

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	
Copayments			
<ul style="list-style-type: none"> Office Visits (performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic) 		\$10 copayment per visit	20% coinsurance
<ul style="list-style-type: none"> Virtual Visits (performed through the CBC Virtual Care platform or an approved virtual visit participating provider) 		\$10 copayment per visit (PCP)/\$20 copayment per visit (Specialist)	Not Covered
<ul style="list-style-type: none"> Specialist Office Visit 		\$20 copayment per visit	20% coinsurance
<ul style="list-style-type: none"> Emergency Room 		\$75 copayment per visit, waived if admitted	
<ul style="list-style-type: none"> Urgent Care 		\$35 copayment per visit	
<ul style="list-style-type: none"> Inpatient (Per Admission) 		Not Applicable	50% coinsurance
<ul style="list-style-type: none"> 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), for Participating Providers only).		\$4,075 per member \$8,150 per family	\$6,350 per member \$12,700 per family
SUMMARY OF BENEFITS	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Nonparticipating Providers
PREVENTIVE CARE : Administered in accordance with Preventive Health Guidelines and PA state mandates			
Preventive Care Services			
<ul style="list-style-type: none"> Pediatric Preventive Care 		Covered in full, waive deductible	20% coinsurance after deductible
<ul style="list-style-type: none"> Adult Preventive Care 		Covered in full, waive deductible	20% coinsurance after deductible
Immunizations		Covered in full, waive deductible	20% coinsurance, waive deductible
Mammograms			
<ul style="list-style-type: none"> Screening Mammogram 		One per benefit period	Covered in full, waive deductible
<ul style="list-style-type: none"> Diagnostic Mammogram 			Covered in full after deductible
Gynecological Services			
<ul style="list-style-type: none"> Screening Gynecological Exam & Pap Smear 		One per benefit period	Covered in full, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board			Covered in full after deductible
Acute Inpatient Rehabilitation		60 days/benefit period	Covered in full after deductible
Skilled Nursing Facility		100 days/benefit period	Covered in full after deductible
Surgery			
<ul style="list-style-type: none"> Surgical Procedure & Anesthesia 			Covered in full after deductible
Maternity Services and Newborn Care			Covered in full after deductible
Diagnostic Services			
<ul style="list-style-type: none"> Radiology 			Covered in full after deductible
<ul style="list-style-type: none"> Laboratory 			Covered in full after deductible
<ul style="list-style-type: none"> Medical tests 			Covered in full after deductible
Outpatient Surgery			Covered in full after deductible
Outpatient Therapy Services			
<ul style="list-style-type: none"> Physical Medicine 			Copayment applies
<ul style="list-style-type: none"> Occupational Therapy 			Copayment applies
<ul style="list-style-type: none"> Speech Therapy 			Copayment applies
<ul style="list-style-type: none"> Respiratory Therapy 			Copayment applies
<ul style="list-style-type: none"> Manipulation Therapy 			Copayment applies
<ul style="list-style-type: none"> Acupuncture 			Not Covered
Emergency Services			Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient
Mental Health Care Services			
<ul style="list-style-type: none"> Inpatient Services 		Covered in full after deductible	20% professional and 50% facility coinsurance after deductible
<ul style="list-style-type: none"> Outpatient Services 		Copayment applies	20% professional and 50% facility coinsurance after deductible
Substance Use Disorder Services			
<ul style="list-style-type: none"> Rehabilitation – Inpatient 		Covered in full after deductible	20% professional and 50% facility coinsurance after deductible
<ul style="list-style-type: none"> Rehabilitation – Outpatient 		Copayment applies	20% professional and 50% facility coinsurance after deductible
Home Health Care Services		90 visits/benefit period	Covered in full after deductible
Durable Medical Equipment (DME)			Covered in full after deductible
Prosthetic Appliances			Covered in full after deductible
Orthotic Devices			Covered in full after deductible

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