Capital BLUE

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# Benefit Highlights
## Silver PPO HSA 2250/0/25

**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)<br>*Deductible is combined to include medical & prescription drug benefits.* | $2,250 per member<br>$4,500 per family | $5,000 per member<br>$10,000 per family |
| **Copayments** | | |
| • **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*) | $25 copayment per visit after deductible | 50% coinsurance |
| • **Specialist Office Visit** | $45 copayment per visit after deductible | 50% coinsurance |
| • **Emergency Room** | $250 copayment per visit after deductible, waived if admitted | |
| • **Urgent Care** | $100 copayment per visit after deductible | |
| • **Inpatient** (Per Admission) | Not Applicable | 50% coinsurance |
| • **Outpatient Surgery Copayment** (facility) | Not Applicable | 50% coinsurance |
| • **High Tech Imaging** | $200 copayment after deductible | 50% coinsurance |
| **Coinsurance** | Not Applicable | 50% coinsurance |
| **Out-of-Pocket Maximum** *(includes Deductible, Copayments and Coinsurance for Medical (including ER), Prescription Drug, Pediatric Dental, and Pediatric Vision services) for Participating Providers only*. When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the benefit period ends. | $6,550 per member<br>$13,100 per family | $10,000 per member<br>$20,000 per family |

| SUMMARY OF BENEFITS | Limits and Maximums | Amounts *Members* Are Responsible For: | |
|---|---|---|---|
| | | ***Participating Providers*** | ***Non-Participating Providers*** |
| **PREVENTIVE CARE:** *Administered in accordance with Preventive Health Guidelines and PA state mandates* | | | |
| **Preventive Care Services** | | | |
| • Pediatric Preventive Care | | Covered in full, waive deductible | 50% coinsurance after deductible |
| • Adult Preventive Care | | Covered in full, waive deductible | 50% coinsurance after deductible |
| **Immunizations** | | Covered in full, waive deductible | 50% coinsurance, waive deductible |
| **Mammograms** | | | |
| • Screening Mammogram | One per benefit period | Covered in full, waive deductible | 50% coinsurance, waive deductible |
| • Diagnostic Mammogram | | Covered in full after deductible | 50% coinsurance after deductible |
| **Gynecological Services** | | | |
| • Screening Gynecological Exam & Pap Smear | One per benefit period | Covered in full, waive deductible | 50% coinsurance, waive deductible |
| **BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET** | | | |
| **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** | 120 days/benefit period | Covered in full after deductible | 50% coinsurance after deductible |
| **Surgery** | | | |
| • Surgical Procedure & Anesthesia | | Covered in full after deductible | 50% coinsurance after deductible |
| **Maternity Services and Newborn Care** | | Covered in full after deductible | 50% coinsurance after deductible |
| **Diagnostic Services** | | | |
| • High Tech Imaging (MRI, CT, PET, SPECT Scans, etc.) | | $200 copayment after deductible | 50% coinsurance after deductible |
| • Radiology (other than High Tech Imaging) | | Covered in full after deductible | 50% coinsurance after deductible |
| • Independent Laboratory | | Covered in full after deductible | 50% coinsurance after deductible |
| • Facility-owned Laboratory | | $75 copayment after deductible | 50% coinsurance after deductible |
| **Outpatient Surgery** | | Covered in full after deductible | 50% coinsurance after deductible |
| **Outpatient Therapy Services** | | | |
| • Physical Medicine & Occupational Therapy | 30 visits combined rehabilitative<br>30 visits combined habilitative<br>(per benefit period) | $45 copayment after deductible | 50% coinsurance after deductible |
| • Speech Therapy | 30 visits combined rehabilitative<br>30 visits combined habilitative<br>(per benefit period) | $45 copayment after deductible | 50% coinsurance after deductible |
| • Respiratory/Pulmonary Therapy (rehabilitative) | 36 visits/benefit period | $45 copayment after deductible | 50% coinsurance after deductible |
| • Manipulation Therapy | 20 visits/benefit period | $45 copayment after deductible | 50% coinsurance after deductible |
| **Emergency Services** | | Covered in full after deductible<br>Emergency room copayment applies, waived if admitted inpatient | |
| **Mental Health Care Services** | | | |
| • Inpatient Services | | Covered in full after deductible | 50% coinsurance after deductible |
| • Outpatient Services | | $45 copayment after deductible | 50% coinsurance after deductible |
| **Substance Abuse Services** | | | |
| • Rehabilitation – Inpatient | | Covered in full after deductible | 50% coinsurance after deductible |
| • Rehabilitation – Outpatient | | $45 copayment after deductible | 50% coinsurance after deductible |
| **Home Health Care Services** | 60 visits/benefit period | Covered in full after deductible | 50% coinsurance after deductible |
| **Durable Medical Equipment (DME)** | | Covered in full after deductible | 50% coinsurance after deductible |
| **Prosthetic Appliances** | | Covered in full after deductible | 50% coinsurance after deductible |
| **Orthotic Devices** | | Covered in full after deductible | 50% coinsurance after deductible |

