Capital BlueCross

# PPO

## Plan 1200-Q

This integrated medical and drug plan is an IRS qualified high deductible health plan (HDHP).

| | AMOUNTS YOU ARE RESPONSIBLE FOR: | |
|---|---|---|
| **DEDUCTIBLE (Includes medical and prescription drug benefits)** | **Network Providers** | **Out-of-Network Providers*** |
| Per benefit period (The benefit period for this coverage is a calendar year.)<br>For contracts which cover only the subscriber, the subscriber must meet the entire single coverage deductible before he/she is eligible for covered benefits. For contracts which cover the subscriber and one or more dependents, the entire family deductible must be met before any family member is eligible for covered benefits.<br>Deductible is combined with the deductible on the Rx Plan 1200-Q highlight sheet. Members can satisfy this combined deductible with medical and/or prescription drug benefits. | $1,200 single coverage<br>$2,400 family coverage | $2,400 single coverage<br>$4,800 family coverage |
| **OUT-OF-POCKET MAXIMUM (Includes deductible, coinsurance and copayments for medical and prescription drug benefits)** | | |
| For contracts which cover only the subscriber, the subscriber must meet the entire single coverage out-of-pocket maximum before payment for all other benefits incurred during the remainder of the benefit period will be made at 100% of the Plan Allowance. For contracts which cover the subscriber and one or more dependents, the entire family out-of-pocket maximum amount must be met before payment for all other benefits incurred during the remainder of the benefit period will be made at 100% of the Plan Allowance for any family member. Certain out-of-network facility providers will continue to be paid at the percentage set forth in the contract.<br>Out-of-pocket maximum is combined with the out-of-pocket maximum on the Rx Plan 1200-Q highlight sheet. Members can satisfy this combined out-of-pocket maximum with medical and/or prescription drug benefits. | $5,000 single coverage<br>$10,000 family coverage | Does Not Apply |
| **PREVENTIVE CARE SAFETY NET:** *The deductible is waived for the following preventive services unless otherwise noted* | | |
| **PREVENTIVE CARE** | | |
| Adult routine physical exams and preventive care (age 18 and over) | $20 copayment per visit | 20% coinsurance, with a $400 benefit period maximum, deductible applies |
| Pediatric routine physical exams & preventive care (includes well-baby care) | $20 copayment per visit | 20% coinsurance, deductible applies |
| • Childhood immunizations | Covered in full | 20% coinsurance |
| Annual gynecological exam | $20 copayment per visit | 20% coinsurance |
| • Annual mammogram (age 40 and over)<br>• Annual Pap Smear test | Covered in full | 20% coinsurance |
| **BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET** | | |
| **PHYSICIAN SERVICES** | | |
| • Office visits | $20 copayment per visit | 20% coinsurance |
| • Maternity and newborn care<br>• Lab tests, x-rays, inpatient visits, surgery and anesthesia | Covered in full | 20% coinsurance |
| **OTHER PROVIDER SERVICES** | | |
| • Outpatient physical therapy (30 visits per benefit period)<br>• Manipulation therapy (20 visits per benefit period)<br>• Occupational & speech therapy (30 visits each type per benefit period) | $20 copayment per visit | 20% coinsurance |
| • Home health care (90 visits per benefit period) | Covered in full | 20% coinsurance |
| • Hospice ($50,000 lifetime maximum) | Covered in full | 20% coinsurance |
| **OUTPATIENT HOSPITAL SERVICES** | | |
| Professional fees & facility services, including: lab, x-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis, anesthesia and surgery | Covered in full | 20% professional coinsurance; 50% coinsurance at certain facility providers |
| **INPATIENT HOSPITAL SERVICES** | | |
| Professional fees & facility services, including: room and board, and other covered services | Covered in full | 20% professional coinsurance; 50% coinsurance at certain facility providers |
| **EMERGENCY CARE** | | |
| Emergency treatment for accident or medical emergency | $75 emergency room copayment (waived if admitted) | |
| Ambulance services for emergency care | Covered in full | Covered in full |
| **DURABLE MEDICAL EQUIPMENT, SUPPLIES, PROSTHETICS & ORTHOTICS** | Covered in full | 20% coinsurance |
| **MENTAL HEALTH CARE** | | |
| Inpatient care (30 days per benefit period; additional days as required by law) | Covered in full | 50% coinsurance |
| Psychiatric partial hospitalization (included as part of inpatient days) | Covered in full | Not covered |
| Outpatient psychiatric services (60 visits per benefit period; additional visits as required by law) | $20 copayment per visit | 50% coinsurance |
| **SUBSTANCE ABUSE CARE** | | |
| • Inpatient care (30 days per benefit period; 90 days per lifetime)<br>• Outpatient care (30 visits per benefit period; 120 visits per lifetime) | Covered in full | Not covered |
| **LIFETIME MAXIMUM BENEFIT** | Unlimited | Unlimited |

