CAPCO

Plan Name	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
Plan Type	Hybrid	Hybrid	HDHP
Plan features	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
Primary Care Physician (PCP)	Not required	Not required	Not required
Referrals	Not required	Not required	Not required
Out of network benefits	Covered at 60%, subject to the	Covered at 50%, subject to the	Covered at 100%, subject to the
Out of fictwork beliefits	deductible	deductible	deductible
Out of area benefits	Coverage provided worldwide through	Coverage provided worldwide through	Coverage provided worldwide through
Out of area benefits	the BlueCard® program	the BlueCard® program	the BlueCard® program
	Qualified dependents and students are	Qualified dependents and students are	Qualified dependents and students are
Student/Dependent coverage	covered to age 26	covered to age 26	covered to age 26
Domestic partner	Covered	Covered	Covered
bomestic partner	Blue365 - Exclusive access to	Blue365 - Exclusive access to	Blue365 - Exclusive access to
Wellness Incentives			
	information, discounts & savings	information, discounts & savings	information, discounts & savings
Plan cost-sharing highlights	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
Office visit copay (Primary Care	Adult: \$25 copay per visit; Members to	Adult: \$40 copay per visit; Members to	No copay, office visit covered at 100% in
Physician)	age 19: \$0 copay per visit	age 19: \$0 copay per visit	network and 100% out-of network,
Titysiciani	age 13. 30 copay per visit	age 13. 30 copay per visit	subject to the deductible
			No copay, office visit covered at 100% in
Office visit copay (Specialist)	\$40 copay per visit	\$60 copay per visit	network and 100% out-of-network,
, , , ,	. , , ,	, .	subject to the deductible
	Combined in and Out-of-Network: \$500	In-Network only: \$1,000 Individual /	In-Network only: \$6,350 Individual /
Deductible		* 1 1	• • •
	Individual / \$1500 Family	\$3,000 Family	\$12,700 Family
Coinsurance	In-Network: Covered at 80%; Out-of-	In-Network: Covered at 70%; Out-of-	In-Network: Covered at 100%; Out-of-
Comparance	Network: Covered at 60%	Network: Covered at 50%	Network: Covered at 100%
Out of pocket maximum	Combined in and Out-of-Network: \$1500	In-Network only: \$3,000 Individual /	In-Network: \$6,350 Individual / \$12,700
Out of pocket maximum	Individual / \$4500 Family	\$9.000 Family	Family
Lifetime maximum	None	None	None
*Preventive Healthcare Services	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
Well child visits	Covered in full	Covered in full	Covered in full
Adult routine physical exams	Covered in full for 1 exam per year	Covered in full for 1 exam per year	Covered in full for 1 exam per year
Adult immunizations	Covered in full	Covered in full	Covered in full
Mammography	Covered in full	Covered in full	Covered in full
Pap smear	Covered in full	Covered in full	Covered in full
Routine GYN Exam	Covered in full	Covered in full	Covered in full
Prostate cancer screening	Covered in full	Covered in full	Covered in full
Colonoscopy	Preventive screening covered in full	Preventive screening covered in full	Preventive screening covered in full
Physician Office Services	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
	Adult: \$25 copay per visit to your PCP;	Adult: \$40 copay per visit to your PCP;	
	\$40 copay per visit to a specialist Child:	\$60 copay per visit to a specialist Child:	Covered at 100%, subject to the
Diagnostic office visits	\$0 copay per visit to your PCP; \$40	\$0 copay per visit to your PCP; \$60	deductible
	copay per visit to your rer, 340	copay per visit to your rer, 300	deddelble
	copay per visit to a specialist	copay per visit to a specialist	Covered at 100%, subject to the
Diagnostic x-rays	\$40 copay per visit	\$60 copay per visit	
			deductible
Diagnostic laboratory and pathology	Covered in full	Covered in full	Covered at 100%, subject to the
			deductible
	Adult: \$25 copay per visit to your PCP;	Adult: \$40 copay per visit to your PCP;	_
Allorgy tosts	\$40 copay per visit to a specialist Child:	\$60 copay per visit to a specialist Child:	Covered at 100%, subject to the
Allergy tests	\$0 copay per visit to your PCP; \$40	\$0 copay per visit to your PCP; \$60	deductible
	copay per visit to a specialist	copay per visit to a specialist	
	Adult: \$25 copay per visit to your PCP;	Adult: \$40 copay per visit to your PCP;	
	\$40 copay per visit to a specialist Child:	\$60 copay per visit to a specialist Child:	Covered at 100%, subject to the
Allergy injections	\$0 copay per visit to a specialist Ciliu.		deductible
		\$0 copay per visit to your PCP; \$60	deductible
	copay per visit to a specialist	copay per visit to a specialist	
Chemotherapy	\$25 copay per visit	\$40 copay per visit	Covered at 100%, subject to the
Chemotherapy	323 copay per visit	940 copay per visit	deductible
Radiation therapy	\$40 copay per visit	¢60 conoi-it	Covered at 100%, subject to the
Radiation therapy	\$40 copay per visit	\$60 copay per visit	deductible
	\$40 copay for one routine exam every	\$60 copay for one routine exam every	Covered at 100%, subject to the
Routine vision	year. \$60 eyewear allowance available	year. \$60 eyewear allowance available	deductible for one routine exam per
Moutine vision	, ,	• • •	·
	per year	per year	year
Maternity Services	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
Prenatal care	Covered in full	Covered in full	Covered in full
Hospital care for mom (including	Covered at 80%, subject to the	Covered at 70%, subject to the	Covered at 100%, subject to the
delivery)	deductible	deductible	deductible
,		Covered at 70%, subject to the	Covered at 100%, subject to the
Name and a second	Covered at 80%, subject to the	Covered at 7070, Subject to the	
Newborn nursery care	-		deductible
