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Capital

BENEFIT HIGHLIGHTS

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Select Provider Plan

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)	$500 per member $1,000 per family	Not covered
Coinsurance (percentage you pay after your deductible is met)	10% coinsurance	Not covered
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	Not covered
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist and specialist) Visits – delivered via the Capital Blue Cross Virtual Care platform	$25 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	$25 copayment per visit	Not covered
Specialist Office Visits (In-person, Telehealth)	$50 copayment per visit	Not covered
Urgent Care Services	$50 copayment per visit	Not covered
Emergency Room	10% coinsurance after deductible	
Preventive Care		
Pediatric and Adult Preventive Care	No charge, waive deductible	Not covered
Screening Gynecological Exam & Screening Pap Smear (one per benefit period)	No charge, waive deductible	Not covered
Screening Mammogram (one per benefit period)	No charge, waive deductible	Not covered
Diagnostic Mammogram	10% coinsurance after deductible	Not covered
Facility / Surgical Services		
Inpatient Hospital Room and Board	10% coinsurance after deductible	Not covered
Acute Inpatient Rehabilitation (60 days per benefit period)	10% coinsurance after deductible	Not covered
Skilled Nursing Facility (100 days per benefit period)	10% coinsurance after deductible	Not covered
Maternity Services	Prenatal care-No charge, waive deductible. Initial Office visit copay applies. Post-natal care-10% coinsurance after deductible	Not covered
New Born Care	No charge, waive deductible	Not covered
Surgical Procedure and Anesthesia (professional charges)	10% coinsurance after deductible	Not covered
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	10% coinsurance after deductible	Not covered
Outpatient Surgery at Acute Care Hospital (facility charge only)	10% coinsurance after deductible	Not covered
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	10% coinsurance after deductible	Not covered
Radiology (other than high tech imaging)	10% coinsurance after deductible	Not covered
Independent Laboratory	10% coinsurance after deductible	Not covered
Facility-owned Laboratory (i.e. Health System owned)	10% coinsurance after deductible	Not covered
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy & Occupational Therapy (100 combined visits per benefit period)	$50 copayment per visit	Not covered
Speech Therapy	$50 copayment per visit	Not covered
Respiratory Therapy	$50 copayment per visit	Not covered
Manipulation Therapy	$50 copayment per visit	Not covered
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	10% coinsurance after deductible	Not covered
MH Outpatient Services	$25 copayment per visit	Not covered
SUD Detoxification Inpatient	10% coinsurance after deductible	Not covered
SUD Rehabilitation Outpatient	$25 copayment per visit	Not covered
Additional Services		
Home Health Care Services	10% coinsurance after deductible	Not covered

Durable Medical Equipment and Supplies	10% coinsurance after deductible	Not covered
Prosthetic Appliances	10% coinsurance after deductible	Not covered
Orthotic Devices	10% coinsurance after deductible	Not covered

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital Blue Cross. An independent licensee of the Blue Cross Blue Shield 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. 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.