***Programs are subject to change.* This information highlights PPO benefits when you visit a network provider and is *not* intended to be a complete list or complete description of available services. Contact your employer, marketing representative or broker for additional benefit details.**

Network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the provider's charges and the Plan Allowance.

Inpatient admissions as well as certain other services and equipment may require preauthorization. Please refer to your Certificate of Coverage or contact your employer, marketing representative or broker for a more detailed description of services that require preauthorization.

*Some out-of-network facility providers are not covered.

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

***Benefits are underwritten by Capital Advantage Insurance Company, a wholly-owned subsidiary of Capital BlueCross.***

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CBC-246 (2/1/2005)
Community Rated Benefits

*The group contract will contain standard benefit exclusions and limitations (which will vary by contract and riders purchased). As examples, except as specifically set forth in the group contract, no benefits may be provided for services, supplies or charges:*

1. Which are not Medically Necessary and Appropriate as determined by CAIC;
2. Which are not billed by and either performed by or under the supervision of a Provider as defined in the Group Contract;
3. Which are Experimental or Investigational in nature as defined in the Group Contract;
4. For any illness or injury which occurs in the course of employment if benefits or compensation are available in whole or in part, under any federal, state or local government's worker's compensation law or occupational disease law, including but not limited to, the United States Longshoreman's and Harbor Worker's Compensation Act as amended from time to time. This exclusion applies whether or not the Member claims the benefits or compensation;
5. For any illness or injury suffered after the Member's Effective Date of coverage as a result of an act of war, whether declared or undeclared;
6. For services received by veterans and active military personnel at facilities operated by the Veteran's Administration or by the Department of Defense, unless payment is required by law;
7. For which a Member would have no legal obligation to pay;
8. Which are received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
9. For services and operations for cosmetic purposes done to improve the appearance of any portion of the body and from which no significant improvement in physiologic function can be expected, except as otherwise required by law. This exclusion does not apply to services to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes;
10. Rendered by a Provider who is a member of the Member's Immediate Family;
11. Which were incurred prior to the Member's Effective Date of coverage;
12. Incurred after the date of termination of the Member's coverage except as provided for in the Group Contract;
13. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, radio and television, beauty/barber shop services, guest trays, chairlifts, elevators, spa or health club memberships, whether or not recommended by a Provider;
14. For supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices;
15. For telephone consultations between a Provider and a Member, charges for failure to keep a scheduled visit with a Provider, or charges for completion of a claim form or obtaining copies of medical records;
16. For Custodial Care, domiciliary care or rest cures;
17. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
18. For screening examinations except as specifically provided for in the Group Contract;
19. For oral surgery, except as specifically provided in the Group Contract;
20. Directly related to the care, filling, removal, or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth except as specifically provided in the Group Contract. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided for and defined in the Group Contract;
21. For eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury;
22. For hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids and all related services;
23. For treatment of obesity, except for surgical treatment of morbid obesity;
24. For treatment in connection with sexual dysfunction not related to organic disease or injury;
25. For treatment leading to or in connection with transsexual surgery except for sickness or injury resulting from such surgery;
26. For any treatment leading to or in connection with assisted fertilization such as, but not limited to, artificial insemination, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT);
27. For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disease (CMD), with intraoral prosthetics, procedures or devices or with any method to alter vertical dimension and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic disease or physical trauma;
28. For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable under any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
29. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
30. For equipment costs related to services performed on high-cost technological equipment such as, but not limited to, computed tomography scanners (CT scanners), lithotripters, and magnetic resonance imaging scanners, as defined by CAIC;
31. Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program, including services performed by a resident Physician under the supervision of a Professional Provider;
32. Which exceed the Plan Allowance;
33. For payment made under Medicare when Medicare is primary; however, this exclusion shall not apply when the Group is obligated by law to offer the Member all the Benefits of the Group Contract and the Member so elects this coverage as primary;
34. The amount of any penalty applied under the Preauthorization provision of the Group Contract when a Non-Participating Provider was utilized or the Member failed to present his or her Identification Card to the Provider;
35. For all prescription and over-the-counter drugs dispensed by a pharmacy or Physician for the Outpatient use of a Member; except for allergy serums and pharmacological agents used for controlling blood sugar;
36. For all prescription and over the counter drugs dispensed by a Home Health Care Agency Provider, with the exception of intravenous drugs administered under a treatment plan approved by CAIC;
37. Which are Copayments and/or Coinsurance required of the Member;
38. For Inpatient admissions at Non-Participating Facility Providers, without Preadmission Certification, which are primarily for diagnostic studies, which could have been performed on an Outpatient basis;
39. For nutritional counseling and services intended to produce weight loss;
40. For Inpatient stays to bring about weight reduction;
41. For dietary or food supplements unless specified in the Group Contract;
42. For procedures to reverse sterilization;
43. For private duty nursing services;
44. For music therapy and/or recreational therapy; or
45. For any other service or treatment except as provided in the Group Contract.

