

\$1,000 Deductible

Benefit	In-Network	Out-of-Network
Deductible The amount an individual or family must pay each plan year before payments begin for services.	\$1,000 member \$2,000 family	\$2,000 member \$4,000 family
Out-of-Pocket Expense Limit The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year. (excludes deductible)	\$3,000 member \$6,000 family	\$6,000 member \$12,000 family
Adult Preventive Services 100% to a maximum of \$750, then deductible and 80%. Includes one routine vision exam per member per plan year (the vision exam maximum does not apply toward other preventive service maximums).	100%	60% after deductible
Child Preventive Services Unlimited visits birth through age two; limited to one (1) visit per plan year from age 3 through 17. Includes one vision exam per member per plan year (the vision exam maximum does not apply toward other preventive maximums).	100%	60% after deductible
Physician Office Visits One co-payment per physician per day Primary Care Specialist	\$20 co-pay \$40 co-pay	60% after deductible
Colonoscopies/Flexible Sigmoidoscopies 100% to a maximum of \$3,000 per plan year, then deductible and coinsurance	100%	60% after deductible
Chiropractic Care Maximum of \$1,000 per plan year	\$40 co-pay	60% after deductible
Outpatient Diagnostic Laboratory Services	80%	80%
Outpatient Diagnostic Testing/X-Ray Services	80% after deductible	60% after deductible
Outpatient Physical, Occupational and Speech Therapy Combined plan year maximum of 30 visits	80% after deductible	60% after deductible
Home Health Care Maximum of 25 visits per plan year	80% after deductible	60% after deductible
Outpatient Private Duty Nursing Lifetime maximum of \$25,000	80% after deductible	60%, after deductible
Urgent Care Services	\$40 co-pay	60% after deductible
Emergency Room Services Co-payment waived if admitted	\$100 co-pay, then 80% after deductible	\$100 co-pay, then 80% after deductible
Ambulance Services	80% after deductible	In-Network deductible, then 80%
Anesthesiology Services	80% after deductible	60% after deductible
Skilled Nursing Facility 100 days per plan year maximum.	80% after deductible	60% after deductible
Hospice Facility/Home Hospice Lifetime maximum of \$10,000	80% after deductible	60%after deductible
Durable Medical Equipment \$25,000 plan year maximum.	80% after deductible	60% after deductible
Wigs/Artificial Hairpieces After radiation therapy or chemotherapy, lifetime maximum of 2	80% after deductible	60% after deductible
Inpatient Hospital Services	80% after deductible	60% after deductible

\$1,000 Deductible continued

Benefit	In-Network	Out-of-Network
Inpatient Mental Health/Substance Abuse	80% after deductible	60% after deductible
Outpatient Mental Health/Substance Abuse	\$20 co-pay	60% after deductible
Pre-Admission Certification Inpatient stays, organs transplants, tissue transplants and certain outpatient services (refer to your Summary Plan Description for a complete listing)	\$500 non-compliance penalty	\$500 non-compliance penalty
Prescription Drug Benefit (Retail – 30 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	\$10 \$35 \$60	None
Prescription Drug Benefit (Mail Order – 90 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	\$20 \$70 \$120	None
Annual Essential Benefit Maximum	\$2,000,000	
<i>These pages summarize the benefits of your health care plan. Your Summary Plan Description defines the full terms and conditions in greater detail. Should any questions arise concerning benefits, the Summary Plan Description shall govern.</i>		

The CBA Blue SYSTEMSPPLUS PROTOTYPE EMPLOYEE HEALTH Plan utilizes the National BlueCard® PPO Network.