

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.

<b>YOUR MEDICAL PLAN SUMMARY OF COST SHARING</b>		
	<b>Member Responsibilities</b>	
	<b>If provider is participating</b>	<b>If provider is nonparticipating</b>
➤ <b>Deductible</b> (per benefit period)	\$2,000 per member \$4,000 per family	\$5,000 per member \$10,000 per family
➤ <b>Coinsurance</b> (percentage you pay after your deductible is met)	No member coinsurance	50% coinsurance
➤ <b>Out-of-Pocket Maximum</b> (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 participating providers only.)	\$7,900 per member \$15,800 per family	\$10,000 per member \$20,000 per family
<b>Office Visit / Urgent Care / Emergency Room Copayments</b>		
➤ <b>Virtual Visits</b> (performed through our Virtual Care tool or an approved virtual visit with a participating provider)	\$10 copayment per visit	Not covered
➤ <b>Office Visit Plus – Total Care</b>	\$15 copayment per visit	50% coinsurance
<b>Office Visits</b> (performed by a family practitioner, general practitioner, internist, pediatrician or participating retail clinic)	\$30 copayment per visit	50% coinsurance
<b>Specialist Office Visits</b>	\$50 copayment per visit	50% coinsurance
<b>Urgent Care Services</b>	\$75 copayment per visit	
<b>Emergency Room</b>	\$200 copayment per visit, waived if admitted	
<b>Preventive Care</b>		
<b>Pediatric and Adult Preventive Care</b>	No charge	50% coinsurance after deductible
<b>Screening Gynecological Exam and Pap Smear</b> (one per benefit period)	No charge	50% coinsurance, waive deductible
<b>Screening Mammogram</b> (one per benefit period)	No charge	50% coinsurance, waive deductible
<b>Diagnostic Mammogram</b>	No charge after deductible	50% coinsurance after deductible
<b>Facility / Surgical Services</b>		
<b>Inpatient Hospital Room and Board</b>	No charge after deductible	50% coinsurance after deductible
<b>Acute Inpatient Rehabilitation</b> (60 days per benefit period)	No charge after deductible	50% coinsurance after deductible
<b>Skilled Nursing Facility</b> (120 days per benefit period)	No charge after deductible	50% coinsurance after deductible
<b>Maternity Services and Newborn Care</b>	No charge after deductible	50% coinsurance after deductible
<b>Surgical Procedure and Anesthesia</b> (professional charges)	No charge after deductible	50% coinsurance after deductible
➤ <b>Outpatient Surgery at Ambulatory Surgical Center</b> (facility charge only)	\$250 copayment, waive deductible	Not covered
<b>Outpatient Surgery at Acute Care Hospital</b> (facility charge only)	\$500 copayment after deductible	50% coinsurance after deductible
<b>Diagnostic Services</b>		
<b>High Tech Imaging</b> (such as MRI, CT, PET)	No charge after deductible	50% coinsurance after deductible
<b>Radiology</b> (other than high tech imaging)	No charge after deductible	50% coinsurance after deductible
➤ <b>Independent Laboratory</b>	\$30 copayment, waive deductible	50% coinsurance after deductible
<b>Facility-owned Laboratory</b> (i.e. Health System owned)	\$50 copayment after deductible	50% coinsurance after deductible
<b>Therapy Services (Rehabilitative and Habilitative Services)</b>		
<b>Physical Therapy and Occupational Therapy</b> (rehabilitative and habilitative, 60 visits combined per benefit period)	\$50 copayment per visit	50% coinsurance after deductible
<b>Speech Therapy</b> (rehabilitative and habilitative, 60 visits per benefit period)	\$50 copayment per visit	50% coinsurance after deductible
<b>Respiratory/Pulmonary Therapy</b> (20 rehabilitative visits per benefit period)	\$50 copayment per visit	50% coinsurance after deductible
<b>Manipulation Therapy</b> (20 visits per benefit period)	\$50 copayment per visit	50% coinsurance after deductible
<b>Acupuncture</b> (15 visits per benefit period)	\$50 copayment per visit	50% coinsurance after deductible
<b>Mental Health (MH) and Substance Use Disorder Services (SUD)</b>		
<b>MH Inpatient Services</b>	No charge after deductible	50% coinsurance after deductible
<b>MH Outpatient Services</b>	\$50 copayment per visit	50% coinsurance after deductible
<b>SUD Detoxification Inpatient</b>	No charge after deductible	50% coinsurance after deductible
<b>SUD Rehabilitation Outpatient</b>	\$50 copayment per visit	50% coinsurance after deductible
<b>Additional Services</b>		
<b>Home Health Care Services</b> (60 visits per benefit period)	No charge after deductible	50% coinsurance after deductible
<b>Durable Medical Equipment and Supplies</b>	No charge after deductible	50% coinsurance after deductible
<b>Prosthetic Appliances</b>	No charge after deductible	50% coinsurance after deductible
<b>Orthotic Devices</b>	No charge after deductible	50% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. An independent licensee of the BlueCross BlueShield Association.



