PersonalBlue PPO℠

IA PPO 1500/85

Medically Underwritten

HIGHLIGHTS	AMOUNTS YOU ARE RESPONSIBLE FOR:	
DEDUCTIBLE	**Participating Providers**	**Non-Participating Providers**
Per benefit period	$1,500 per member $3,000 per family	$1,500 per member $3,000 per family
OUT-OF-POCKET MAXIMUM		
When the out-of-pocket maximum is reached, the Plan pays 100% until the end of the benefit period (excludes deductibles and copayments)	$2,250 per member $4,500 per family	
PREVENTIVE CARE	***Deductible applies to all services unless otherwise noted***	
• Adult routine physical exams and preventive care (age 18 and over) • Pediatric routine physical exams & preventive care (includes well-baby care) • Annual gynecological exam • Childhood immunizations • Annual mammogram (age 40 and over) • Annual Pap Smear test	Covered in full (exempt from deductible)	Not covered
PHYSICIAN SERVICES		
• Office visits (exempt from deductible)	$30 copayment per visit	50% coinsurance
• Office visits to specialist (exempt from deductible)	$40 copayment per visit	50% coinsurance
• Lab tests, x-rays, inpatient visits, surgery and anesthesia	15% coinsurance	50% coinsurance
MATERNITY SERVICES		
• Routine delivery	Not covered	Not covered
• Complications of Pregnancy	15% coinsurance	50% coinsurance
OTHER PROVIDER SERVICES		
• Outpatient physical medicine (15 visits per benefit period) • Manipulation therapy (10 visits per benefit period) • Occupational & speech therapy (15 visits combined per benefit period) • Radiation therapy • Respiratory therapy (15 visits per benefit period) • Home health care (15 visits per benefit period) • Hospice ($50,000 lifetime maximum)	15% coinsurance	50% coinsurance
OUTPATIENT HOSPITAL SERVICES		
Professional fees & facility services, including: lab, x-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis, anesthesia and surgery	15% coinsurance	50% coinsurance
INPATIENT HOSPITAL SERVICES		
Professional fees & facility services, including: room and board, and other covered services	15% coinsurance	50% coinsurance
EMERGENCY CARE		
Emergency treatment for accident or medical emergency	Covered in full; $100 emergency room copayment (waived if admitted); deductible waived	
DURABLE MEDICAL EQUIPMENT AND SUPPLIES		
Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics $3,500 per benefit period (in and out of network combined)	15% coinsurance	50% coinsurance
MENTAL HEALTH CARE		
• Inpatient care • Outpatient mental health care services (individual & group psychotherapy psychological testing and family counseling)	Not covered	Not covered
SUBSTANCE ABUSE CARE		
• Inpatient care • Outpatient care	Not covered	Not covered
BENEFIT MAXIMUMS		
• Benefit Period Maximum	Unlimited	
• Lifetime Maximum Benefit	Unlimited	

IMPORTANT NOTICE: Programs are subject to change. This is not a contract. This is a general description of benefits, limitations and exclusions available to individuals with our PPO coverage. However, the actual terms and conditions of coverage available to you are set forth in the contract issued to you.

Members are responsible for applicable deductible, copayments, and coinsurance amounts. Participating providers agree to accept our allowance as payment—often less than their normal charge. If you visit a non-participating provider, you are responsible for 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 contract for a more detailed description of services that require preauthorization.

If you purchased the Prescription Drug Supplemental Rider, the outpatient prescription drug exclusion does not apply and a description of the prescription drug coverage is briefly described on a separate summary of coverage.

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

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross an independent licensee of the BlueCross BlueShield Association.

PPO — Standard Benefit Exclusions

EXCLUSIONS - Except as specifically provided in this Contract, no medical care Benefits will be provided for services, drugs, supplies or charges:

1. Which are not billed by and either performed by or under the supervision of a Provider as defined in the Contract;
2. 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, wigs, chairlifts, elevators, spa, health club memberships, or any other modification to real or personal property whether or not recommended by a Provider;
3. For supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices;
4. For telephone and electronic 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;
5. For Custodial Care, domiciliary care or rest cures;
6. For palliative or cosmetic foot care unrelated to diabetes, 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;
7. For screening examinations, except as specifically provided for in the Medical Care Schedule of Benefits of the Contract;
8. For preventive care services or wellness services or programs, except as specifically provided in Medical Care Schedule of Benefits of the Contract;
9. For pregnancy and maternity services, except as specifically provided in the Medical Care Schedule of Benefits of the Contract;
10. 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 may be required by law. 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 Medical Care Schedule of Benefits of the Contract;
11. For oral surgery, including surgical extractions of full or partial bony impactions, except as specifically provided in the Medical Care Schedule of Benefits of the Contract;
12. 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;
13. For hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids and all related services;
14. For treatment of obesity, except for surgical treatment of morbid obesity;
15. For treatment leading to or in connection with transsexual surgery except for sickness or injury resulting from such surgery;
16. 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;
17. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
18. For equipment repair, servicing or maintenance 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 Capital;
19. 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;
20. For payment made under Medicare when Medicare is primary;
21. For the amount of any penalty applied under the Preauthorization provision of this Contract when a Non-Participating Provider was utilized or the Member failed to present his or her Identification Card to the Provider;
22. For Inpatient admissions at Non-Participating Facility Providers which are primarily for diagnostic studies and which could have been performed on an Outpatient basis;
23. For Inpatient stays to bring about weight reduction;
24. For treatment in connection with sexual dysfunction not related to organic disease or injury;
25. For procedures to reverse sterilization;
26. For routine neonatal circumcision;
27. For local infiltration anesthetic;
28. For private duty nursing;
29. For music therapy and/or recreational therapy;
30. For the purchase, fitting, necessary adjustment, repairs and replacement of Orthotic Devices, except as provided in the Contract and as may be required by law;
31. For abortions, except when the abortion is necessary to avert the death of the mother and in cases of rape and/or incest; or
32. For any other service or treatment except as provided in the Medical Care Schedule of Benefits.

EXCLUSIONS - Except as specifically provided in this Contract, no medical care Benefits or Prescription Drug Benefits will be provided for services, drugs, supplies or charges:

1. Which are not Medically Necessary and Appropriate as determined by Capital;
2. Which are Experimental or Investigational in nature as defined in the Contract;
3. 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;
4. For any losses sustained or expenses incurred after the Member's Effective Date of coverage as a result of an act of war, whether declared or undeclared;
5. 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;
6. For which a Member would have no legal obligation to pay;
7. 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;
8. For drugs, services and operations for cosmetic purposes used or performed 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 drugs, services and operations for cosmetic purposes necessitated by a covered sickness or injury or a procedure to improve or correct a functional impairment, restore a bodily function or correct deformity resulting from birth defect, disease or accidental injury;
9. For services or drugs received or prescribed by a Provider or Prescriber who is a member of the Member's Immediate Family;
10. Which were incurred prior to the Member's Effective Date of coverage;
11. Incurred after the date of termination of the Member's coverage except as provided for in Section 5.5 of the Contract;
12. For any treatment or drugs leading to or in connection with fertility and/or 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);
13. For the contraceptive therapeutic class of Prescription Drugs and products. This exclusion applies even if such drugs are Medically Necessary and Appropriate to treat an illness or medical condition unrelated to contraception so long as there are other drugs which can be used to treat the non-contraceptive condition besides the contraceptive drug;
14. 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 in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
15. Which exceed the Plan Allowance, except for Emergency Services;
16. For all over-the-counter drugs for the Outpatient use of a Member, except for chemotherapy agents and pharmacological agents used for controlling blood sugar, including insulin;
17. For all over-the-counter drugs dispensed by a Home Health Care Agency Provider;
18. Which are Deductibles, Copayments and/or Coinsurance required of the Member under this Contract;
19. For nutritional counseling, services, and Prescription Drugs intended to produce weight loss;
20. Furnished to a Member for a Pre-Existing Condition during the first twelve (12) months after the date on which the Member is first covered under this Contract;
21. For dietary or food supplements, except for nutritional supplements as specified in the Schedules of Benefits of the Contract;
22. For all Prescription Drugs dispensed by a Home Health Care Agency, with the exception of intravenous drugs administered under a treatment plan approved by Capital;
23. For services for Mental Illness or Substance Abuse;
24. For all types of skin tag removal, regardless of symptoms or signs that might be present, except when the condition of diabetes is present; or
25. For any other service or treatment except as provided in the Medical Care Schedule of Benefits or the Prescription Drugs Schedule of Benefits.
26. For all prescription drugs dispensed by a pharmacy or Provider for the Outpatient use of a Member, whether or not billed by a Facility Provider, except allergy serums and mandated pharmacological agents used for controlling blood sugar.

PersonalBlue PPO℠

My Rx
Individual Account
Prescription Drug Program

	AMOUNTS YOU ARE RESPONSIBLE FOR:		
DEDUCTIBLE	**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)
Per benefit period*	$100 per member $300 per family		
BENEFIT MAXIMUM			
Generic Prescriptions	Unlimited	Unlimited	Unlimited
Brand Prescriptions	12 prescription limit including refills, (combined with Mail Service and Specialty Pharmacy)	12 prescription limit including refills, (combined with Retail and Specialty Pharmacy)	12 prescription limit including refills, (combined with Retail and Mail Service)

(If a Member reaches his/her Benefit Maximum per Benefit Period, Benefits for diabetic supplies mandated by law will still be available).