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# Rx

## Plan 1200-Q

This integrated medical and drug plan is an IRS qualified high deductible health plan (HDHP).

| HIGHLIGHTS | AMOUNTS YOU ARE RESPONSIBLE FOR: | |
|---|---|---|
| **DEDUCTIBLE (Includes medical and prescription drug benefits)** | **Retail (up to a 30-day supply)** | **Mail Service (up to a 90-day supply)** |
| Per benefit period (The benefit period for this coverage is a calendar year.)<br>For contracts, which cover only the subscriber, the subscriber must meet the entire single coverage deductible before he/she is eligible for covered benefits. For contracts, which cover the subscriber and one or more dependents, the entire family deductible must be met before any family member is eligible for covered benefits. | Deductible is combined with the deductible on the PPO Plan 1200-Q highlight sheet. Members can satisfy this combined deductible with medical and/or prescription drug benefits.<br><br>All pharmacy charges will accumulate to the In-network Medical deductible. | |
| **OUT-OF-POCKET MAXIMUM (Includes deductible, coinsurance and copayments for medical and prescription drug benefits)** | | |
| For contracts which cover only the subscriber, the subscriber must meet the entire single coverage out-of-pocket maximum before payment for all other benefits incurred during the remainder of the benefit period will be made at 100% of the Plan Allowance. For contracts which cover the subscriber and one or more dependents, the entire family out-of-pocket maximum amount must be met before payment for all other benefits incurred during the remainder of the benefit period will be made at 100% of the Plan Allowance for any family member. | Out-of-pocket maximum is combined with the out-of-pocket maximum on the PPO Plan 1200-Q highlight sheet. Members can satisfy this combined out-of-pocket maximum with medical and/or prescription drug benefits.<br><br>All pharmacy charges will accumulate to the In-network Out-Of-Pocket Maximum. | |
| **PRESCRIPTION DRUG TIER** | | |
| Generic prescription drug | $10 copay | $25 copay |
| Brand Preferred prescription drug | $30 copay | $70 copay |
| Brand Non-Preferred prescription drug | $50 copay | $135 copay |

