

**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:	
	Hospitalization/Medical Surgical	Major Medical
Deductible (per benefit period)	Not Applicable	\$450 per member \$1,350 per family
<b>Copayments</b>		
<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>	Not Applicable	Coinsurance applies
<ul style="list-style-type: none"> <li>Specialist Office Visit</li> </ul>	Not Applicable	Coinsurance applies
<ul style="list-style-type: none"> <li>Emergency Room</li> </ul>	Covered in full, waive deductible	
<ul style="list-style-type: none"> <li>Urgent Care</li> </ul>	Covered in full, waive deductible	
<ul style="list-style-type: none"> <li>Inpatient (Per Admission)</li> </ul>	Not Applicable	Not Applicable
<ul style="list-style-type: none"> <li>Outpatient Surgery Copayment (facility)</li> </ul>	Not Applicable	Not Applicable
Coinsurance	Not Applicable	20% coinsurance
Out-of-Pocket Maximum	Not Applicable	Not Applicable

SUMMARY OF BENEFITS	Limits and Maximums	Amounts Members Are Responsible For:	
		Hospitalization/Medical Surgical	Major Medical
<b>PREVENTIVE CARE: Administered in accordance with Preventive Health Guidelines and PA state mandates</b>			
<b>Preventive Care Services</b>			
<ul style="list-style-type: none"> <li>Pediatric Preventive Care</li> </ul>		Not Covered	Not Covered
<ul style="list-style-type: none"> <li>Adult Preventive Care</li> </ul>		Not Covered	Not Covered
<b>Immunizations</b>		Covered in full	20% coinsurance, waive deductible
<b>Mammograms</b>			
<ul style="list-style-type: none"> <li>Screening Mammogram</li> </ul>	One per benefit period	Covered in full	20% coinsurance, waive deductible
<ul style="list-style-type: none"> <li>Diagnostic Mammogram</li> </ul>		Covered in full	20% coinsurance after deductible
<b>Gynecological Services</b>			
<ul style="list-style-type: none"> <li>Screening Gynecological Exam &amp; Pap Smear</li> </ul>	One per benefit period	Covered in full	20% coinsurance, waive deductible
<b>BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET</b>			
<b>Acute Care Hospital Room &amp; Board</b>		Covered in full for participating facility providers; 25% coinsurance for non-participating facility providers	20% coinsurance after deductible
<b>Acute Inpatient Rehabilitation</b>		Covered in full for participating facility providers; 25% coinsurance for non-participating facility providers	20% coinsurance after deductible
<b>Skilled Nursing Facility</b>		Not Covered	Not Covered
<b>Surgery</b>			
<ul style="list-style-type: none"> <li>Surgical Procedure &amp; Anesthesia</li> </ul>		Covered in full for participating facility providers; 25% coinsurance for non-participating facility providers	20% coinsurance after deductible
<b>Maternity Services and Newborn Care</b>		Covered in full	20% coinsurance after deductible
<b>Diagnostic Services</b>			
<ul style="list-style-type: none"> <li>Radiology</li> </ul>		Covered in full	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Lab</li> </ul>		Covered in full	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Medical tests</li> </ul>		Covered in full	20% coinsurance after deductible
<b>Outpatient Surgery</b>		Covered in full	20% coinsurance after deductible
<b>Outpatient Therapy Services</b>			
<ul style="list-style-type: none"> <li>Physical Medicine</li> </ul>		Covered under Major Medical	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Occupational Therapy</li> </ul>		Covered under Major Medical	20% coinsurance after deductible for facility providers only
<ul style="list-style-type: none"> <li>Speech Therapy</li> </ul>		Covered under Major Medical	20% coinsurance after deductible for facility providers only
<ul style="list-style-type: none"> <li>Respiratory Therapy</li> </ul>		Covered under Major Medical	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Manipulation Therapy</li> </ul>		Covered under Major Medical	20% coinsurance after deductible
<b>Emergency Services</b>		Covered in full, waive 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.

SUMMARY OF BENEFITS	Limits and Maximums	Amounts Members Are Responsible For:	
		Hospitalization/Medical Surgical	Major Medical
<b>Mental Health Care Services</b>	30 days/benefit period	Covered in full for participating facility providers; 25% coinsurance for non-participating facility providers	50% coinsurance after deductible
<ul style="list-style-type: none"> <li>Inpatient Services</li> <li>Outpatient Services</li> </ul>			
<b>Substance Abuse Services</b>	30 days/benefit period; 90 days/lifetime	Covered in full for participating facility providers only	Not Covered
<ul style="list-style-type: none"> <li>Rehabilitation – Inpatient</li> </ul>			
<ul style="list-style-type: none"> <li>Rehabilitation – Outpatient</li> </ul>	60 visits/benefit period; 120 visits/lifetime	Covered in full for participating facility providers only	Not Covered
<b>Home Health Care Services</b>	30 visits/benefit period	Covered in full, participating facility providers only	Not Covered
<b>Durable Medical Equipment (DME)</b>		Covered under Major Medical	20% coinsurance after deductible
<b>Prosthetic Appliances</b>		Covered under Major Medical	20% coinsurance after deductible
<b>Orthotic Devices</b>		Covered under Major Medical	20% coinsurance after deductible

SUMMARY OF BENEFITS	Amounts Members Are Responsible For:		
<b>PRESCRIPTION DRUG DEDUCTIBLE</b>	\$50 per member		
Per benefit period*	\$50 per family		
<b>Out-of-Pocket Maximum</b> (includes Deductible and Copayments for Prescription Drugs, for Participating Providers only).	\$6,350 per member		
	\$12,700 per family		
	<b>Retail Pharmacy</b> (up to a 30-day supply)	<b>Mail Service Pharmacy</b> (up to a 90-day supply)	<b>Specialty Pharmacy</b> (up to a 30-day supply)
<b>PRESCRIPTION DRUG TIER</b>	<b>BENEFIT</b>		
Generic Preferred Prescription Drugs	\$10 copayment	\$20 copayment	\$100 copayment
Generic Non-Preferred Prescription Drugs	\$10 copayment	\$20 copayment	\$100 copayment
Brand Preferred Prescription Drugs	\$35 copayment	\$40 copayment	\$100 copayment
Brand Non-Preferred Prescription Drugs	\$50 copayment	\$100 copayment	\$100 copayment
<b>Network</b>	CVS Caremark National Pharmacy Network Include CVS 90		
<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	\$35 copayment	\$40 copayment	Not covered
Brand Non-Preferred Prescription Drugs	\$50 copayment	\$100 copayment	Not covered
<b>FORMULARY SYSTEM</b>	Open		
<b>UTILIZATION PROGRAM</b>	<b>BENEFIT</b>		
Generic Substitution Program	<b>Voluntary Generic Substitution Program</b> - The member pays the applicable copayment/coinsurance for a generic drug and for a brand drug, even if an approved generic drug equivalent is available and regardless of whether the physician or member requested such brand drug be dispensed.		
Specialty Pharmacy	One original fill at a retail pharmacy for most specialty medications; subsequent refills are covered only through Accredo Health Group, Inc.		
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>Not Applicable.</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. 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](http://www.capbluecross.com).  
Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size >51.

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.