Capital BlueCross

PPO

Agents Health Plan

HIGHLIGHTS	AMOUNTS YOU ARE RESPONSIBLE FOR:	
DEDUCTIBLE	**Network Providers**	**Out-of-Network Providers***
Per benefit period**	$500 per member $1,500 per family	$1,000 per member $3,000 per family
OUT-OF-POCKET MAXIMUM		
When the out-of-pocket maximum is reached, benefits are paid at 100% of the Plan Allowance until the benefit period ends. Certain out-of-network facility providers will continue to be paid at 50% of the Plan Allowance. Out-of-network outpatient psychiatric services are excluded from the out-of-pocket maximum.	None	$2,000 per member $6,000 per family
	Deductible applies to all services unless a copayment is applied or otherwise noted.	
PREVENTIVE CARE		
Adult routine physical exams and preventive care (age 18 and over)	$15 copayment per visit	20% coinsurance, with a $400 benefit period maximum
Pediatric routine physical exams & preventive care (includes well-baby care)	$15 copayment per visit	20% coinsurance
Annual gynecological exam	$15 copayment per visit	20% coinsurance, deductible waived
• Childhood immunizations • Annual mammogram (age 40 and over) • Annual Pap Smear test	Covered in full, deductible waived	20% coinsurance, deductible waived
PHYSICIAN SERVICES		
• Office visits	$15 copayment per visit	20% coinsurance
• Maternity and newborn care • 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) • Manipulation therapy (20 visits per benefit period) • Occupational & speech therapy (30 visits each type per benefit period)	$15 copayment per visit	20% coinsurance
• Home health care (90 visits per benefit period)	Covered in full	20% coinsurance
• Hospice ($50,000 benefit 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	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
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)	$15 copayment per visit	50% coinsurance
SUBSTANCE ABUSE CARE		
• Inpatient care (30 days per benefit period; 90 days per lifetime) • 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.

**The benefit period for this coverage is a calendar year.

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.

Independent licensees of the Blue Cross and Blue Shield Association

***PPO* — Standard Benefit Exclusions**

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 music therapy and/or recreational therapy;
43. For private duty nursing services;
44. For any other service or treatment except as provided in the Group Contract.

© 2005 Capital BlueCross
All rights reserved