| PRESCRIPTION CATEGORY | BENEFIT | |
|---|---|---|
| Contraceptives | Covered | Covered |
| Fertility Drugs | Not covered | Not covered |
| Sexual Dysfunction Drugs | Not covered | Not covered |
| Weight Loss Drugs | Not covered | Not covered |
| Injectables (self-administered) | Covered unless specifically excluded | Covered unless specifically excluded |
| Insulin | Covered | Covered |
| Fluoride Products | Covered | Covered |
| Growth Hormones | Covered (prior authorization required) | Covered (prior authorization required) |
| Nicotine Replacement Products (prescription) | Not covered | Not covered |
| Vitamins (prescription, non-prenatal) | Not covered | Not covered |
| Prenatal Vitamins (prescription) | Covered | Covered |
| Anti-Flu Therapies | Not covered | Not covered |
| Diabetic Supplies | Covered | Covered |
| Acne Products | Not covered | Not covered |
| Over-the-Counter Equivalents | Not covered | Not covered |
| Prescription Hair Growth Products | Not covered | Not covered |
| Photo Aged Skin Products and Depigmentation Products | Not covered | Not covered |

| UTILIZATION PROGRAM | BENEFIT | |
|---|---|---|
| Generic Substitution Program | *Mandatory Generic Substitution Program* – In addition to the applicable brand drug coinsurance/copayment, the member pays the difference between the brand drug and the generic drug cost (when there is a generic equivalent) even if the prescribing physician or member requested the brand drug to be dispensed in place of an approved generic drug equivalent. | |
| Quantity Level Limits (per prescription, per day supply or per copayment) | Applicable to selected drugs | Applicable to selected drugs |
| Prior Authorization | Applicable to selected drugs | Applicable to selected drugs |

**This is a general description of benefits, limitations and exclusions of the prescription drug card plan coverage issued by Capital Advantage Insurance Company and is not intended to be a complete list or complete description of available services; the terms and conditions of coverage shall be governed solely by the contract issued to the group. Contact your employer or marketing representative for additional benefit details.**

The pharmacy network includes many chain and independent retail pharmacies nationwide. Visit **www.express-scripts.com** to find a participating pharmacy.

Participating pharmacies agree to accept our allowance as payment in full, often less than their normal charge. If you use a non-participating pharmacy, you will have to pay the difference between what the pharmacy charges and the Plan Allowance in addition to any deductible, coinsurance or copayment and may need to complete and submit a claim form for reimbursement. Balances paid to non-participating pharmacies and ancillary charges are not applied to the deductible and out-of-pocket maximum.

*Deductibles under this program are not separate from the medical deductibles described in your company's health benefits coverage.*

***Benefits are underwritten by Capital Advantage Insurance Company, a wholly-owned subsidiary of Capital BlueCross.***

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## Rx *1200-Q Plan* – Standard Benefit Exclusions

***The group contract will contain standard benefit exclusions and limitations (which will vary by contract and riders purchased).***

### LIMITATIONS

***Limitations to Benefits set forth in the Contract include:***

1. A Participating or Non-Participating Provider need not dispense a Prescription Order that for any reason, in its professional judgment, should not be filled.
2. A Member may purchase a Non-Preferred Drug if it could be used to treat his or her condition. If, however, a Member purchases a Non-Preferred Drug, the Member may be required to pay a higher Copayment/Coinsurance, based on the Member's benefit plan and as indicated on the Schedule of Benefits.
3. A Member may purchase a Brand Drug, even if a Generic Drug equivalent is available, if it could be used to treat his or her condition. If, however, a Member purchases a Brand Drug and a Generic Drug equivalent is available, the Member is responsible for paying the difference between the cost of the Generic Drug and the cost of the Brand Drug in addition to the applicable Copayment or Coinsurance even if the Prescriber specifies "Brand Medically Necessary" (or substantially similar language).
4. Refills may be dispensed subject to federal and state law limitations, and only in accordance with the number of refills designated on the original Prescription Order. Refills may not be dispensed more than one (1) year after the date of the original Prescription Order. When a Prescription Order is written for a Prescription Drug that has previously been dispensed to a Member or a Prescription Order is presented for a refill, the Prescription Drug will be dispensed only at such time as the Member has used sixty-six percent (66%) of the previous supply dispensed through Mail Service Pharmacy or seventy-five percent (75%) of the previous supply dispensed through a Retail Pharmacy in accordance with the associated Prescription Order.
5. Certain Prescription Drugs will not be available for Mail Service Dispensing due to safety or quality concerns. Such Prescription Drugs will be subject to Retail Dispensing only.
6. All Prescription Drugs are subject to availability at the Retail Pharmacy or Mail Service Pharmacy.
7. Prescription Drugs classified by the federal government as narcotics may be subject to dispensing or dosage limitations based on standards of good pharmaceutical practice or regulations.
8. CAIC reserves the right to determine the reasonable supply of any Prescription Drug based on standards of good pharmaceutical practice.
9. Certain Prescription Drugs, which are dispensed pursuant to a Prescription Order for the Outpatient use of the Member, are subject to quantity limits. Benefits for these Prescription Drugs shall be available based on the quantity which CAIC will determine, in its sole discretion, is a reasonable per prescription or per day supply for Retail or Mail Service Dispensing.
10. Certain Prescription Drugs require evaluation of requests (prior authorization) for coverage prior to the delivery of Covered Drugs.

