



eBasics™

Offered by
Capital Advantage Insurance Company
A Capital BlueCross Company

www.capbluecross.com

**Benefit Highlights
PPO Plan 2000/80**

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>	\$2,000 per member \$4,000 per family	
Copayments		
• Office Visits (Family Practitioner, General Practitioner, Internist, Pediatrician)	\$20 copayment per visit	Coinsurance applies
• Specialist Office Visit <i>Office visits (including specialist visits) are subject to a 10 visit maximum per family per benefit period excluding preventive, mental health and substance abuse visits.</i>	\$40 copayment per visit	Coinsurance applies
• Emergency Room	\$200 copayment per visit, waived if admitted	
• Urgent Care	\$75 copayment per visit	Coinsurance applies
• Inpatient (Per Admission)	Not Applicable	Coinsurance applies
• Outpatient Surgery Copayment (facility)	Not Applicable	Coinsurance applies
Coinsurance	20% coinsurance	50% coinsurance
Out-of-Pocket Maximum	\$5,000 per member \$10,000 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	50% coinsurance after deductible
• Adult Preventive Care		Covered in full, waive deductible	50% coinsurance after deductible
Immunizations		Covered in full, waive deductible for PA mandated childhood immunizations	50% coinsurance, waive deductible for PA mandated childhood immunizations
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	50% coinsurance, waive deductible
• Diagnostic Mammogram		20% coinsurance after deductible	50% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam	One per benefit period	Covered in full, waive deductible	50% coinsurance, waive deductible
• Screening 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		20% coinsurance after deductible	50% coinsurance after deductible
Acute Inpatient Rehabilitation	60 days/benefit period	20% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility	100 days/benefit period	20% coinsurance after deductible	50% coinsurance after deductible
Surgery			
• Surgical Procedure		20% coinsurance after deductible	50% coinsurance after deductible
• Anesthesia		20% coinsurance after deductible	50% coinsurance after deductible
Maternity Services and Newborn Care		20% coinsurance after deductible	50% coinsurance after deductible
Diagnostic Services			
• Radiology		20% coinsurance after deductible	50% coinsurance after deductible
• Laboratory		20% coinsurance after deductible	50% coinsurance after deductible
• Medical tests		20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine	10 visits/benefit period combined	Copayment applies	50% coinsurance after deductible
• Occupational Therapy		Copayment applies	50% coinsurance after deductible
• Speech Therapy		Copayment applies	50% coinsurance after deductible
• Respiratory Therapy		Copayment applies	50% coinsurance after deductible
• Manipulation Therapy		Not Covered	Not Covered
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
Medical Transport			
• Emergency Ambulance		20% coinsurance, waive deductible	
• Non-Emergency Ambulance		20% coinsurance after deductible	50% coinsurance after deductible

Benefits are underwritten by Capital Advantage Insurance Company®, a subsidiary of Capital BlueCross. Independent licensee of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

SUMMARY OF BENEFITS (CONTINUED)	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating Providers
Mental Health Care Services • Inpatient Services	Group size >51 Coverage for Serious Mental Illness services only	20% coinsurance after deductible	50% coinsurance after deductible
	Group size <51 Coverage for Serious Mental Illness services only	20% coinsurance after deductible	50% coinsurance after deductible
• Outpatient Services	Group size >51 Coverage for Serious Mental Illness services only	Specialist copayment applies	50% coinsurance after deductible
	Group size <51 Coverage for Serious Mental Illness services only	Specialist copayment applies	50% coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient	Group size >51	20% coinsurance after deductible	50% coinsurance after deductible
	Group size <51	20% coinsurance after deductible	50% coinsurance after deductible
• Rehabilitation – Outpatient	Group size >51	Specialist copayment applies	50% coinsurance after deductible
	Group size <51	Specialist copayment applies	50% coinsurance after deductible
Home Health Care Services	45visits/ benefit period	20% coinsurance after deductible	50% coinsurance after deductible
Hospice Care	\$50,000 lifetime max	20% coinsurance after deductible	50% coinsurance after deductible
Durable Medical Equipment (DME)	\$15,000/benefit period	20% coinsurance after deductible	50% coinsurance after deductible
Prosthetic Appliances and Orthotic Devices	\$15,000/benefit period	20% coinsurance after deductible	50% coinsurance after deductible
Diabetic Supplies and Education		20% coinsurance after deductible	50% coinsurance after deductible
Infertility Services		20% coinsurance after deductible	50% coinsurance after deductible
Assisted Fertilization		Not Covered	Not Covered
Nutritional Counseling • Children Diagnosed with Obesity and • Adults with BMI of 30 or Higher	2 sessions/benefit period	Copayment applies	50% coinsurance after deductible

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 assess 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 Works SM 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 explanation 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 – Extractions of full or partial bony impactions – Private duty nursing services – Treatment of obesity, except for surgical treatment of morbid obesity – Procedures to reverse sterilization – Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcisions – Manipulation Therapy.

