*HMO options begin on page 3

CAPCO - traditional medical options

Plan Name	Simply Blue 25-500	Signature Hybrid 1	Signature Deductible 3
Plan Type : 9/1/2025	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 a seperate deductible	Covered at 50%, subject to a seperate deductible	Covered at 50%, subject to a seperate deductible
Out of area benefits	Coverage provided worldwide through the BlueCard® program	Coverage provided worldwide through the BlueCard® program	Coverage provided worldwide through the BlueCard® program
Student/Dependent coverage	Qualified dependents and students are covered to age 26	Qualified dependents and students are covered to age 26	Qualified dependents and students are covered to age 26
Domestic partner	Covered	Covered	Covered
Wellness Incentives	Blue365 - Exclusive access to information, discounts & savings	Blue365 - Exclusive access to information, discounts & savings	Blue365 - Exclusive access to information, discounts & savings
Plan cost-sharing highlights	**Simply Blue 25-500**	**Signature Hybrid 1**	**Signature Deductible 3**
Office visit copay (Primary Care Physician)	Adult: $25 copay per visit; Members to age 19: $0 copay per visit	Adult: $40 copay per visit; Members to age 19: $0 copay per visit	No copay, office visit covered at 70% in-network and 50% out-of network, subject to the deductible
Office visit copay (Specialist)	$40 copay per visit	$60 copay per visit	No copay, office visit covered at 100% in-network and 100% out-of-network, subject to the deductible
Deductible	Combined in and Out-of-Network: $500 Individual / $1500 Family	In-Network only: $1,000 Individual / $3,000 Family	In-Network only: $5,500 Individual / $11,000 Family
Coinsurance	In-Network: Covered at 80%; Out-of-Network: Covered at 60%	In-Network: Covered at 70%; Out-of-Network: Covered at 50%	In-Network: Covered at 70%; Out-of-Network: Covered at 50%
Out of Pocket Maximum (OOPM)	In-Network: $1500 Individual / $4500 Family	In-Network only: $3,000 Individual / $9,000 Family	In-Network: $6,350 Individual / $12,700 Family
OOPM Per Person Cap	$1500 In-Network	$3000 In-Network	$6650 In-Network
***Preventive Healthcare Services**	**Simply Blue 25-500**	**Signature Hybrid 1**	**Signature Deductible 3**
Well child visits and immunizations	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**
Diagnostic office visits	Adult: $25 copay per visit to your PCP; $40 copay per visit to a specialist Child under age 19: $0 copay per visit to your PCP; $40 copay per visit to a specialist	Adult: $40 copay per visit to your PCP; $60 copay per visit to a specialist Child under age 19: $0 copay per visit to your PCP; $60 copay per visit to a specialist	Covered at 70%, subject to the deductible
Diagnostic x-rays	$40 copay per visit	$60 copay per visit	Covered at 70%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered in full	Covered at 70%, subject to the deductible
Allergy tests	Adult: $25 copay per visit to your PCP; $40 copay per visit to a specialist Child: $0 copay per visit to your PCP; $40 copay per visit to a specialist	Adult: $40 copay per visit to your PCP; $60 copay per visit to a specialist Child: $0 copay per visit to your PCP; $60 copay per visit to a specialist	Covered at 70%, subject to the deductible
Allergy injections	Adult: $25 copay per visit to your PCP; $40 copay per visit to a specialist Child: $0 copay per visit to your PCP; $40 copay per visit to a specialist	Adult: $40 copay per visit to your PCP; $60 copay per visit to a specialist Child: $0 copay per visit to your PCP; $60 copay per visit to a specialist	Covered at 70%, subject to the deductible
Chemotherapy	$25 copay per visit	$40 copay per visit	Covered at 70%, subject to the deductible
Radiation therapy	$40 copay per visit	$60 copay per visit	Covered at 70%, subject to the deductible
Routine vision	$40 copay for one routine exam every year. $60 eyewear allowance available per year	$60 copay for one routine exam every year. $60 eyewear allowance available per year	Covered at 70%, subject to the deductible for one routine exam per 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 delivery)	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 70%, subject to the deductible
Newborn nursery care	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 70%, subject to the deductible
Prescription Drug	**Simply Blue 25-500**	**Signature Hybrid 1**	**Signature Deductible 3**
Short-term and maintenance drugs	$5/$35/$70; $0 copay for generics for members to age 19	$7 copay for generics only, $0 copay for generics for members to age 19	$10/$35/$70 Integrated RX. Preventive RX not subject to the Deductible

