Capital BLUE

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BENEFIT HIGHLIGHTS

PPO 500 Plan

Building Trades Health & Welfare Fund

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)	$500 per member $1,000 per family	$1,000 per member $2,000 per family
Coinsurance (percentage you pay after your deductible is met)	20% coinsurance	40% coinsurance
Coinsurance Out-of-Pocket Maximum (Includes coinsurance amounts, when this amount is satisfied, no further coinsurance is applied.)	$1,500 per member $3,000 per family	$8,000 per member $16,000 per family
Out-of-Pocket Maximum (The most you pay per benefit period, after which benefits are paid at 100%. This includes deductible, copayments and coinsurance for medical including ER and prescription drug, for in-network providers only.)	$2,500 per member $5,000 per family	Unlimited
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist) Visits – delivered via the Capital BlueCross Virtual Care platform	$10 copayment per visit	Not covered
Office Visit Plus – Total Care	$10 copayment per visit	40% coinsurance after deductible
Office Visits and Consultations (In-person & Telehealth) - performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	$30 copayment per visit	40% coinsurance after deductible
Specialist Office Visits (In-person, Telehealth & via the Capital BlueCross Virtual Care platform)	$40 copayment per visit	40% coinsurance after deductible Virtual Care – Not covered
Urgent Care Services	$50 copayment per visit	40% coinsurance after deductible
Emergency Room	$100 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and Adult Preventive Care	No charge	40% coinsurance after deductible
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge	40% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge	40% coinsurance, waive deductible
Diagnostic Mammogram	20% coinsurance after deductible	40% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	20% coinsurance after deductible	50% coinsurance after deductible
Acute Inpatient Rehabilitation (60 days per benefit period)	20% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	20% coinsurance after deductible	50% coinsurance after deductible
Maternity Services and Newborn Care	20% coinsurance after deductible	40% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	20% coinsurance after deductible	Not covered
Outpatient Surgery at Acute Care Hospital (facility charge only)	20% coinsurance after deductible	50% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible
Radiology (other than high tech imaging)	20% coinsurance after deductible	40% coinsurance after deductible
Independent Laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	20% coinsurance after deductible	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (30 visits per benefit period)	$40 copayment per visit	40% coinsurance after deductible
Occupational Therapy (12 visits per benefit period)	$40 copayment per visit	40% coinsurance after deductible
Speech Therapy (12 visits per benefit period)	$40 copayment per visit	40% coinsurance after deductible
Respiratory Therapy (30 visits per benefit period)	$40 copayment per visit	40% coinsurance after deductible
Manipulation Therapy (30 visits per benefit period)	$40 copayment per visit	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	20% coinsurance after deductible	50% coinsurance after deductible
MH Outpatient Services	$40 copayment per visit	40% coinsurance after deductible
SUD Detoxification Inpatient	20% coinsurance after deductible	50% coinsurance after deductible
SUD Rehabilitation Outpatient	$40 copayment per visit	40% coinsurance after deductible
Additional Services		
Home Health Care Services (90 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Durable Medical Equipment and Supplies	20% coinsurance after deductible	40% coinsurance after deductible
Prosthetic Appliances	20% coinsurance after deductible	40% coinsurance after deductible
Orthotic Devices	20% coinsurance after deductible	40% coinsurance after deductible