

## \$500 Deductible

Benefit	In-Network	Out-of-Network
<b>Deductible</b> The amount an individual or family must pay each plan year before payments begin for services.	\$500 member \$1,000 family	\$1,000 member \$2,000 family
<b>Out-of-Pocket Expense Limit</b> The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year	\$1,000 member \$2,000 family	\$2,000 member \$4,000 family
<b>Adult Preventive Services</b> 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
<b>Child Preventive Services</b> 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
<b>Physician Office Visits</b> One co-payment per physician per day	\$20 co-pay	60% after deductible
<b>Colonoscopies/Flexible Sigmoidoscopies</b> 100% to a maximum of \$3,000 per plan year, then deductible and coinsurance	100%	60% after deductible
<b>Chiropractic Care</b> Maximum of \$1,000 per plan year	\$20 co-pay	60% after deductible
<b>Outpatient Diagnostic Laboratory Services</b>	80%	80%
<b>Outpatient Diagnostic Testing/X-Ray Services</b>	80% after deductible	60% after deductible
<b>Outpatient Physical, Occupational and Speech Therapy</b> Combined plan year maximum of 30 visits	80% after deductible	60% after deductible
<b>Home Health Care</b> Maximum of 25 visits per plan year	80% after deductible	60% after deductible
<b>Outpatient Private Duty Nursing</b> Lifetime maximum of \$25,000	80% after deductible	60%, after deductible
<b>Urgent Care Services</b>	\$40 co-pay	60% after deductible
<b>Emergency Room Services</b> Co-payment waived if admitted	\$100 co-pay, then 80% after deductible	\$100 co-pay, then 80% after deductible
<b>Ambulance Services</b>	80% after deductible	In-Network deductible, then 80%
<b>Anesthesiology Services</b>	80% after deductible	In-Network deductible, then 80%
<b>Skilled Nursing Facility</b> 100 days per plan year maximum.	80% after deductible	60% after deductible
<b>Hospice Facility/Home Hospice</b> Lifetime maximum of \$10,000	80% after deductible	60%after deductible
<b>Durable Medical Equipment</b> \$25,000 plan year maximum.	80% after deductible	60% after deductible
<b>Wigs/Artificial Hairpieces</b> After radiation therapy or chemotherapy, lifetime maximum of 2	80% after deductible	In-Network deductible, then 80%
<b>Inpatient Hospital Services</b>	80% after deductible	60% after deductible

**\$500 Deductible continued**

Benefit	In-Network	Out-of-Network
<b>Inpatient Mental Health/Substance Abuse</b>	80% after deductible	60% after deductible
<b>Outpatient Mental Health/Substance Abuse</b>	\$20 co-pay	60% after deductible
<b>Pre-Admission Certification</b> 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
<b>Prescription Drug Benefit (Retail – 30 Day Supply)</b> Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	\$10 \$25 \$50	None
<b>Prescription Drug Benefit (Mail Order – 90 Day Supply)</b> Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	\$20 \$50 \$100	None
<b>Annual Essential Benefit Maximum</b>	\$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.