### EXCLUSIONS

***Except as specifically provided in the Contract and in addition to any limitations set forth in the Contract, no benefits shall be provided for:***

1. Prescription Drugs and supplies that are not Medically Necessary and Appropriate as determined by CAIC, or its designee.
2. Drugs that do not legally require a prescription (other than insulin), i.e. over-the-counter products including but not limited to nutritional or dietary supplements.
3. Prescription Drugs that have an over-the-counter equivalent.
4. Devices or appliances including but not limited to therapeutic devices, artificial appliances, or similar devices or appliances except Diabetic Supplies.
5. The administration or injection of Prescription Drugs.
6. Prescription Drugs dispensed in a physician's office.
7. Prescription Drugs for which the Member is not legally obligated to pay.
8. Prescription Drugs or supplies received by veterans and active military personnel at facilities operated by the Veteran's Administration or by the Department of Defense, unless payment is required by law.
9. Prescription Drugs or supplies for any illness or injury which occurs in the course of employment if benefits or compensation are available in whole or in part, under any federal, state or local government's workers' compensation law or occupational disease law, including but not limited to, the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the Member claims the benefits or compensation.
10. Prescription Drugs or supplies for any illness or injury suffered after the Member's Effective Date of coverage as a result of an act of war, whether declared or undeclared.
11. Prescription Drugs received in and billed by a hospital, nursing home, home for the aged, convalescent home, home health care agency, or similar institution.
12. Prescription Drugs that are Experimental or Investigational in nature as determined by CAIC or its designee in accordance with the definition set forth in the Group Contract.
13. Prescription Drugs or supplies for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under any plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable under any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law.
14. Prescription Drugs or supplies received either before the Member' Effective Date of coverage or after the Member's coverage is terminated.
15. Allergy serums, desensitization serums, venom.
16. Immunization agents, biological sera, blood, blood products.
17. Prescription Drugs utilized to promote hair growth.
18. Prescription Drugs utilized for cosmetic purposes or to enhance physical or athletic performance or appearance.
19. Prescription Drugs utilized to treat infertility or impotency.
20. Prescription Drugs utilized for weight loss purposes.
21. Nicotine replacement products.
22. Prescription vitamins (other than pre-natal).
23. Anti-flu therapies.
24. Tretinoin products.
25. Prescription Drugs utilized in conjunction with non-covered medical services.
26. Prescription Drugs that require prior authorization if prior authorization is not obtained before dispensing the Prescription Drugs.
27. Prescription Drug charges or payments which exceed the Plan Allowance.
28. Prescription Drugs which are received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
29. Prescription Drugs prescribed by a Prescriber who is a member of the Member's immediate family.
30. Copayments and/or Coinsurance, Deductibles, any differences paid between Brand Drug and Generic Drug prices, and balances paid to Non-Participating Pharmacies that are required of the Member.
31. Durable Medical Equipment.
32. Injectable medications that cannot be self-administered.
33. Request for reimbursement of Covered Drugs submitted after the allowed timeframe for reimbursement.
34. Prescription Drugs for any other service or treatment except as provided in this Group Contract.

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