

**THIS IS NOT A CONTRACT.** This information highlights some of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (COC). Refer to your COC for benefit details.

SUMMARY OF COST-SHARING		Amounts Members Are Responsible For:	
		Participating Providers	Nonparticipating Providers
Deductible (per benefit period)		\$500 per member \$1,000 per family	\$1,000 per member \$2,000 per family
<b>Copayments</b>			
• Office Visits (performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist.)		\$20 copayment per visit	20% coinsurance
• Virtual Visits (performed through the CBC Virtual Care platform or an approved virtual visit participating provider)		\$10 copayment per visit	Not Covered
• Specialist Office Visit		\$30 copayment per visit	20% coinsurance
• Emergency Room		\$100 copayment per visit, waived if admitted	
• Urgent Care		\$45 copayment per visit	20% coinsurance
• Inpatient (Per Admission)		Not Applicable	50% coinsurance
• Outpatient Surgery Copayment (facility)		Not Applicable	50% coinsurance
Coinsurance		Not Applicable	20% coinsurance
Out-of-Pocket Maximum (includes Deductible, Copayments and Coinsurance for Medical (including ER))		\$4,075 per member \$8,150 per family	\$2,000 per member \$4,000 per family
SUMMARY OF BENEFITS	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Nonparticipating Providers
<b>PREVENTIVE CARE:</b> Administered in accordance with Preventive Health Guidelines and PA state mandates			
<b>Preventive Care Services</b>			
• Pediatric Preventive Care		Covered in full, waive deductible	20% coinsurance after deductible
• Adult Preventive Care		Covered in full, waive deductible	20% coinsurance after deductible
<b>Immunizations</b>		Covered in full, waive deductible	20% coinsurance, waive deductible
<b>Mammograms</b>			
• Screening Mammogram		One per benefit period	Covered in full, waive deductible
• Diagnostic Mammogram			Covered in full after deductible
<b>Gynecological Services</b>			
• Screening Gynecological Exam & Pap Smear		One per benefit period	Covered in full, waive deductible
<b>BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET</b>			
<b>Acute Care Hospital Room &amp; Board</b>		Covered in full after deductible	50% coinsurance after deductible
<b>Acute Inpatient Rehabilitation</b>		60 days/benefit period	Covered in full after deductible
<b>Skilled Nursing Facility</b>		100 days/benefit period	Covered in full after deductible
<b>Surgery</b>			
• Surgical Procedure & Anesthesia		Covered in full after deductible	20% coinsurance after deductible
<b>Maternity Services and Newborn Care</b>		Covered in full after deductible	20% coinsurance after deductible
<b>Diagnostic Services</b>			
• Radiology		Covered in full after deductible	20% coinsurance after deductible
• Laboratory		Covered in full after deductible	20% coinsurance after deductible
• Medical tests		Covered in full after deductible	20% coinsurance after deductible
<b>Outpatient Surgery</b>		Covered in full after deductible	20% coinsurance after deductible
<b>Outpatient Therapy Services</b>			
• Physical Medicine		30 visits/benefit period	Copayment applies
• Occupational Therapy		30 visits/benefit period	Copayment applies
• Speech Therapy		30 visits/benefit period	Copayment applies
• Respiratory Therapy			Copayment applies
• Manipulation Therapy		20 visits/benefit period	Copayment applies
• Acupuncture			Not Covered
<b>Emergency Services</b>		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
<b>Mental Health Care Services</b>			
• Inpatient Services		Covered in full after deductible	20% professional and 50% facility coinsurance after deductible
• Outpatient Services		Copayment applies	20% professional and 50% facility coinsurance after deductible
<b>Substance Use Disorder Services</b>			
• Rehabilitation – Inpatient		Covered in full after deductible	20% professional and 50% facility coinsurance after deductible
• Rehabilitation – Outpatient		Copayment applies	20% professional and 50% facility coinsurance after deductible
<b>Home Health Care Services</b>		90 visits/benefit period	Covered in full after deductible
<b>Durable Medical Equipment (DME)</b>		Covered in full after deductible	20% coinsurance after deductible
<b>Prosthetic Appliances</b>		Covered in full after deductible	20% coinsurance after deductible
<b>Orthotic Devices</b>		Covered in full after deductible	20% coinsurance after deductible

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