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Capital

BENEFIT HIGHLIGHTS

CapitalBlueCross.com

Custom Choice Plus

PPL Services

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)	No member deductible	$200 per member $400 per family
Coinsurance (percentage you pay after your deductible is met)	No member coinsurance	20% coinsurance
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.)	$6,350 per member $12,700 per family	$6,350 per member $12,700 per family
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist) Visits – delivered via the Capital Blue Cross Virtual Care platform	$15 copayment per visit	Not covered
Virtual Care (specialist) Visits – delivered via the Capital Blue Cross Virtual Care platform	$15 copayment per visit	Not covered
Office Visits and Consultations (In-person & Telehealth) - performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	$15 copayment per visit	20% coinsurance after deductible
Specialist Office Visits (In-person & Telehealth)	$20 copayment per visit	20% coinsurance after deductible
Urgent Care Services	$20 copayment per visit	20% coinsurance after deductible
Emergency Room	$35 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and Adult Preventive Care	No charge	Not covered
Screening Gynecological Exam (one per benefit period)	No charge	Not covered
Screening Pap Smear (one per benefit period)	No charge	Not covered
Screening Mammogram (one per benefit period)	No charge	Not covered
Diagnostic Mammogram	No charge	20% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	No charge	20% coinsurance after deductible
Acute Inpatient Rehabilitation & Skilled Nursing Facility (100 combined days per benefit period)	No charge	20% coinsurance after deductible
Maternity Services and Newborn Care	No charge	20% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	No charge	20% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	No charge	20% coinsurance after deductible
Outpatient Surgery at Acute Care Hospital (facility charge only)	No charge	20% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	No charge	20% coinsurance after deductible
Radiology (other than high tech imaging)	No charge	20% coinsurance after deductible
Independent Laboratory	No charge	20% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	No charge	20% coinsurance after deductible
Therapy Services (Rehabilitative Services)		
Physical Therapy (20 visits per benefit period)	$20 copayment per visit	20% coinsurance after deductible
Occupational Therapy (20 visits per benefit period)	$20 copayment per visit	20% coinsurance after deductible
Speech Therapy (20 visits per benefit period)	$20 copayment per visit	20% coinsurance after deductible
Respiratory Therapy	$20 copayment per visit	20% coinsurance after deductible
Manipulation Therapy (12 visits per benefit period)	$20 copayment per visit	20% coinsurance after deductible
Habilitative Services		
Habilitation Services (20 visits per benefit period)	20% coinsurance	20% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	No charge	20% coinsurance after deductible
MH Outpatient Services	$15 copayment per visit	20% coinsurance after deductible
SUD Detoxification Inpatient	No charge	20% coinsurance after deductible
SUD Rehabilitation Outpatient	$15 copayment per visit	20% coinsurance after deductible
Additional Services		
Home Health Care Services	20% coinsurance	20% coinsurance after deductible
Durable Medical Equipment and Supplies	20% coinsurance	20% coinsurance after deductible
Prosthetic Appliances	20% coinsurance	20% coinsurance after deductible
Orthotic Devices	Not covered	Not covered

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.
In-network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider's charges and the allowed amount. Out-of-network Providers may balance bill the member. Some out-of-network 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 Blue Cross in its capacity as administrator of programs and provider relations for all companies.