•	deductible	deductible	deductible Signature Deductible 3
Newborn nursery care Prescription Drug	deductible Simply Blue 25-500	deductible Signature Hybrid 1	Signature Deductible 3
Prescription Drug	deductible	deductible	Signature Deductible 3 Covered in Full Integrated Rx with
•	deductible Simply Blue 25-500	deductible Signature Hybrid 1	Signature Deductible 3

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Inpatient Hospital Benefits	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
Hospital benefits	Covered at 80%, subject to the	Covered at 70%, subject to the	Covered at 100%, subject to the
Hospital Delicits	deductible	deductible	deductible
Physician visits in the hospital	Covered at 80%, subject to the	Covered at 70%, subject to the	Covered at 100%, subject to the
	deductible	deductible	deductible
Inpatient physical rehabilitation	Covered at 80%, subject to the	Covered at 70%, subject to the	Covered at 100%, subject to the
	deductible for up to 60 days per year	deductible for up to 60 days per year	deductible for up to 60 days per year
Surgery	Covered at 80%, subject to the	Covered at 70%, subject to the deductible	Covered at 100%, subject to the
	deductible Covered at 80%, subject to the	Covered at 70%, subject to the	deductible Covered at 100%, subject to the
Anesthesia	deductible	deductible	deductible
Emergency Care	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
***************************************	\$250 copay per visit, unless admitted	\$300 copay per visit, unless admitted	Covered at 100%, subject to the
Emergency room care	within 24 hours	within 24 hours	deductible
Freestanding urgent care center	\$40 copay per visit	\$75 copay per visit	Covered at 100%, subject to the deductible
Ambulance	\$250 copay	\$300 copay	Covered at 100%, subject to the deductible
Outpatient Hospital Benefits	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
		•	Covered at 100%, subject to the
Diagnostic x-rays	\$40 copay per visit	\$60 copay per visit	deductible
Diagnostic laboratory and pathology	Covered in full	Covered in full	Covered at 100%, subject to the deductible
Surgical care	Covered at 80%, subject to the	Covered at 70%, subject to the	Covered at 100%, subject to the
Surgical care	deductible	deductible	deductible
Chemotherapy	\$25 copay per visit	\$40 copay per visit	Covered at 100%, subject to the
Спетноптегару	223 copay per visit	940 copay per visit	deductible
Radiation Therapy	\$40 copay per visit	\$60 copay per visit	Covered at 100%, subject to the deductible
Mental Health and Chemical Dependence	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
Inpatient mental health care	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 100%, subject to the deductible
	\$40 copay. Services can be provided in	\$60 copay. Services can be provided in	Covered at 100%, subject to the
Outpatient mental health care	an outpatient facility or in a provider	an outpatient facility or in a provider	deductible Services can be provided in
	office	office	an outpatient facility or in a provider's
			office
Inpatient chemical dependence	Covered at 80%, subject to the	Covered at 70%, subject to the	Covered at 100%, subject to the
	deductible	deductible	deductible
Outpatient chemical dependence	\$40 copay per visit	\$60 copay per visit	Covered at 100%, subject to the
Other Services		C:	deductible
Other Services	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3 Covered at 100%, subject to the
Diabetic insulin and supplies	\$25 copay for up to a 30 day supply	\$40 copay for up to a 30 day supply	deductible for up to a 30 day supply
	Covered at 80%, subject to the	Covered at 70%, subject to the	Covered at 100%, subject to the
Skilled nursing facility	deductible for up to 45 days per year	deductible for up to 45 days per year	deductible for up to 45 days per year
	Covered in full for up to 40 visits per	Covered in full for up to 40 visits per	Covered at 100%, subject to the
Home care	year	vear	deductible for up to 40 visits per year
		A	Covered at 100%, subject to the
Hospice	Covered in full for unlimited days	Covered in full for unlimited days	deductible for unlimited visits per year
	\$40 copay for up to a combined total of	\$60 copay for up to a combined total of	Covered at 100%, subject to the
Outpatient therapy	45 visits per year for physical, speech	45 visits per year for physical, speech	deductible for a combined total of 45
Outpatient therapy			visits per year for physical, speech and
	and occupational therapy	and occupational therapy	occupational therapy
Durable medical equipment	Covered at 80% subject to the	Covered at 70% subject to the	Covered at 100%, subject to the
Darable medical equipment	deductible	deductible	deductible
External prosthetics	Covered at 80%, subject to the	Covered at 70%, subject to the	Covered at 100%, subject to the
	deductible	deductible	deductible
Chiropractic	\$40 copay per visit	\$40 copay per visit	Covered at 100%, subject to the
-			deductible
Acupuncture	\$40 copay for up to 10 visits per year	\$60 copay for up to 10 visits per year	Covered at 100%, subject to the
			deductible, for up to 10 visits per year Covered at 100%, subject to the
Dental	\$40 copay per visit for accidental injury	\$60 copay per visit for accidental injury	deductible for accidental injury to
	to sound, natural teeth and for care due		
	to congenital disease or anomaly	to congenital disease or anomaly	sound, natural teeth and for care due to
	-	\$60 construction having areas	congenital disease or anomaly
Hoaring	\$40 copay for one routine hearing exam	\$60 copay for one routine hearing exam per year. Adult Hearing Aids Not	
Hearing	per year.		one routine hearing exam per year. Hearing aid(s) covered once every three years.
	• •	Covered	analy covered once every times years.