| SUMMARY OF BENEFITS (CONTINUED) | Limits and Maximums | Amounts Members Are Responsible For: | |
|---|---|---|---|
| | | ***Participating Providers*** | ***Non-Participating Providers*** |
| **PRESCRIPTION DRUG DEDUCTIBLE**<br>(Includes medical and prescription drug benefits)<br>Per benefit period | | $2,250 per member<br>$4,500 per family | $5,000 per member<br>$10,000 per family |
| | **Retail Pharmacy (up to a 30-day supply)** | **Mail Service Pharmacy (up to a 90-day supply)** | **Specialty Pharmacy (up to a 30-day supply)** |
| **PRESCRIPTION DRUG TIER** | **BENEFIT** | | |
| Generic Preferred Prescription Drugs | $7 copayment | $18 copayment | 20% coinsurance up to $250/refill |
| Generic Non-Preferred Prescription Drugs | $25 copayment | $63 copayment | 20% coinsurance up to $250/refill |
| Brand Preferred Prescription Drugs | $55 copayment | $138 copayment | 20% coinsurance up to $350/refill |
| Brand Non-Preferred Prescription Drugs | $80 copayment | $200 copayment | 20% coinsurance up to $450/refill |
| **Preventive Coverage (ie: Contraceptives)*** | Covered in full, waive deductible | | |
| **Network** | CVS Caremark National Pharmacy Network | | |
| **PRESCRIPTION DRUG TIER (Contraceptives)** | **BENEFIT** | | |
| Generic Prescription Drugs | $0 copayment | $0 copayment | Not covered |
| Select Brand Prescription Drugs** | $0 copayment | $0 copayment | Not covered |
| Brand Preferred Prescription Drugs | $55 copayment | $138 copayment | Not covered |
| Brand Non-Preferred Prescription Drugs | $80 copayment | $200 copayment | Not covered |
| **FORMULARY SYSTEM** | Open | | |
| **UTILIZATION PROGRAM** | **BENEFIT** | | |
| Generic Substitution Program | **Restrictive Generic Substitution** – 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. | | |
| Voluntary Maintenance Choice | The dispensing of maintenance covered drugs for up to a 90 day supply is available through Mail Service or at CVS Pharmacies. | | |
| Specialty Pharmacy | 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 www.capbluecross.com. | | |
| Quantity Level Limits (per prescription, day supply or copayment) | Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com. | | |
| Prior Authorization and Enhanced Prior Authorization | Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com. | | |
| **Pediatric Vision Services - Benefit frequencies are based on date of service** | | | |
| • Vision Exam | Once every 12 months | Covered in full | $32 allowance |
| • Eyeglass Lenses | Once every 12 months | Single – Covered in full<br>Bi-focal – Covered in full<br>Tri-focal – Covered in full<br>Polycarbonate – Covered in full | Single - $24<br>Bi-focal - $36<br>Tri-focal - $46<br>Polycarbonate – Not covered |
| • Frames*** | Once every 12 months | Standard Frames: Paid in full on frames selected from a frame collection<br>All Other Frames: Balance of retail charge less 30% after $100 allowance | Balance of retail charge after $30 allowance |
| • Contact Lenses***<br>Payment will be made for either lenses or contact lenses within a benefit period. Payment will not be made for both. | Once every 12 months | Balance of retail charge less 25% after $75 allowance | $50 allowance |
| **Pediatric Dental Services** | | | |
| • Deductible | | $50 per person | |
| • Preventive Services | | Covered full, waive deductible | |
| • Basic Services | | 20% coinsurance after deductible | |
| • Major Services | | 50% coinsurance after deductible | |
| • Orthodontia (Medically Necessary) | 12 month waiting period | 50% coinsurance after deductible | |
| • Annual Program Maximum | Per Person | Not Applicable | |
| • Lifetime Orthodontia Maximum | | Not Applicable | |

*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.*

**Certain preventive contraceptives are required to be covered at no cost to you when filled at a participating pharmacy with a valid prescription in accordance with Preventive Health Guidelines.*

**Select Brands include contraceptives for which there is no generic equivalent.

***Frames and contact lens allowances at Walmart® Vision Centers may vary from any allowances indicated above. Refer to your COC for benefit details.

