Capital BLUE

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Benefit Highlights

PPO H S A 2000Q/100

Schuylkill Intermediate

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) *Deductible is waived for PREVENTIVE SERVICES unless otherwise noted.* *Deductible is combined to include medical & prescription drug benefits.*	$2,000 single coverage $4,000 family coverage	
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist)*	$10 copayment/visit after deductible	30% coinsurance after deductible
• **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
• **Specialist Office Visit**	$20 copayment/visit after deductible	30% coinsurance after deductible
• **Emergency Room**	$100 copayment per visit, waived if admitted	
• **Urgent Care**	$35 copayment per visit	
• **Inpatient** (Per Admission)	Not Applicable	50% coinsurance after deductible
• **Outpatient Surgery Copayment** (facility)	Not Applicable	50% coinsurance after deductible
Coinsurance (includes coinsurance amounts) When this amount is satisfied, no further coinsurance is applied	Not Applicable	$5,000 single coverage $10,000 family coverage
Maximum Out-of-Pocket Liability *(Includes copayment and deductible amounts) When this amount is satisfied, there are no further member out-of-pocket costs for services that are provided by participating providers.*	$6,750 single coverage $13,500 family coverage	No maximum. Copayments continue to be your out-of-pocket cost. Also, balance billing by *non-participating providers* continues to be your out-of pocket costs.

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			
• Pediatric Preventive Care		Covered in full, No deductible, No copay	30% coinsurance after deductible
• Adult Preventive Care		Covered in full, No deductible, No copay	30% coinsurance after deductible
Immunizations		Covered in full, No deductible	30% coinsurance after deductible
Mammograms			
• Screening Mammogram	One per 12 month period	Covered in full, No deductible	30% coinsurance, waive deductible
Gynecological Services			
• Screening Gynecological Exam	One per 12 month period	Covered in full, No deductible, No copay	30% coinsurance, waive deductible
• Screening Pap Smear	One per 12 month period	Covered in full, No deductible	30% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		Covered in full after deductible	50% coinsurance after deductible
Acute Inpatient Rehabilitation		Covered in full after deductible	50% coinsurance after deductible
Skilled Nursing Facility		Covered in full after deductible	50% coinsurance after deductible
Surgery			
• Surgical Procedure & Anesthesia		Covered in full after deductible	30% coinsurance after deductible
Maternity Services and Newborn Care		Covered in full after deductible	30% coinsurance after deductible
Diagnostic Services			
• Radiology		Covered in full after deductible	30% coinsurance after deductible
• Laboratory		Covered in full after deductible	30% coinsurance after deductible
• Medical tests		Covered in full after deductible	30% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine		Copayment/visit after deductible	30% coinsurance after deductible
• Occupational Therapy		Copayment/visit after deductible	30% coinsurance after deductible
• Speech Therapy		Copayment/visit after deductible	30% coinsurance after deductible
• Respiratory Therapy		Covered in full after deductible	30% coinsurance after deductible
• Manipulation Therapy	20 visits/benefit period	Copayment/visit after deductible	Not covered
Emergency Services		Covered in full after deductible Emergency room copayment applies, waived if admitted	
Mental Health Care Services • Inpatient Services		Covered in full after deductible	30% professional and 50% facility coinsurance after deductible
• Outpatient Services		Copayment/visit after deductible	30% professional and 50% facility coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient		Covered in full after deductible	30% professional and 50% facility coinsurance after deductible
• Rehabilitation – Outpatient		Copayment/visit after deductible	30% professional and 50% facility coinsurance after deductible
Home Health Care Services	90 visits/benefit period	Covered in full after deductible	50% coinsurance after deductible
Durable Medical Equipment (DME)		Covered in full after deductible	30% coinsurance after deductible
Prosthetic Appliances and Orthotic Devices		Covered in full after deductible	30% coinsurance after deductible