BENEFIT HIGHLIGHTS

CapitalBlueCross.com

PPO 800 Plan

Phoebe-Devitt Homes

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 Benefits Booklet (also known as "Certificate of Coverage"). Refer to your Benefits Booklet for complete details.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is in-network	If provider is out-of-network
Deductible (per benefit period)	$800 per member $1,600 per family	$3,000 per member $6,000 per family
Coinsurance (Percentage you pay after your deductible is met.)	No member coinsurance	40% coinsurance after deductible
Out-of-pocket maximum (The most you pay per benefit period, after which benefits are paid at 100%).	Overall in-network out-of-pocket maximum includes deductible, copayments, and coinsurance for medical and prescription drugs: $9,200 single coverage $18,400 family coverage	Out-of-network medical coinsurance-only maximum: $9,200 single coverage $18,400 family coverage Overall out-of-network out-of-pocket not applicable
Office Visit / Urgent Care / Emergency Room Copayments		
VirtualCare (non-specialist) visits—delivered via the Capital Blue Cross VirtualCare platform	$10 copayment per visit	Not applicable
VirtualCare (specialist) visits—delivered via the Capital Blue Cross VirtualCare platform	$10 copayment per visit	Not applicable
Office visits and consultations (in-person & telehealth)—performed by a family practitioner, general practitioner, internist, pediatrician network retail clinic or in-person	$35 copayment per visit	40% coinsurance after deductible
Specialist office visits (in-person & telehealth)	$45 copayment per visit	40% coinsurance after deductible
Urgent care services	$40 copayment per visit	40% coinsurance after deductible
Emergency room	$200 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and adult preventive care	No charge, deductible waived	40% coinsurance after deductible
Screening gynecological exam and pap smear	No charge, deductible waived	40% coinsurance, deductible waived
Screening mammogram	No charge, deductible waived	40% coinsurance, deductible waived
Facility / Surgical Services		
Inpatient hospital room and board including maternity services and newborn care	No charge after deductible	40% coinsurance after deductible
Acute inpatient rehabilitation (60 days per benefit period)	No charge after deductible	40% coinsurance after deductible
Skilled nursing facility (100 days per benefit period)	No charge after deductible	40% coinsurance after deductible
Surgical procedure and anesthesia (professional charges)	No charge after deductible	40% coinsurance after deductible
Outpatient surgery at ambulatory surgical center (facility charge only)	No charge after deductible	40% coinsurance after deductible
Outpatient surgery at acute care hospital (facility charge only)	No charge after deductible	40% coinsurance after deductible
Diagnostic Services		
High tech imaging (such as MRI, CT, PET)	No charge after deductible	40% coinsurance after deductible
Radiology (other than high tech imaging)	No charge after deductible	40% coinsurance after deductible
Independent laboratory	No charge after deductible	40% coinsurance after deductible
Facility-owned laboratory (i.e. Health System owned)	No charge after deductible	40% coinsurance after deductible
Diagnostic mammogram	No charge, deductible waived	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical therapy (20 visits per benefit period)	$45 copayment per visit	40% coinsurance after deductible
Occupational therapy (12 visits per benefit period)	$45 copayment per visit	40% coinsurance after deductible
Speech therapy (12 visits per benefit period)	$45 copayment per visit	40% coinsurance after deductible
Respiratory therapy	No charge after deductible	40% coinsurance after deductible
Manipulation therapy (20 visits per benefit period)	$45 copayment per visit	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH & SUD detoxification inpatient services	No charge after deductible	40% coinsurance after deductible
MH & SUD rehabilitation outpatient services	$30 copayment per visit	40% coinsurance after deductible
Additional Services		
Home healthcare services (90 visits per benefit period)	No charge after deductible	40% coinsurance after deductible
Durable medical equipment and supplies; prosthetic appliances and orthotic devices	No charge after deductible	40% coinsurance after deductible

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