ACTIVE MAPD PLAN DESIGN SUMMARY
PLAN NAME: Capital Blue Cross PPO Plan

HOW MUCH PARTICIPANT WILL PAY	Capital Blue Cross PPO Plan		
MEDICAL *[Use 'NC' to designate that a service is not covered]*	**In-Network**	**Out-of-Network**	Check if deductible applies
Annual Deductible/Person	$0	$0	
Annual Out-of-Pocket Maximum/Person	$3,400 (In-Network) Excludes: OTC, Fitness, Medical Nutrition Therapy, Routine and Non-Medicare Comprehensive Dental, Routine Vision, Routine Hearing, and Part D Drugs	$3,400 (Combined In and Out of Network) Excludes: OTC, Fitness, Medical Nutrition Therapy, Routine and Non-Medicare Comprehensive Dental, Routine Vision, Routine Hearing, and Part D Drugs	
Doctor Visits	PCP- $5 copay per visit Specialist- $15 copay per visit	PCP- $5 copay per visit Specialist- $15 copay per visit	
Preventive Care	$0 Copay	$0 Copay	
Outpatient Surgery	$0 Copay	30% Coinsurance	
Emergency Room Waived if admitted?	$50 Copay Y ■ No □	$50 Copay Y ■ N □	
Urgent Care	$20 Copay	$20 Copay	
Diagnostic Testing	$0 Copay	30% Coinsurance	
Outpatient Therapy	$15 Copay	$15 Copay	
Durable Medical Equipment	20% Coinsurance	20% Coinsurance	
Outpatient Mental Health	$15 Copay Individual and Group	$15 Copay Individual and Group	
Hospitalization	$0 Copay per stay	$0 Copay per stay	
Inpatient Mental Health	$0 Copay per stay	$0 Copay per stay	
Routine Physical Exams	$0 Copay (annual wellness exam)	$0 Copay (annual wellness exam)	
Ob/Gyn Exams	$0 Copay	$0 Copay	
Mammograms	$0 Copay	$0 Copay	
Skilled Nursing Facility	$0 Copay days 1-20 $30 Copay days 21-100	20% Coinsurance	
Vision Exams	$0 Copay for routine vision exam (1 every calendar year combined In and Out of Network)	50% Coinsurance (1 every calendar year combined In and Out of Network)	

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MEDICAL *[Use 'NC' to designate that a service is not covered]*	**In-Network**	**Out-of-Network**	Check if deductible applies
Hearing Exams	$0 Copay for routine hearing exam (1 every calendar year. Must use our vendor)	$0 Copay for routine hearing exam (1 every calendar year. Must use our vendor)	
Prescription Lenses (Once every 12 months)	One set of eyeglasses (frames and lenses) or contacts every calendar year (combined In and Out of Network) Frames and lenses or contacts: $150 plan allowance every calendar year (combined In and Out of Network)	One set of eyeglasses (frames and lenses) or contacts every calendar year (combined In and Out of Network) Frames and lenses or contacts: $150 plan allowance every calendar year (combined In and Out of Network)	
Hearing Aids (Once every 12 months)	$499/$699/$999 copay every year copay per ear (Must use our vendor)	$499/$699/$999 copay every year copay per ear (Must use our vendor)	
Dental Care	Routine coverage: $0 Copay for routine dental visit Limit of 2 per calendar year (visit includes exam, cleaning, up to 8 bitewing x-rays and fluoride treatment) Preventive and Comprehensive coverage: $1,500 plan maximum allowance per calendar year (combined In and Out of Network). 50% coinsurance includes: -Restorative Services: Crowns and Teeth Fillings Amalgam & Composite -Periodontal Services: Perio Maint. only	Routine coverage: 50% Coinsurance for routine dental visit Limit of 2 per calendar year (visit includes exam, cleaning, up to 8 bitewing x-rays and fluoride treatment) Comprehensive coverage: $1,500 plan maximum allowance per calendar year	

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MEDICAL *[Use 'NC' to designate that a service is not covered]*	**In-Network**	**Out-of-Network**	Check if deductible applies
	-Oral and Maxillofacial Surgery: Simple Extractions only -Endodontics: Root canals, Pulpotomy -Prosthodontics, removable: Dentures, Partials -Prosthodontics, fixed: Bridges Adjustments and Repairs of Prosthetics -Adjunctive General Services: Palliative Emergency Treatment, sedation, anesthesia, and teledentistry -Diagnostics: intra-oral radiology; problem focused dental exams	(combined In and Out of Network). 50% coinsurance includes: -Restorative Services: Crowns and Teeth Fillings Amalgam & Composite -Periodontal Services: Perio Maint. only -Oral and Maxillofacial Surgery: Simple Extractions only -Endodontics: Root canals, Pulpotomy -Prosthodontics, removable: Dentures, Partials -Prosthodontics, fixed: Bridges Adjustments and Repairs of Prosthetics -Adjunctive General Services: Palliative Emergency Treatment, sedation, anesthesia, and teledentistry -Diagnostics: intra-oral radiology; problem focused dental exams	

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PRESCRIPTION DRUGS *[Use 'NC' to designate that a tier is not covered]*	**Retail Pharmacy** *(up to a 30-day supply)*		**Mail Order** *(up to a 100-day supply)*	
	Preferred Pharmacy	Non-Preferred Pharmacy	Preferred Pharmacy	Non-Preferred Pharmacy
Annual Deductible	$0	No distinction	$0	No distinction
Initial Coverage				
Preferred generic drugs	$0 copay	No distinction	$0 copay	No distinction
Non-preferred generic drugs	$4 copay	No distinction	$12 copay	No distinction
Preferred brand drugs	$30 copay	No distinction	$90 copay	No distinction
Non-preferred brand drugs	$55 copay	No distinction	$165 copay	No distinction
Specialty drugs	33% (30 day supply only)	No distinction	N/A	No distinction
Coverage Gap	$2,100		$2,100	
Preferred generic drugs				
Non-preferred generic drugs				
Preferred brand drugs				
Non-preferred brand drugs				
Specialty drugs				
Catastrophic Coverage subject to minimums/maximums	Cost Sharing $0		Cost Sharing $0	

***OTC allowance - $45 per quarter**

Note: If the plan does not distinguish between Preferred and Non-Preferred Pharmacies, please complete only the "Preferred Pharmacy" column, and include a note of confirmation that there is no distinction.