy</li> </ul>		30 visits/benefit period Copayment applies	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Manipulation Therapy</li> </ul>		Copayment applies	20% coinsurance after deductible
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
Mental Health Care Services			
<ul style="list-style-type: none"> <li>Inpatient Services</li> </ul>		Covered in full after deductible	20% professional and 50% facility coinsurance after deductible
<ul style="list-style-type: none"> <li>Outpatient Services</li> </ul>		Copayment applies	20% professional and 50% facility coinsurance after deductible
Substance Abuse Services			
<ul style="list-style-type: none"> <li>Rehabilitation – Inpatient</li> </ul>		Covered in full after deductible	20% professional and 50% facility coinsurance after deductible
<ul style="list-style-type: none"> <li>Rehabilitation – Outpatient</li> </ul>		Covered in full, waive deductible	20% professional and 50% facility coinsurance after deductible
Home Health Care Services		90 visits/benefit period Covered in full after deductible	20% coinsurance after deductible
Durable Medical Equipment (DME)		Covered in full after deductible	20% coinsurance after deductible
Prosthetic Appliances		Covered in full after deductible	20% coinsurance after deductible
Orthotic Devices		Covered in full after deductible	20% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. Independent licensee of the BlueCross BlueShield Association

SUMMARY OF BENEFITS	Amounts Members Are Responsible For:		
<b>PRESCRIPTION DRUG DEDUCTIBLE</b>			
Per benefit period*	\$25 per member		
	<b>Retail Pharmacy (up to a 30-day supply)</b>	<b>Mail Service Pharmacy (up to a 90-day supply)</b>	<b>Specialty Pharmacy (up to a 30-day supply)</b>
<b>PRESCRIPTION DRUG TIER</b>	<b>BENEFIT</b>		
Generic Preferred Prescription Drugs	25% coinsurance	\$25 copayment	25% coinsurance \$150 maximum
Generic Non-Preferred Prescription Drugs	25% coinsurance	\$25 copayment	25% coinsurance \$150 maximum
Brand Preferred Prescription Drugs	25% coinsurance	\$75 copayment	25% coinsurance \$150 maximum
Brand Non-Preferred Prescription Drugs	45% coinsurance	\$125 copayment	25% coinsurance \$150 maximum
<b>Network</b>	CVS Caremark National Pharmacy Network		
<b>PRESCRIPTION DRUG TIER (Contraceptives)</b>	<b>BENEFIT</b>		
Generic Prescription Drugs	\$0 copayment	\$0 copayment	Not covered
Select Brand Prescription Drugs**	\$0 copayment	\$0 copayment	Not covered
Brand Preferred Prescription Drugs	25% coinsurance .	\$75 copayment	Not covered
Brand Non-Preferred Prescription Drugs	45% coinsurance	\$125 copayment	Not covered
<b>FORMULARY SYSTEM</b>	Open		
<b>UTILIZATION PROGRAM</b>	<b>BENEFIT</b>		
Generic Substitution Program	<b>Restrictive Generic Substitution</b> – In addition to the coinsurance/copayment, the member pays the difference between the brand drug and generic drug price (when there is a generic drug alternative) <u>unless</u> the prescribing physician requests that the brand drug be dispensed.		
Specialty Pharmacy	<b>For most specialty medications, coverage is available only when dispensed by Accredo Health Group, Inc.</b>		
Quantity Level Limits (per prescription, day supply or copayment)	<b>Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to <a href="http://www.capbluecross.com">www.capbluecross.com</a>.</b>		
Prior Authorization and Enhanced Prior Authorization	<b>Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to <a href="http://www.capbluecross.com">www.capbluecross.com</a>.</b>		

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.**

For more information or to locate a participating provider, visit [www.capbluecross.com](http://www.capbluecross.com).

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size >51.