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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 deductible	Covered at 70%, subject to the deductible	Covered at 70%, subject to the deductible
Physician visits in the hospital	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 70%, subject to the deductible
Inpatient physical rehabilitation	Covered at 80%, subject to the deductible for up to 60 days per year	Covered at 70%, subject to the deductible for up to 60 days per year	Covered at 70%, subject to the deductible for up to 60 days per year
Surgery	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 70%, subject to the deductible
Anesthesia	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 70%, subject to the deductible
Emergency Care	**Simply Blue 25-500**	**Signature Hybrid 1**	**Signature Deductible 3**
Emergency room care	$250 copay per visit, unless admitted within 24 hours	$300 copay per visit, unless admitted within 24 hours	Covered at 70%, subject to the deductible
Freestanding urgent care center	$40 copay per visit	$75 copay per visit	Covered at 70%, subject to the deductible
Ambulance	$250 copay	$300 copay	Covered at 70%, subject to the deductible
Outpatient Hospital Benefits	**Simply Blue 25-500**	**Signature Hybrid 1**	**Signature Deductible 3**
Diagnostic x-rays	$40 copay per visit	$60 copay per visit	Covered at 70%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered in full	Covered at 70%, subject to the deductible
Surgical care	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 70%, subject to the deductible
Chemotherapy	$25 copay per visit	$40 copay per visit	Covered at 70%, subject to the deductible
Radiation Therapy	$40 copay per visit	$60 copay per visit	Covered at 70%, 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 70%, subject to the deductible
Outpatient mental health care	$40 copay, Child under age 19 is $0 copay. Services can be provided in an outpatient facility or in a provider office	$60 copay, Child under age 19 is $0 copay. Services can be provided in an outpatient facility or in a provider office	Covered at 70%, subject to the deductible Services can be provided in an outpatient facility or in a provider's office
Inpatient chemical dependence	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 70%, subject to the deductible
Outpatient chemical dependence	$40 copay per visit	$60 copay per visit	Covered at 70%, subject to the deductible
Other Services	**Simply Blue 25-500**	**Signature Hybrid 1**	**Signature Deductible 3**
Diabetic insulin and supplies	$25 copay for up to a 30 day supply	$40 copay for up to a 30 day supply	Covered at 70%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Covered at 80%, subject to the deductible for up to 45 days per year	Covered at 70%, subject to the deductible for up to 45 days per year	Covered at 70%, subject to the deductible for up to 45 days per year
Home care	Covered in full for up to 40 visits per year	Covered in full for up to 40 visits per year	Covered at 70%, subject to the deductible
Hospice	Covered in full for unlimited days	Covered in full for unlimited days	Covered at 70%, subject to the deductible
Outpatient therapy	$40 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	$60 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 70%, subject to the deductible for a combined total of 45 visits per year for physical, speech and occupational therapy
Durable medical equipment	Covered at 80% subject to the deductible	Covered at 70% subject to the deductible	Covered at 70%, subject to the deductible
External prosthetics	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 70%, subject to the deductible
Chiropractic	$40 copay per visit	$40 copay per visit	Covered at 70%, 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 70%, subject to the deductible, for up to 10 visits per year
Dental	$40 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	$60 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 70%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	$40 copay for one routine hearing exam per year.	$60 copay for one routine hearing exam per year.	Covered at 70%, subject to the deductible, for one routine hearing exam per year.
*** All benefits summarized on this document are for In-Network services, and this is only a guide. The actual Excellus contract is the final determination of how all services are covered.**			

