

**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
<b>Deductible</b> (per benefit period) <i>Deductible is waived for PREVENTIVE SERVICES unless otherwise noted.</i> <i>Deductible is combined to include medical &amp; prescription drug benefits.</i>	\$3,000 single coverage \$6,000 family coverage	\$6,000 single coverage \$12,000 family coverage
<b>Copayments</b>		
<ul style="list-style-type: none"> <li>• <b>Office Visits</b> (performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic)</li> </ul>	20% coinsurance	50% coinsurance
<ul style="list-style-type: none"> <li>• <b>Specialist Office Visit</b></li> </ul>	20% coinsurance	50% coinsurance
<ul style="list-style-type: none"> <li>• <b>Emergency Room</b></li> </ul>	20% coinsurance	
<ul style="list-style-type: none"> <li>• <b>Urgent Care</b></li> </ul>	20% coinsurance	50% coinsurance
<ul style="list-style-type: none"> <li>• <b>Inpatient</b> (Per Admission)</li> </ul>	Not Applicable	50% coinsurance
<ul style="list-style-type: none"> <li>• <b>Outpatient Surgery Copayment</b> (facility)</li> </ul>	Not Applicable	50% coinsurance
<b>Coinsurance</b>	20% coinsurance	50% coinsurance
<b>Out-of-Pocket Maximum</b> <i>Includes deductible, coinsurance and copayments for medical &amp; prescription drug benefits.</i>	\$5,000 single coverage \$10,000 family coverage	\$10,000 single coverage \$20,000 family coverage

SUMMARY OF BENEFITS	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating Providers
<b>PREVENTIVE CARE:</b> Administered in accordance with Preventive Health Guidelines and PA state mandates			
<b>Preventive Care Services</b>			
<ul style="list-style-type: none"> <li>• Pediatric Preventive Care</li> <li>• Adult Preventive Care</li> </ul>		Covered in full, waive deductible	50% coinsurance after deductible
<b>Immunizations</b>		Covered in full, waive deductible	50% coinsurance, waive deductible
<b>Mammograms</b>			
<ul style="list-style-type: none"> <li>• Screening Mammogram</li> <li>• Diagnostic Mammogram</li> </ul>	One per benefit period	Covered in full, waive deductible	50% coinsurance, waive 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	50% coinsurance, waive deductible
<b>BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET</b>			
<b>Acute Care Hospital Room &amp; Board</b>		20% coinsurance after deductible	50% coinsurance after deductible
<b>Acute Inpatient Rehabilitation</b>	60 days/benefit period	20% coinsurance after deductible	50% coinsurance after deductible
<b>Skilled Nursing Facility</b>	100 days/benefit period	20% coinsurance after deductible	50% coinsurance after deductible
<b>Surgery</b>			
<ul style="list-style-type: none"> <li>• Surgical Procedure &amp; Anesthesia</li> </ul>		20% coinsurance after deductible	50% coinsurance after deductible
<b>Maternity Services and Newborn Care</b>		20% coinsurance after deductible	50% coinsurance after deductible
<b>Diagnostic Services</b>			
<ul style="list-style-type: none"> <li>• Radiology</li> <li>• Laboratory</li> <li>• Medical tests</li> </ul>		20% coinsurance after deductible	50% coinsurance after deductible
<b>Outpatient Surgery</b>		20% coinsurance after deductible	50% coinsurance after deductible
<b>Outpatient Therapy Services</b>			
<ul style="list-style-type: none"> <li>• Physical Medicine</li> <li>• Occupational Therapy</li> <li>• Speech Therapy</li> <li>• Respiratory Therapy</li> <li>• Manipulation Therapy</li> </ul>	30 visits/benefit period 30 visits/benefit period 20 visits/benefit period	20% coinsurance after deductible	50% coinsurance after deductible
<b>Emergency Services</b>		20% coinsurance after deductible	
<b>Mental Health Care Services</b>			
<ul style="list-style-type: none"> <li>• Inpatient Services</li> <li>• Outpatient Services</li> </ul>		20% coinsurance after deductible	50% coinsurance after deductible
<b>Substance Abuse Services</b>			
<ul style="list-style-type: none"> <li>• Rehabilitation – Inpatient</li> <li>• Rehabilitation – Outpatient</li> </ul>		20% coinsurance after deductible	50% coinsurance after deductible
<b>Home Health Care Services</b>	90 visits/benefit period	20% coinsurance after deductible	50% coinsurance after deductible
<b>Durable Medical Equipment (DME)</b>		20% coinsurance after deductible	50% coinsurance after deductible
<b>Prosthetic Appliances</b>		20% coinsurance after deductible	50% coinsurance after deductible
<b>Orthotic Devices</b>		20% coinsurance after deductible	50% 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.*

HIGHLIGHTS	Amounts Members Are Responsible For:		
DEDUCTIBLE (Includes medical and prescription drug benefits)	Retail Pharmacy (up to a 31-day supply)	Mail Service Pharmacy (up to a 90-day supply)	Specialty Pharmacy (up to a 30-day supply)
<b>PRESCRIPTION DRUG TIER</b>	<b>BENEFIT</b>		
Generic Preferred Prescription Drugs	\$20 copayment	\$40 copayment	\$20 copayment
Generic Non-Preferred Prescription Drugs	\$20 copayment	\$40 copayment	\$20 copayment
Brand Preferred Prescription Drugs	\$40 copayment	\$80 copayment	\$40 copayment
Brand Non-Preferred Prescription Drugs	\$50 copayment	\$100 copayment	\$50 copayment
<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	\$40 copayment	\$80 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>Restrictive Generic Substitution</b> – In addition to the coinsurance/ copayment, the member pays the difference between the brand and generic drug price (when there is a generic alternative) unless the physician requests the brand be dispensed.		
Specialty Pharmacy	<b>For most specialty medications, coverage is available only when dispensed by a Capital BlueCross Preferred Specialty Network. For a list of Preferred Specialty Networks, please refer to the Specialty Pharmacy information located in The Guide to Rx Benefits at <a href="http://www.capbluecross.com">www.capbluecross.com</a>.</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.

Capital BlueCross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you, or someone you're helping, has questions about your health plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800.962.2242 (TTY: 711).

Spanish—Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de su plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800.962.2242 (TTY: 711).

Chinese—如果您，或是您正在協助的對象，有關於您的健康计划方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話[在此插入數字 800.962.2242 (TTY: 711)]。