

SUMMARY OF COST-SHARING	Amounts Members Are Responsible For:	
	Participating Providers	Non-Participating Providers
Deductible (per benefit period) <i>Deductible applies to all services unless a Copayment is applied or otherwise noted</i>	\$600 per member \$1,800 per family	
Copayments		
• Office Visits (Family Practitioner, General Practitioner, Internist, Pediatrician)	Coinsurance applies	Coinsurance applies
• Specialist Office Visit	Coinsurance applies	Coinsurance applies
• Emergency Room	Coinsurance applies	Coinsurance applies
• Urgent Care	Coinsurance applies	Coinsurance applies
• Inpatient (Per Admission)	Coinsurance applies	Coinsurance applies
• Outpatient Surgery Copayment (facility)	Coinsurance applies	Coinsurance applies
Coinsurance	Coinsurance applies	Coinsurance applies
Out-of-Pocket Maximum (includes Deductible and Coinsurance for all services) 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 \$12,700 per family	
Coverage Lifetime Maximum	None	

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	Not covered
• Adult Preventive Care		Covered in full, waive deductible	Not covered
• Sigmoidoscopy and PSA tests		Covered in full, waive deductible	20% coinsurance after deductible
Immunizations		Covered in full, waive deductible	20% coinsurance after deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	20% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam	One per benefit period	Covered in full, waive deductible	20% coinsurance after deductible
• Screening Pap Smear	One per benefit period		20% coinsurance after deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		20% coinsurance after deductible	20% coinsurance after deductible
• Transplant Services		20% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility	120 days/benefit period	20% coinsurance after deductible	20% coinsurance after deductible
Surgery			
• Surgical Procedure		20% coinsurance after deductible	20% coinsurance after deductible
• Anesthesia		20% coinsurance after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care		20% coinsurance after deductible	20% coinsurance after deductible
Diagnostic Services			
• Radiology		20% coinsurance after deductible	20% coinsurance after deductible
• Laboratory		20% coinsurance after deductible	20% coinsurance after deductible
• Medical tests		20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine		20% coinsurance after deductible	20% coinsurance after deductible
• Occupational Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Speech Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Respiratory Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Manipulation Therapy		20% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		20% coinsurance after deductible	20% coinsurance after deductible
Medical Transport			
• Emergency Ambulance		20% coinsurance after deductible	
• Medically Necessary Ambulance		20% coinsurance after deductible	20% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company or by Capital Advantage Insurance Company, subsidiaries of Capital BlueCross and independent licensees of the BlueCross BlueShield Association.

SUMMARY OF BENEFITS (CONTINUED)	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating Providers
Mental Health Care Services • Inpatient Services		20% coinsurance after deductible	20% coinsurance after deductible
• Outpatient Services		20% coinsurance after deductible	20% coinsurance after deductible
Substance Abuse Services • Rehabilitation - Inpatient		20% coinsurance after deductible	20% coinsurance after deductible
• Rehabilitation – Outpatient		20% coinsurance after deductible	20% coinsurance after deductible
Home Health Care Services	120 visits/benefit period	20% coinsurance after deductible	20% coinsurance after deductible
Hospice Care		20% coinsurance after deductible	20% coinsurance after deductible
Private Duty Nursing	240 hours/benefit period	20% coinsurance after deductible	20% coinsurance after deductible
Durable Medical Equipment (DME)		20% coinsurance after deductible	20% coinsurance after deductible
Prosthetic Appliances and Orthotic Devices		20% coinsurance after deductible	20% coinsurance after deductible
Diabetic Supplies and Education		20% coinsurance after deductible	20% coinsurance after deductible
Infertility Services	\$2,500 benefit lifetime max/subscriber & spouse each	50% coinsurance after deductible	50% coinsurance after deductible
Assisted Fertilization		Not Covered	Not Covered

OTHER STANDARD PLAN FEATURES	
Preauthorization	Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs.
Disease Management	Disease Management Programs are a collaborative process that assesses the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression.
Nurse Line	Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE.
Better Health WorksSM Personal Profile	Answer questions about yourself and the way you live and, based on the answers you provide, you will receive customized recommendations for your health situation. Support is available to follow through on these recommendations and to make positive health changes.
mycapbluecross.com	Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWell SM member newsletter, view explanations of benefits, and much more.

STANDARD BENEFIT EXCLUSIONS. The following list highlights **some** standard benefit exclusions. It is **NOT** intended to be a complete list or a complete description of all categories of benefit exclusions.

Cosmetic procedures – Acupuncture – Routine foot care; or support devices of the feet – Eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses – Corneal surgery and other procedures to correct refractive errors – Prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider – Hearing aids or examinations for the prescription or fitting of hearing aids – All dental services rendered after stabilization of a member in an emergency following an accidental injury – Treatment of obesity, except for surgical treatment of morbid obesity – Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcisions – Procedures to reverse sterilization.

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 complete description of available services. Refer to your Certificate of Coverage for benefit details.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered.

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

Refer to your Certificate of Coverage for the applicable benefit period.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for groups size >51.