

This information is not a contract, but highlights some of the benefits available to you 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 (also known as "benefit booklet"). Refer to your benefit booklet for complete details.

<b>YOUR MEDICAL PLAN SUMMARY OF COST SHARING</b>		
	<b>Member Responsibilities</b>	
	<b>If provider is participating</b>	<b>If provider is nonparticipating</b>
<b>Deductible</b> (per benefit period)	\$500 per member \$1,000 per family	\$1,000 per member \$3,000 per family
<b>Coinsurance</b> (percentage you pay after your deductible is met)	No member coinsurance	20% coinsurance
<b>Out-of-Pocket Maximum</b> (The most you pay per benefit period, after which benefits are paid at 100%. This includes deductible, copayments and coinsurance for medical including ER for participating providers only.)	\$3,675 per member \$7,350 per family	\$2,000 per member \$6,000 per family
<b>Office Visit / Urgent Care / Emergency Room Copayments</b>		
<b>Virtual Care (non-specialist) Visits</b> – delivered via The Capital BlueCross Virtual Care platform	\$20 copayment per visit	Not covered
<b>Virtual Care (specialist) Visits</b> – delivered via The Capital BlueCross Virtual Care platform	\$30 copayment per visit	Not covered
<b>Office Visits and Consultations (In-person &amp; Telehealth)</b> - performed by a family practitioner, general practitioner, internist, pediatrician or participating retail clinic	\$20 copayment per visit	30% coinsurance after deductible
<b>Specialist Office Visits (In-person and Telehealth)</b>	\$30 copayment per visit	30% coinsurance after deductible
<b>Urgent Care Services</b>	\$40 copayment per visit	30% coinsurance after deductible
<b>Emergency Room</b>	\$100 copayment per visit, waived if admitted	
<b>Preventive Care</b>		
<b>Pediatric and Adult Preventive Care</b>	No charge, waive deductible	20% coinsurance after deductible
<b>Screening Gynecological Exam and Pap Smear</b> (one per benefit period)	No charge, waive deductible	20% coinsurance, waive deductible
<b>Screening Mammogram</b> (one per benefit period)	No charge, waive deductible	20% coinsurance, waive deductible
<b>Diagnostic Mammogram</b>	No charge after deductible	20% coinsurance after deductible
<b>Facility / Surgical Services</b>		
<b>Inpatient Hospital Room and Board</b>	No charge after deductible	20% coinsurance after deductible
<b>Acute Inpatient Rehabilitation</b> (60 days per benefit period)	No charge after deductible	20% coinsurance after deductible
<b>Skilled Nursing Facility</b> (100 days per benefit period)	No charge after deductible	20% coinsurance after deductible
<b>Maternity Services and Newborn Care</b> (professional charges)	No charge after deductible	20% coinsurance after deductible
<b>Surgical Procedure and Anesthesia</b> (professional charges)	No charge after deductible	20% coinsurance after deductible
<b>Outpatient Surgery at Ambulatory Surgical Center</b> (facility charge only)	No charge after deductible	Not covered
<b>Outpatient Surgery at Acute Care Hospital</b> (facility charge only)	No charge after deductible	20% coinsurance after deductible
<b>Diagnostic Services</b>		
<b>High Tech Imaging</b> (such as MRI, CT, PET)	No charge after deductible	20% coinsurance after deductible
<b>Radiology</b> (other than high tech imaging)	No charge after deductible	20% coinsurance after deductible
<b>Independent Laboratory</b>	No charge after deductible	20% coinsurance after deductible
<b>Facility-owned Laboratory</b> (i.e. Health System owned)	No charge after deductible	20% coinsurance after deductible
<b>Therapy Services (Rehabilitative and Habilitative Services)</b>		
<b>Physical Therapy</b> (30 visits per benefit period)	\$30 copayment per visit	30% coinsurance after deductible
<b>Occupational Therapy</b>	\$30 copayment per visit	30% coinsurance after deductible
<b>Speech Therapy</b>	\$30 copayment per visit	30% coinsurance after deductible
<b>Respiratory Therapy</b>	\$30 copayment per visit	30% coinsurance after deductible
<b>Manipulation Therapy</b> (30 visits per benefit period)	\$30 copayment per visit	30% coinsurance after deductible
<b>Mental Health (MH) and Substance Use Disorder Services (SUD)</b>		
<b>MH Inpatient Services</b>	No charge after deductible	20% coinsurance after deductible
<b>MH Outpatient Services</b>	\$30 copayment per visit	20% coinsurance after deductible
<b>SUD Detoxification Inpatient</b>	No charge after deductible	20% coinsurance after deductible
<b>SUD Rehabilitation Outpatient</b>	\$30 copayment per visit	20% coinsurance after deductible

<b>Additional Services</b>		
<b>Home Health Care Services</b> (90 visits per benefit period)	No charge after deductible	20% coinsurance after deductible
<b>Durable Medical Equipment and Supplies</b>	No charge after deductible	20% coinsurance after deductible
<b>Prosthetic Appliances</b>	No charge after deductible	20% coinsurance after deductible
<b>Orthotic Devices</b>	No charge after deductible	20% coinsurance after deductible

*Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. An independent licensee of the BlueCross BlueShield Association.*

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments required under any other health benefits coverage you may have.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit a nonparticipating provider, you are responsible for paying the deductible, coinsurance and the difference between the nonparticipating provider's charges and the allowed amount. Nonparticipating Providers may balance bill the member. Some nonparticipating facility providers are not covered. In certain situations, a facility fee may be associated with an outpatient visit to a professional provider. Members should consult with the provider of the services to determine whether a facility fee may apply to that provider. An additional cost sharing amount may apply to the facility fee.

 Voice activated paper.

Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.