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.**

**On behalf of Capital BlueCross, Dominion National assists in the administration of the BlueCross Dental benefits. Dominion National is an independent company.**

**On behalf of Capital BlueCross, National Vision Administrators, LLC (NVA) provides the network and assists in the administration of network management services for the BlueCross Vision benefits program. NVA is an independent company.**

For more information or to locate a participating provider, visit www.capbluecross.com.

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# Benefit Highlights
## Gold PPO 500/0/40 Rx 0

**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) | $500 per member<br>$1,000 per family | $5,000 per member<br>$10,000 per family |
| **Copayments** | | |
| • **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*) | $40 copayment per visit | 50% coinsurance |
| • **Specialist Office Visit** | $65 copayment per visit | 50% coinsurance |
| • **Emergency Room** | $250 copayment per visit, waived if admitted | |
| • **Urgent Care** | $125 copayment per visit | |
| • **Inpatient** (Per Admission) | Not Applicable | 50% coinsurance |
| • **Outpatient Surgery Copayment** (facility) | Not Applicable | 50% coinsurance |
| • **High Tech Imaging** | $250 copayment after deductible | 50% coinsurance |
| **Coinsurance** | Not Applicable | 50% coinsurance |
| **Out-of-Pocket Maximum** *(includes Deductible, Copayments and Coinsurance for Medical (including ER), Prescription Drug, Pediatric Dental, and Pediatric Vision services)* for Participating Providers only. When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the benefit period ends. | $6,350 per member<br>$12,700 per family | $10,000 per member<br>$20,000 per family |

| SUMMARY OF BENEFITS | Limits and Maximums | Amounts *Members* Are Responsible For: | |
|---|---|---|---|
| | | ***Participating Providers*** | ***Non-Participating Providers*** |
| **PREVENTIVE CARE:** | *Administered in accordance with Preventive Health Guidelines and PA state mandates* | | |
| **Preventive Care Services** | | | |
| • Pediatric Preventive Care | | Covered in full, waive deductible | 50% coinsurance after deductible |
| • Adult Preventive Care | | Covered in full, waive deductible | 50% coinsurance after deductible |
| **Immunizations** | | Covered in full, waive deductible | 50% coinsurance, waive deductible |
| **Mammograms** | | | |
| • Screening Mammogram | One per benefit period | Covered in full, waive deductible | 50% coinsurance, waive deductible |
| • Diagnostic Mammogram | | Covered in full after deductible | 50% coinsurance after deductible |
| **Gynecological Services** | | | |
| • Screening Gynecological Exam & Pap Smear | One per benefit period | Covered in full, waive deductible | 50% coinsurance, waive deductible |
| **BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET** | | | |
| **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** | 120 days/benefit period | Covered in full after deductible | 50% coinsurance after deductible |
| **Surgery** | | | |
| • Surgical Procedure & Anesthesia | | Covered in full after deductible | 50% coinsurance after deductible |
| **Maternity Services and Newborn Care** | | Covered in full after deductible | 50% coinsurance after deductible |
| **Diagnostic Services** | | | |
| • High Tech Imaging (MRI, CT, PET, SPECT Scans, etc.) | | $250 copayment after deductible | 50% coinsurance after deductible |
| • Radiology (other than High Tech Imaging) | | Covered in full after deductible | 50% coinsurance after deductible |
| • Independent Laboratory | | Covered in full, waive deductible | 50% coinsurance after deductible |
| • Facility-owned Laboratory | | $75 copay after deductible | 50% coinsurance after deductible |
| **Outpatient Surgery** | | Covered in full after deductible | 50% coinsurance after deductible |
| **Outpatient Therapy Services** | | | |
| • Physical Medicine & Occupational Therapy | 30 visits combined rehabilitative<br>30 visits combined habilitative<br>(per benefit period) | $65 copayment per visit | 50% coinsurance after deductible |
| • Speech Therapy | 30 visits combined rehabilitative<br>30 visits combined habilitative<br>(per benefit period) | $65 copayment per visit | 50% coinsurance after deductible |
| • Respiratory/Pulmonary Therapy (rehabilitative) | 36 visits/benefit period | $65 copayment per visit | 50% coinsurance after deductible |
| • Manipulation Therapy | 20 visits/benefit period | $65 copayment per visit | 50% coinsurance after deductible |
| **Emergency Services** | | Covered in full, waive deductible<br>Emergency room copayment applies, waived if admitted inpatient | |
| **Mental Health Care Services** | | | |
| • Inpatient Services | | Covered in full after deductible | 50% coinsurance after deductible |
| • Outpatient Services | | $65 copayment per visit | 50% coinsurance after deductible |
| **Substance Abuse Services** | | | |
| • Rehabilitation – Inpatient | | Covered in full after deductible | 50% coinsurance after deductible |
| • Rehabilitation – Outpatient | | $65 copayment per visit | 50% coinsurance after deductible |
| **Home Health Care Services** | 60 visits/benefit period | Covered in full after deductible | 50% coinsurance after deductible |
| **Durable Medical Equipment (DME)** | | Covered in full after deductible | 50% coinsurance after deductible |
| **Prosthetic Appliances** | | Covered in full after deductible | 50% coinsurance after deductible |
| **Orthotic Devices** | | Covered in full after deductible | 50% coinsurance after deductible |