PRESCRIPTION DRUG TIER			
Generic Prescription Drugs	$15 copayment	$40 copayment	$50 copayment
Preferred Brand Prescription Drugs	$40 copayment	$100 copayment	$100 copayment
Non-Preferred Brand Prescription Drugs	$60 copayment	$150 copayment	$200 copayment
Lifestyle Drugs	100% of the discounted price	100% of the discounted price	100% of the discounted price
FORMULARY SYSTEM	Open		
PRESCRIPTION CATEGORY	**BENEFIT**		
Contraceptives (oral and injectable) Benefits are limited to coverage for those prescribed contraceptive products or devices as mandated by law, including but not limited to, contraceptive implants such as intrauterine devices (IUD). *For contraceptive therapeutic categories that have no generic option, an available brand drug as determined by Capital may be purchased at no cost share to the Member.	Covered in full*	Covered in full*	Not covered
Diabetic Meters and Test Strips	Covered	Covered	Not covered
Prenatal Vitamins (prescription)	Not covered	Not 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
Specialty Injectables (self-administered)	Not covered	Not covered	Covered
Non-Specialty Injectables (self-administered)	Covered	Covered	Covered
Mental Health prescriptions	Covered	Covered	Covered
UTILIZATION PROGRAM	**BENEFIT**		
Generic Substitution Program	Mandatory 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) regardless of whether the prescribing physician requests that the brand drug be dispensed.*		
Quantity Level Limits (per prescription, day supply or copayment)	Applicable to selected drugs	Applicable to selected drugs	Applicable to selected drugs
Prior Authorization	Applicable to selected drugs	Applicable to selected drugs	Applicable to selected drugs

Programs are subject to change. This information highlights benefits, limitations and exclusions of the Capital BlueCross 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.

*Refer to your contract 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.

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Prescription Drug Program — Standard Benefit Limitations and Exclusions

The contract will contain standard benefit limitations and exclusions.

LIMITATIONS - Limitations to benefits set forth in the 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, as indicated in the contract.
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), even if 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 sixty percent (60%) of the previous supply dispensed through the designated mail service pharmacy or seventy-five percent (75%) of the previous supply dispensed 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, unless approved by Capital BlueCross.
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 contract and in addition to any limitations set forth in the contract, no benefits shall be provided for services, supplies, or prescription drugs:

1. For prescription drugs that have an over-the-counter equivalent;
2. For devices or appliances including but not limited to therapeutic devices, artificial appliances, or similar devices or appliances except for diabetic supplies, as specified in the contract;
3. For the administration or injection of prescription drugs;
4. 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;
5. For items or services paid for by Medicare when Medicare is primary consistent with the Medicare Secondary Payer Laws;
6. For care of conditions that federal, state or local law requires to be treated in a public facility;
7. Which are court ordered services when not medically necessary and/or not a covered benefit;
8. 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;
9. Which exceed the allowable amount;
10. 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;
11. Which are received by a member in a country with which United States law prohibits transactions;
12. For prescription drugs utilized primarily to enhance physical or athletic performance or appearance;
13. 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;
14. For travel expenses incurred in conjunction with benefits unless specifically identified as a covered benefit elsewhere in the contract;
15. 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;
16. For durable medical equipment;
17. For blenderized baby food, regular shelf food, or special infant formula;
18. For immunization agents, biological sera, blood, blood products;
19. For requests for reimbursement of covered drugs submitted after the allowed timeframe for reimbursement;
20. For all prescription drugs and over-the-counter drugs dispensed in a physician's office or by a facility provider;
21. For prescription drugs utilized to promote hair growth;
22. For prescription drugs utilized for cosmetic purposes;
23. For injectable medications that cannot be self-administered;
24. For coverage through coordination of benefits;
25. 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;
26. Which are received through a retail pharmacy for retail dispensing and submitted for reimbursement under mail service dispensing benefits;
27. For prescription drugs utilized in connection with non-covered medical services;
28. For allergy serums, desensitization serums, venom;
29. For prescription drugs utilized to treat infertility;
30. 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;
31. For prescription vitamins (other than prenatal);
32. For prescription drugs utilized for weight loss purposes;
33. For smoking cessation products;
34. For prescription drugs that require prior authorization if prior authorization is not obtained before dispensing the prescription drugs;
35. For quantities that exceed the limits/levels established by Capital;
36. Unless otherwise set forth in the contract, drugs that do not legally require a prescription as determined by Capital;
37. For any other prescription drugs, service or treatment, except as provided in the contract.