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 or contact your employer for the applicable benefit period.

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



HIGHLIGHTS	AMOUNTS YOU ARE RESPONSIBLE FOR:		
DEDUCTIBLE Per benefit period*	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)
	None		
OUT-OF-POCKET MAXIMUM When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the benefit period ends.	None		
PRESCRIPTION DRUG TIER			
Generic Prescription Drugs	\$15 copayment	\$40 copayment	\$15 copayment
Preferred Brand Prescription Drugs	\$30 copayment	\$75 copayment	\$30 copayment
Non-Preferred Brand Prescription Drugs	\$50 copayment	\$125 copayment	\$50 copayment
Lifestyle Drugs	100% of the discounted price	100% of the discounted price	100% of the discounted price
Network	CVS Caremark National Pharmacy Network		
FORMULARY SYSTEM	Open		
PRESCRIPTION CATEGORY	BENEFIT		
Contraceptives (oral and injectable)	Covered	Covered	Not covered
Specialty Drugs (self-administered)	Covered	Not covered	Covered
Prenatal Vitamins (prescription)	Covered	Covered	Not covered
Anti-Flu Therapies	Covered	Not covered	Not covered
Diabetic Supplies	Covered	Covered	Not covered
Topical Retinoid (Acne) Products (prior authorization required)	Covered with age limit	Covered with age limit	Not covered
Over-the-Counter Equivalents	Not covered	Not covered	Not covered
LIFESTYLE DRUGS	AMOUNTS YOU ARE RESPONSIBLE FOR:		
Fertility Drugs	100% of the discounted price	100% of the discounted price	100% of the discounted price
Sexual Dysfunction Drugs	100% of the discounted price	100% of the discounted price	Not covered
Weight Loss Drugs	100% of the discounted price	100% of the discounted price	Not covered
Smoking Cessation Drugs (prescription)	100% of the discounted price	100% of the discounted price	Not covered
Vitamins (prescription, non-prenatal)	100% of the discounted price	100% of the discounted price	Not covered
UTILIZATION PROGRAM	BENEFIT		
Generic Substitution Program	Restrictive Generic Substitution – In addition to the coinsurance/copayment, the member pays the difference between the brand drug and generic drug price (when there is a generic drug alternative) unless the prescribing physician requests that the brand drug be dispensed.		
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 .		

This is not a Contract. Programs are subject to change. This information highlights benefits, limitations and exclusions of the Capital Advantage Insurance Company® prescription drug coverage 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, marketing representative, or broker for additional benefit details.

*Refer to your Certificate of Coverage or contact your employer for the applicable benefit period.

The pharmacy network includes many chain and independent retail pharmacies nationwide. Visit www.capbluecross.com to find a participating pharmacy. **CuraScript® is the exclusive vendor for specialty prescription drugs.**

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 are responsible for paying the difference between the non-participating pharmacy's charges and the allowable amount in addition to any deductible, coinsurance or copayment. You also will need to complete and submit a claim form for reimbursement. 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.

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.

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, CuraScript, Inc. assists in the delivery of specialty medications directly to our Members. Curascript is an independent company.

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Option 8 – Standard Benefit Limitations and Exclusions

The group contract will contain standard benefit limitations and exclusions.

LIMITATIONS - Limitations to benefits set forth in the group contract include:

1. A participating pharmacy or non-participating pharmacy 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 brand drug if it could be used to treat his or her condition. If, however, a member purchases a non-preferred brand drug, the member may be required to pay a higher copayment/coinsurance, based on the member's benefit plan and as indicated in the Certificate of Coverage.
3. Members may purchase a brand drug, even if an approved generic drug equivalent could be used to treat their condition. If, however, a member purchases a brand drug and such approved generic drug equivalent is available, the member is responsible for paying the applicable brand drug coinsurance and/or copayment in addition to the difference between the cost of the approved generic drug and the cost of the brand drug (i.e. ancillary charge), unless the prescribing physician indicates no substitution is permissible and requires the brand drug to be dispensed in place of the approved generic drug equivalent.
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 through a retail pharmacy or specialty 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 or specialty pharmacy dispensing only.
6. All prescription drugs are subject to availability at the retail pharmacy, specialty pharmacy, or mail service pharmacy.
7. Select specialty prescription drugs will be subject to dispensing only through a designated specialty pharmacy.
8. 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 state or federal regulations.
9. Capital reserves the right to determine the reasonable supply of any prescription drug based on standards of good pharmaceutical practice.
10. 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 Capital will determine, in its sole discretion, is a reasonable per prescription or per day supply for retail dispensing, specialty pharmacy dispensing, or mail service dispensing.
11. Certain prescription drugs require prior authorization for coverage prior to the delivery of covered drugs.