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

| SUMMARY OF BENEFITS (CONTINUED) | Limits and Maximums | Amounts Members Are Responsible For: | |
|---|---|---|---|
| **BENEFITS LISTED BELOW DO NOT APPLY BENEFIT PERIOD MEDICAL DEDUCTIBLE** | | | |
| | | ***Participating Providers*** | ***Non-Participating Providers*** |
| **PRESCRIPTION DRUG DEDUCTIBLE**<br>Per benefit period | | None | $5,000 per member<br>$10,000 per family |
| | **Retail Pharmacy (up to a 30-day supply)** | **Mail Service Pharmacy (up to a 90-day supply)** | **Specialty Pharmacy (up to a 30-day supply)** |
| **PRESCRIPTION DRUG TIER** | **BENEFIT** | | |
| Generic Preferred Prescription Drugs | $4 copayment | $10 copayment | 20% coinsurance up to $250/refill |
| Generic Non-Preferred Prescription Drugs | $15 copayment | $38 copayment | 20% coinsurance up to $250/refill |
| Brand Preferred Prescription Drugs | $45 copayment | $113 copayment | 20% coinsurance up to $350/refill |
| Brand Non-Preferred Prescription Drugs | $70 copayment | $175 copayment | 20% coinsurance up to $450/refill |
| **Preventive Coverage** | Covered in full, waive deductible | | |
| **Network** | CVS Caremark National Pharmacy Network | | |
| **PRESCRIPTION DRUG TIER (Contraceptives)** | **BENEFIT** | | |
| Generic Prescription Drugs | $0 copayment | $0 copayment | Not covered |
| Select Brand Prescription Drugs* | $0 copayment | $0 copayment | Not covered |
| Brand Preferred Prescription Drugs | $45 copayment | $113 copayment | Not covered |
| Brand Non-Preferred Prescription Drugs | $70 copayment | $175 copayment | Not covered |
| **FORMULARY SYSTEM** | Open | | |
| **UTILIZATION PROGRAM** | **BENEFIT** | | |
| Generic Substitution Program | **Restrictive Generic Substitution** – 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. | | |
| Voluntary Maintenance Choice | The dispensing of maintenance covered drugs for up to a 90 day supply is available through Mail Service or at CVS Pharmacies. | | |
| Specialty Pharmacy | 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 www.capbluecross.com. | | |
| Quantity Level Limits (per prescription, day supply or copayment) | Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com. | | |
| Prior Authorization and Enhanced Prior Authorization | Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com. | | |
| **Pediatric Vision Services - Benefit frequencies are based on date of service** | | | |
| • Vision Exam | Once every 12 months | Covered in full | $32 allowance |
| • Eyeglass Lenses | Once every 12 months | Single – Covered in full<br>Bi-focal – Covered in full<br>Tri-focal – Covered in full<br>Polycarbonate – Covered in full | Single - $24<br>Bi-focal - $36<br>Tri-focal - $46<br>Polycarbonate – Not covered |
| • Frames** | Once every 12 months | Standard Frames: Paid in full on frames selected from a frame collection<br>All Other Frames: Balance of retail charge less 30% after $100 allowance | Balance of retail charge after $30 allowance |
| • Contact Lenses**<br>Payment will be made for either lenses or contact lenses within a benefit period. Payment will not be made for both. | Once every 12 months | Balance of retail charge less 25% after $75 allowance | $50 allowance |
| **Pediatric Dental Services** | | | |
| • Deductible | | $50 per person | |
| • Preventive Services | | Covered full, waive deductible | |
| • Basic Services | | 20% coinsurance after deductible | |
| • Major Services | | 50% coinsurance after deductible | |
| • Orthodontia (Medically Necessary) | 12 month waiting period | 50% coinsurance after deductible | |
| • Annual Program Maximum | Per Person | Not Applicable | |
| • Lifetime Orthodontia Maximum | | Not Applicable | |

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*Select Brands include contraceptives for which there is no generic equivalent.

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*Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.*