**COST SHARING FOR PRESCRIPTION DRUGS DOES NOT APPLY TO THE MEDICAL DEDUCTIBLE SHOWN ON PAGE 1**

**YOUR PRESCRIPTION DRUG SUMMARY OF COST-SHARING**

	Member Responsibilities		
	If provider is participating		If provider is nonparticipating
Deductible (per benefit period, brand only)	\$250 per member \$500 per family		\$250 per member \$500 per family
	Retail Pharmacy (up to a 30 day supply)	Home Delivery (up to a 90 day supply)	Specialty Pharmacy (up to a 30 day supply)
<b>Prescription Drug Tier</b>			
Generic Preferred	\$4 copayment	\$8 copayment	\$95 copayment
Generic Nonpreferred	\$15 copayment	\$30 copayment	20% coinsurance up to \$350 per fill
Brand Preferred	\$45 copayment	\$90 copayment	\$95 copayment
Brand Nonpreferred	\$70 copayment	\$140 copayment	20% coinsurance up to \$350 per fill
<b>Contraceptives* (self-administered)</b>			
Generic	\$0 copayment	\$0 copayment	Not covered
Select Brands (no generic equivalent available)	\$0 copayment	\$0 copayment	Not covered
Brand Preferred	\$45 copayment	\$90 copayment	Not covered
Brand Nonpreferred	\$70 copayment	\$140 copayment	Not covered
<b>Additional Pharmacy Benefits/Details</b>			
Network (for Specialty Pharmacy information please refer to the Guide to Rx Benefits at <a href="http://www.capbluecross.com">www.capbluecross.com</a> )	Broad Plus		
Formulary	Advantage		
\$0 Preventive Rx Coverage	No charge		
Generic Substitution Program	Restrictive Generic Substitution – In addition to the coinsurance/ copayment, the member pays the difference between the brand and generic drug price (when there is a generic alternative) <u>unless</u> the physician requests the brand be dispensed.		
Extended Supply Network	Members have the ability to obtain covered drugs for up to a 90 day supply at participating retail pharmacies.		

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.  
 \*Certain preventive contraceptives are required to be covered at no cost to you when filled at a participating pharmacy with a valid prescription in accordance with Preventive Health Guidelines.

Participating providers and pharmacies agree to accept our allowance as payment in full—often less than their normal charge. If you visit a nonparticipating provider or pharmacy, you are responsible for paying the deductible, coinsurance and the difference between the nonparticipating provider's or nonparticipating pharmacy's charges and the allowed amount. Nonparticipating Providers may balance bill the member. Some nonparticipating facility providers are not covered. Deductibles, any differences paid between brand drug and generic drug prices, and any balances paid to nonparticipating pharmacies are not applied to the out-of-pocket maximum. 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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