Capital BLUE

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BENEFIT HIGHLIGHTS

PPO 200 Plan

IBEW Local No 375

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

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is participating	**If provider is nonparticipating**
Deductible (per benefit period)	$200 per member $400 per family	$400 per member $800 per family
Coinsurance (percentage you pay after your deductible is met)	No member coinsurance	20% coinsurance
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Individual Family	 None None	 $4,000 per member $8,000 per family
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network only) Once met, the plan pays 100% of covered services for the rest of the benefit period) Individual Family	 $7,900 per member $15,800 per family	 Not Applicable Not Applicable
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Visits (performed through our Virtual Care tool or an approved virtual visit with a participating provider)	$10 copayment per visit PCP $35 copayment per visit Specialist	Not covered
Office Visits (performed by a family practitioner, general practitioner, internist, pediatrician or participating retail clinic)	$20 copayment per visit	20% coinsurance after deductible
Specialist Office Visits	$35 copayment per visit	20% coinsurance after deductible
Urgent Care Services	$35 copayment per visit	20% coinsurance after deductible
Emergency Room	$100 copayment per visit, waived if admitted	
Ambulance-Emergency and Non-Emergency	No charge after deductible	20% coinsurance after deductible
Preventive Care		
Adult Physical Exams	No charge, waive deductible	20% coinsurance after deductible
Adult Immunizations	No charge, waive deductible	20% coinsurance after deductible
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge, waive deductible	20% coinsurance waive deductible
Screening Mammogram (one per benefit period)	No charge, waive deductible	20% coinsurance after deductible
Diagnostic Mammogram	No charge, waive deductible	20% coinsurance after deductible
Pediatric Physical Exams	No charge, waive deductible	20% coinsurance after deductible
Pediatric Immunizations	No charge, waive deductible	20% coinsurance after deductible
Diagnostic Services and Procedures	No charge, waive deductible	20% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	No charge after deductible	20% coinsurance after deductible
Acute Inpatient Rehabilitation	No charge after deductible	20% coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	No charge after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care	No charge after deductible	20% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	No charge after deductible	20% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	No charge after deductible	20% coinsurance after deductible
Outpatient Surgery at Acute Care Hospital (facility charge only)	No charge after deductible	20% coinsurance after deductible
Diagnostic Services		
Advanced Imaging (such as MRI, CAT, PET scan, etc.)	No charge after deductible	20% coinsurance after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	No charge after deductible	20% coinsurance after deductible
Independent Laboratory	No charge after deductible	20% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	No charge after deductible	20% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (20 visits per benefit period) Not combined with other therapies.	$35 copayment per visit	20% coinsurance after deductible
Occupational Therapy (12 visits per benefit period) Not combined with other therapies.	$35 copayment per visit	20% coinsurance after deductible
Speech Therapy (12 visits per benefit period) Not combined with other therapies.	$35 copayment per visit	20% coinsurance after deductible

Respiratory Therapy	No charge after deductible	20% coinsurance after deductible
Manipulation Therapy (20 visits per benefit period) Not combined with other therapies.	$35 copayment per visit	20% coinsurance after deductible
Acupuncture (15 visits per benefit period) Not combined with other therapies.	$35 copayment per visit	20% coinsurance after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	No charge after deductible	20% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	No charge after deductible	20% coinsurance after deductible
MH Outpatient Services	No charge after deductible	20% coinsurance after deductible
SUD Detoxification Inpatient	No charge after deductible	20% coinsurance after deductible
SUD Rehabilitation Outpatient	No charge after deductible	20% coinsurance after deductible
Additional Services		
Allergy Extracts and Injections	No charge after deductible	20% coinsurance after deductible
Applied Behavioral Analysis for Autism Spectrum Disorder	No charge after deductible	20% coinsurance after deductible
Assisted Fertilization Procedures	Not covered	Not covered
Dental Services Related to Accidental Injury	Not covered	Not covered
Durable Medical Equipment and Supplies, Orthotics and Prosthetics	No charge after deductible	20% coinsurance after deductible
Home Health Care Services (90 visits per benefit period)	No charge after deductible	20% coinsurance after deductible
Hospice	No charge after deductible	20% coinsurance after deductible
Infertility Counseling, Testing and Treatment	No charge after deductible	20% coinsurance after deductible
Private Duty Nursing (240 hours per benefit period)	No charge after deductible	20% coinsurance after deductible
Transplant Services	No charge after deductible	20% coinsurance after deductible
Preauthorization Requirements	Yes	Yes

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. Participating providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit a nonparticipating provider, you are responsible for paying the deductible, coinsurance and the difference between the nonparticipating provider's charges and the allowed amount. Nonparticipating Providers may balance bill the member. Some nonparticipating 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.

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Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.