

HIGHLIGHTS	AMOUNTS YOU ARE RESPONSIBLE FOR:	
	Participating Providers	Non-Participating Providers*
<b>DEDUCTIBLE</b> Per benefit period**	\$250 per member \$500 per family	
<b>COPAYMENT</b>	\$10 copayment per visit when provided by a Family Practitioner, General Practitioner, Internist and Pediatrician \$20 copayment per visit for all other Professional Providers	20% coinsurance
<b>OUT-OF-POCKET MAXIMUM</b> When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the benefit period ends. Certain non-participating facility providers will continue to be paid at 50% of the allowable amount. Outpatient psychiatric services provided by non-participating providers are excluded from the out-of-pocket maximum.	\$3,000 per member \$6,000 per family	
<b>PREVENTIVE CARE</b>	<i>Deductible applies to all services unless a copayment is applied or otherwise noted.</i>	
• Adult routine physical exams and preventive care (age 19 and over)	Copayment applies	20% coinsurance, with a \$400 benefit period maximum
• Pediatric routine physical exams & preventive care (includes well-baby care)	Copayment applies	20% coinsurance
• Annual gynecological exam	Copayment applies	20% coinsurance, deductible waived
• Childhood immunizations	Covered in full, deductible waived	20% coinsurance, deductible waived
• Annual mammogram (age 40 and over)		
• Annual Pap test		
<b>PHYSICIAN SERVICES</b>		
• Office visits	Copayment applies	20% coinsurance
• Maternity and newborn care	Covered in full	20% coinsurance
• Lab tests, x-rays, inpatient visits, surgery and anesthesia		
<b>OTHER PROVIDER SERVICES</b>		
• Outpatient physical medicine, occupational, respiratory and manipulation therapy (20 visits each type per benefit period)	Copayment applies	20% coinsurance
• Speech therapy (12 visits per benefit period)		
• Home health care (90 visits per benefit period)	Covered in full	20% coinsurance
• Hospice (\$50,000 benefit lifetime maximum)		
<b>OUTPATIENT HOSPITAL SERVICES</b>		
Professional fees & facility services, including: lab, x-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis, anesthesia and surgery	Covered in full	20% professional provider coinsurance; 50% coinsurance at certain facility providers
<b>INPATIENT HOSPITAL SERVICES</b>		
Professional fees & facility services, including: room and board, and other covered services	Covered in full	20% professional provider coinsurance; 50% coinsurance at certain facility providers
<b>EMERGENCY CARE</b>		
• Emergency treatment for accident or medical emergency	Covered in full, \$50 emergency room copayment (waived if admitted); deductible waived	
• Ambulance services for emergency care	Covered in full, deductible waived	Covered in full, deductible waived
<b>DURABLE MEDICAL EQUIPMENT &amp; SUPPLIES</b> (\$15,000 benefit period max)	Covered in full	20% coinsurance
<b>PROSTHETICS</b> (\$15,000 benefit period maximum)	Covered in full	20% coinsurance
<b>MENTAL HEALTH CARE</b>		
• 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)	Copayment applies	50% coinsurance
<b>SUBSTANCE ABUSE CARE</b>		
• Inpatient care (30 days per benefit period; 90 days per lifetime)	Covered in full	Not covered
• Outpatient care (60 visits per benefit period; 120 visits per lifetime) (30 outpatient visits per period may be exchanged on a 2 for 1 basis to secure up to 15 additional non-hospital residential treatment days.)		
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited	Unlimited

**Programs are subject to change. This is not a contract. This information highlights PPO benefits when you visit a participating 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.**

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.

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 non-participating facility providers are not covered.

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

For more information or to locate a participating provider, visit [www.capbluecross.com](http://www.capbluecross.com).