CAPCO - HMO options

HMO Blue $25 Copay (High)	HMO Blue $30 Copay (Low)
HMO Blue $25 Copay	**HMO Blue $30 Copay**
Required	Required
Not Required	Not Required
Urgent & Emergency Care Only	Urgent & Emergency Care Only
Coverage provided worldwide through the BlueCard® program	Coverage provided worldwide through the BlueCard® program
Qualified dependents and students are covered to age 26	Qualified dependents and students are covered to age 26
Covered	Covered
HMO Blue $25 Copay	**HMO Blue $30 Copay**
$25 Copay	$30 Copay
$40 Copay Per	$50 Copay Per
None	None
See benefit	See benefit
Single $6,350 / Family $12,700	Single $6,350 / Family $12,700
HMO Blue $25 Copay	**HMO Blue $30 Copay**
Covered in full	Covered in full
Covered in full for 1 exam per year	Covered in full for 1 exam per year
Covered in full	Covered in full
Covered in full	Covered in full
Covered in full	Covered in full
Covered in full	Covered in full
Covered in full	Covered in full
Preventive screening covered in full	Preventive screening covered in full
HMO Blue $25 Copay	**HMO Blue $30 Copay**
$25 PCP copay / $40 Specialist copay	$30 PCP copay / $50 Specialist copay
$40 copay	$50 copay
$25 copay	$30 copay
$25 PCP copay / $40 Specialist copay	$30 PCP copay / $50 Specialist copay
$25 PCP copay / $40 Specialist copay	$30 PCP copay / $50 Specialist copay
$25 copay per visit	$30 copay per visit
$25 copay per visit	$30 copay per visit
Not covered	Not covered
HMO Blue $25 Copay	**HMO Blue $30 Copay**
Covered in full	Covered in full
Facility $100 copay. Physician $200 copay or 20% coinsurance, whichever is less	Facility $1,000 copay. Physician $300 copay or 20% coinsurance, whichever is less
Covered in full	Covered in full
HMO Blue $25 Copay	**HMO Blue $30 Copay**
$5/$15/$30 , 90 day supply is 2 copays	$7 copay for generics only

HMO Blue $25 Copay	HMO Blue $30 Copay
$100 copay per admission for unlimited visits	$1,000 copay per admission for unlimited visits
Covered in full	Covered in full
$100 copay for up to 60 days per calendar year	Not covered
$100 copay per admission for unlimited visits	Facility $1,000 copay. Physician $300 copay or 20% coinsurance, whichever is less
Covered in full	Covered in full
HMO Blue $25 Copay	**HMO Blue $30 Copay**
$100 copay	$150 copay
$35 copay	$50 copay
$100 copay for emergency transportation	$100 copay for emergency transportation
HMO Blue $25 Copay	**HMO Blue $30 Copay**
$40 copay	$50 copay
$25 copay	$30 copay
Facility $75 copay. Physician $200 copay or 20% coinsurance, whichever is less	Facility $150 copay. Physician $50 copay
$25 copay per visit	$30 copay per visit
$25 copay per visit	$30 copay per visit
HMO Blue $25 Copay	**HMO Blue $30 Copay**
$100 copay, unlimited visits	$1,000 copay, unlimited visits
$25 copay, unlimited visits	$30 copay, unlimited visits
$100 copay, unlimited visits	$1,000 copay, unlimited visits
$25 copay, unlimited visits	$30 copay, unlimited visits
HMO Blue $25 Copay	**HMO Blue $30 Copay**
$25 copay	$30 copay
$100 copay for up to 45 days per calendar year	$1,000 copay for up to 45 days per calendar year
Covered in full for up to 40 visits per calendar year	$30 copay for up to 40 visits per calendar year
$100 copay for 210 days	$1,000 copay for 210 days
$40 Copay for up to 30 visits combined	$50 Copay for up to 30 visits combined
50% Coinsurance	Not covered
50% Coinsurance	Not covered
$40 copay	$50 copay
Not covered	Not covered
$40 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	$50 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
$40 copay for one routine hearing exam per year.	$50 copay for one routine hearing exam per year.