Capital BLUE

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Benefit Highlights
Gold PPO HSA 1500/0/15

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	***NonParticipating Providers***
Deductible (per benefit period) *Deductible is combined to include medical & prescription drug benefits.*	$1,500 per member $3,000 per family	$5,000 per member $10,000 per family
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$15 copayment per visit after deductible	50% coinsurance
• **Specialist Office Visit**	$30 copayment per visit after deductible	50% coinsurance
• **Emergency Room**	$250 copayment per visit after deductible, waived if admitted	
• **Urgent Care**	$75 copayment per visit after deductible	
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 Care) for Participating Providers only.* When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowed amount until the benefit period ends.	$6,350 per member $12,700 per family	$10,000 per member $20,000 per family

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	***NonParticipating 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			
Inpatient 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.)		Covered in full after deductible	50% coinsurance after deductible
• Radiology (other than High Tech Imaging)		Covered in full after deductible	50% coinsurance after deductible
• Independent Laboratory		$15 copayment after deductible	50% coinsurance after deductible
• Facility-owned Laboratory		$30 copayment after deductible	50% coinsurance after deductible
Outpatient Surgery (Ambulatory Surgical Center)		Covered in full after deductible	50% coinsurance after deductible
(Acute Care Hospital)		Covered in full after deductible	50% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine & Occupational Therapy	30 visits combined rehabilitative 30 visits combined habilitative (per benefit period)	$30 copayment after deductible	50% coinsurance after deductible
• Speech Therapy	30 visits combined rehabilitative 30 visits combined habilitative (per benefit period)	$30 copayment after deductible	50% coinsurance after deductible
• Respiratory/Pulmonary Therapy (rehabilitative)	36 visits/benefit period	$30 copayment after deductible	50% coinsurance after deductible
• Manipulation Therapy	20 visits/benefit period	$30 copayment after deductible	50% coinsurance after deductible
Emergency Services		Covered in full after deductible 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		$30 copayment after deductible	50% coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient		Covered in full after deductible	50% coinsurance after deductible
• Rehabilitation – Outpatient		$30 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	***NonParticipating Providers***
PRESCRIPTION DRUG DEDUCTIBLE (Includes medical and prescription drug benefits) Per benefit period		$1,500 per member $3,000 per family	$5,000 per member $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 (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	$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 Care - 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 Bi-focal – Covered in full Tri-focal – Covered in full Polycarbonate – Covered in full	Single - $24 Bi-focal - $36 Tri-focal - $46 Polycarbonate – Not covered
• Frames***	Once every 12 months	Standard Frames: Paid in full on frames selected from a frame collection All Other Frames: Balance of retail charge less 30% after $100 allowance	Balance of retail charge after $30 allowance
• Contact Lenses*** 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)		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 nonparticipating provider or pharmacy, you are responsible for paying the deductible, coinsurance and the difference between the nonparticipating provider's or nonparticipating pharmacy's charges and the allowed amount. NonParticipating Providers may balance bill the member. Some nonparticipating facility providers are not covered. Deductibles, any differences paid between brand drug and generic drug prices, and any balances paid to nonparticipating 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.