

**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 \$750 per family	\$500 per member \$1,500 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>		\$30 copayment per visit	20% coinsurance
<ul style="list-style-type: none"> <li>Specialist Office Visit</li> </ul>		\$30 copayment per visit	20% coinsurance
<ul style="list-style-type: none"> <li>Emergency Room</li> </ul>		\$35 copayment per visit, waived if admitted	
<ul style="list-style-type: none"> <li>Urgent Care</li> </ul>		\$35 copayment per visit	
<ul style="list-style-type: none"> <li>Inpatient (Per Admission)</li> </ul>		Not Applicable	50% coinsurance
<ul style="list-style-type: none"> <li>Outpatient Surgery Copayment (facility)</li> </ul>		Not Applicable	50% coinsurance
<b>Coinsurance</b>		Not Applicable	20% coinsurance
Out-of-Pocket Maximum (includes Deductible, Copayments and Coinsurance for Medical (including ER), and Prescription Drug for Participating Providers only).		\$1,250 per member \$3,750 per family	\$2,000 per member \$6,000 per family
SUMMARY OF BENEFITS		Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating Providers
<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>		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
<b>Immunizations</b>		Covered in full, waive deductible	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, waive deductible
<ul style="list-style-type: none"> <li>Diagnostic Mammogram</li> </ul>			Covered in full 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, 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 after deductible
<b>Acute Inpatient Rehabilitation</b>			50% coinsurance after deductible
<b>Skilled Nursing Facility</b>			Covered in full after deductible
<b>Surgery</b>			50% coinsurance after deductible
<ul style="list-style-type: none"> <li>Surgical Procedure &amp; Anesthesia</li> </ul>			Covered in full after deductible
<b>Maternity Services and Newborn Care</b>			20% coinsurance after deductible
<b>Diagnostic Services</b>			
<ul style="list-style-type: none"> <li>Radiology</li> </ul>			Covered in full after deductible
<ul style="list-style-type: none"> <li>Laboratory</li> </ul>			Covered in full after deductible
<ul style="list-style-type: none"> <li>Medical tests</li> </ul>			Covered in full after deductible
<b>Outpatient Surgery</b>			Covered in full after deductible
<b>Outpatient Therapy Services</b>			20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Physical Medicine</li> </ul>		30 visits/benefit period	Copayment applies
<ul style="list-style-type: none"> <li>Occupational Therapy</li> </ul>		30 visits/benefit period	20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Speech Therapy</li> </ul>		30 visits/benefit period	Copayment applies
<ul style="list-style-type: none"> <li>Respiratory Therapy</li> </ul>			20% coinsurance after deductible
<ul style="list-style-type: none"> <li>Manipulation Therapy</li> </ul>		20 visits/benefit period	Copayment applies
<b>Emergency Services</b>			Covered in full, waive deductible
			Emergency room copayment applies, waived if admitted inpatient
<b>Mental Health Care Services</b>			
<ul style="list-style-type: none"> <li>Inpatient Services</li> </ul>		30 days/benefit period	Covered in full after deductible
<ul style="list-style-type: none"> <li>Outpatient Services</li> </ul>		60 visits/benefit period	Copayment applies
<b>Substance Abuse Services</b>			50% coinsurance after deductible
<ul style="list-style-type: none"> <li>Rehabilitation – Inpatient</li> </ul>		30 days/benefit period; 90 days/lifetime	Covered in full after deductible
<ul style="list-style-type: none"> <li>Rehabilitation – Outpatient</li> </ul>		30 visits/benefit period; 120 visits/lifetime	Not Covered
<b>Home Health Care Services</b>			Covered in full after deductible
<b>Durable Medical Equipment (DME)</b>			20% coinsurance after deductible
<b>Prosthetic Appliances</b>			Covered in full after deductible
<b>Orthotic Devices</b>			20% coinsurance 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.

SUMMARY OF BENEFITS	Amounts Members Are Responsible For:		
<b>PRESCRIPTION DRUG DEDUCTIBLE</b>	\$100 per member		
Per benefit period*	\$100 per family		
	<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	\$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.