EXCLUSIONS - Except as specifically provided in the group contract and in addition to any limitations set forth in the group contract, no benefits shall be provided for services, supplies, or prescription drugs:

1. Which are not medically necessary as determined by Capital, or its designee;
2. For prescription drugs that have an over-the-counter equivalent;
3. For devices or appliances including but not limited to therapeutic devices, artificial appliances, or similar devices or appliances except for diabetic supplies;
4. For the administration or injection of prescription drugs;
5. For prescription drugs received in and billed by a hospital, nursing home, home for the aged, convalescent home, home health care agency, or similar institution;
6. Which are considered by Capital or its designee to be experimental or investigational;
7. For any illness or injury which occurs in the course of employment if benefits or compensation are available or required, in whole or in part, under a workers' compensation policy and/or 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 makes a claim for the benefits or compensation under the applicable workers' compensation policy/coverage and/or the applicable law;
8. For any illness or injury suffered after the member's effective date of coverage which resulted from an act of war, whether declared or undeclared;
9. Which are 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;
10. 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.
11. For the cost of benefits resulting from accidental bodily injury arising out of a motor vehicle accident, to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used, including such benefits mandated by law) of any motor vehicle insurance policy;
12. For items or services paid for by Medicare when Medicare is primary consistent with the Medicare Secondary Payer Laws. This exclusion shall not apply when the contract holder is obligated by law to offer the member the benefits of this coverage as primary and the member so elects this coverage as primary;
13. For care of conditions that federal, state or local law requires to be treated in a public facility;
14. Which are court ordered services when not medically necessary and/or not a covered benefit;
15. Which are rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law;
16. Which exceed the allowable amount;
17. Which are cost-sharing amounts, differences between brand drug and generic drug prices (i.e. ancillary charges), and balances paid to non-participating pharmacies required of the member under this coverage;
18. For which a member would have no legal obligation to pay;
19. Which are incurred prior to the member's effective date of coverage;
20. Which are incurred after the date of termination of the member's coverage except as provided for in the Certificate of Coverage;
21. Which are received by a member in a country with which United States law prohibits transactions;
22. For prescription drugs utilized primarily to enhance physical or athletic performance or appearance;
23. For clinical cancer trial costs (e.g., drugs under investigation; patient travel expenses; data collection and analysis services), except for costs directly associated with medical care and complications, related to a Capital approved trial, which would normally be covered under standard patient therapy benefits;
24. For travel expenses incurred in conjunction with benefits unless specifically identified as a covered benefit elsewhere in the Certificate of Coverage;
25. For all prescription drugs and over-the-counter drugs dispensed during travel by a physician employed by a hotel, cruise line, spa, or similar facility;
26. For durable medical equipment;
27. For blenderized baby food, regular shelf food, or special infant formula;
28. For immunization agents, biological sera, blood, blood products;
29. For requests for reimbursement of covered drugs submitted after the allowed timeframe for reimbursement;
30. For all prescription drugs and over-the-counter drugs dispensed in a physician's office or by a facility provider;
31. For prescription drugs utilized to promote hair growth;
32. For prescription drugs utilized for cosmetic purposes;
33. For injectable medications that cannot be self-administered;
34. For coverage through coordination of benefits;
35. Which are received through the designated and/or non-participating mail service pharmacy for mail service dispensing and submitted for reimbursement under retail dispensing benefits;
36. Which are received through a retail pharmacy for retail dispensing and submitted for reimbursement under mail service dispensing benefits;
37. For prescription drugs utilized in connection with non-covered medical services;
38. For allergy serums, desensitization serums, venom;
39. For prescription drugs utilized to treat infertility;
40. For prescription drugs in connection with sexual dysfunction. This exclusion applies even if such drugs are medically necessary to treat an illness or medical condition unrelated to sexual dysfunction so long as there are other drugs which can be used to treat the non-sexual dysfunction condition besides the sexual dysfunction drug;
41. For prescription vitamins (other than prenatal);
42. For prescription drugs utilized for weight loss purposes;
43. For smoking cessation products;
44. For prescription drugs that require prior authorization if prior authorization is not obtained before dispensing the prescription drugs;
45. For quantities that exceed the limits/levels established by Capital;
46. Unless otherwise set forth in the group contract, drugs that do not legally require a prescription as determined by Capital;
47. For any other prescription drugs, service or treatment, except as provided in the Certificate of Coverage.