**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 provide**

**The PPO benefits set forth on this highlight sheet are subject to the specific benefit exclusions and limitations contained in your Certificate of Coverage. Examples of categories of benefit exclusions to coverage provided by Capital include, but are not limited to, services, supplies, charges or equipment:**

- Which are not medically necessary; which are experimental or investigational; for private duty nursing services; for services and operations for cosmetic purposes; for certain donor and transplant services; for personal hygiene and convenience items; for certain rehabilitative therapies; for speech therapy for certain conditions; for maintenance therapy; for acupuncture; for autopsies; for services related to a non-covered service; for custodial care, domiciliary care or rest cures; for clinical cancer trials; for supportive environmental materials and equipment; for biofeedback; for anesthesia administered by certain providers; for certain prophylactic blood or bone marrow storage; or for certain travel expenses incurred in conjunction with benefits.
- For care of conditions that applicable law requires to be treated in a public facility; for court ordered services when not medically necessary and/or not a covered benefit; for services rendered by a provider who is a relative of the member and for which, in the absence of coverage, no charge would have been made; for telephonic and electronic consultations between a provider and a member; for charges for failure to keep a scheduled appointment with a provider; for services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program; which exceed the allowable amount; which are cost-sharing amounts required of the member; for the amount of any preauthorization penalty; or for inpatient admissions which are primarily for diagnostic studies or for inpatient services which could have been safely performed on an outpatient basis.
- For any illness or injury which occurs in the course of employment if benefits or compensation are available under any employment related law; which are received from a dental or medical department maintained by or on behalf of an employer or similar group; for services received by veterans and active military personnel at facilities operated by the Veteran's Administration or by the Department of Defense, unless required by law; for any illness or injury, resulting from an act of war (declared or undeclared) and suffered after the member's effective date; for payment made under Medicare when Medicare is primary; for treatment or service paid or payable under a policy of motor vehicle insurance; for examination or immunization for employment, licensing or travel; or for certain services rendered while in custody of a governmental body.
- Which were not incurred during the member's effective date of coverage; which are not billed by and either performed by or under the supervision of an eligible provider; for which a member would have no legal obligation to pay; or for services received by a member in a country with which United States law prohibits transactions.
- For certain oral surgery, including surgical extractions of full or partial bony impactions; for services directly related to the care or treatment of injuries or diseases of the teeth, gums or structures directly supporting or attached to the teeth; for treatment of temporomandibular joint syndrome; or for all dental services rendered after stabilization of a member in an emergency following an accidental injury.
- For routine foot care; or for support devices of the feet.
- For eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses; for corneal surgery and other procedures to correct refractive errors; or for hearing aids or examinations for the prescription or fitting of hearing aids and all related services.
- For prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider.
- For all types of nutritional counseling, except where mandated and for children through age 18 who are diagnosed with obesity and adults with a Body Mass Index (BMI) of 30 or more; for inpatient stays to bring about non-surgical weight reduction; for treatment of obesity, except for surgical treatment of morbid obesity; for enteral formulas except when the sole source of nutrition or mandated by law; or for blenderized baby food or special infant formula; for sports medicine treatment intended to primarily enhance athletic performance; for physical medicine and occupational therapy for work hardening; for certain mental health care/substance abuse services; for certain neuropsychological testing; or for certain durable medical equipment, including replacement or repair costs in certain situations.
- For procedures to reverse sterilization; for any treatment leading or relating to or in connection with assisted fertilization, including donor services; for certain infertility services; for the contraceptive therapeutic class of prescription drugs, products or devices; for treatment relating to transsexual surgery; for certain non-neonatal circumcisions; or for treatment in connection with sexual dysfunction not related to organic disease or injury.
- For any other service or treatment, except as provided in the group contract.

**The foregoing list highlights categories of PPO benefit exclusions and is not intended to be a complete list or complete description of all categories of benefit exclusions. Please contact your employer, marketing representative or broker for additional details concerning benefit exclusions, or you may refer to the Schedule of Exclusions set forth in your Certificate of Coverage.**