**Document Assistant**
Ask Alexa "Open My Cap Blue Cross" and follow instructions

Capital

## BENEFIT HIGHLIGHTS

CapitalBlueCross.com

## PPO 3000 Gold Plan

## Flagger Force, LLC

**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) | $3,000 per member<br>$3,000 per family | $10,000 per member<br>$10,000 per family |
| **Coinsurance** (percentage you pay after your deductible is met) | No member coinsurance | 50% 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.) | $6,850 per member<br>$6,850 per family | $20,000 per member<br>$20,000 per family |
| **Office Visit / Urgent Care / Emergency Room Copayments** | | |
| **Virtual Care (non-specialist) Visits** – delivered via the Capital Blue Cross Virtual Care platform | Covered in full, waive deductible | Not covered |
| **Office Visits and Consultations (In-person & Telehealth) -** performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic | $20 copayment per visit | 50% coinsurance after deductible |
| **Specialist Office Visits (In-person, Telehealth & via the Capital Blue Cross Virtual Care platform)** | $40 copayment per visit | 50% coinsurance after deductible<br>Virtual Care – Not covered |
| **Urgent Care Services** | $50 copayment per visit | 50% coinsurance after deductible |
| **Emergency Room** | $250 copayment per visit, waived if admitted | |
| **Preventive Care** | | |
| **Pediatric and Adult Preventive Care** | No charge | 50% coinsurance after deductible |
| **Screening Gynecological Exam and Pap Smear** (one per benefit period) | No charge | 50% coinsurance, waive deductible |
| **Screening Mammogram** (one per benefit period) | No charge | 50% coinsurance, waive deductible |
| **Diagnostic Mammogram** | No charge after deductible | 50% coinsurance after deductible |
| **Facility / Surgical Services** | | |
| **Inpatient Hospital Room and Board** | No charge after deductible | 50% coinsurance after deductible |
| **Acute Inpatient Rehabilitation** (60 days per benefit period) | No charge after deductible | 50% coinsurance after deductible |
| **Skilled Nursing Facility** (100 days per benefit period) | No charge after deductible | 50% coinsurance after deductible |
| **Maternity Services and Newborn Care** | No charge after deductible | 50% coinsurance after deductible |
| **Surgical Procedure and Anesthesia** (professional charges) | No charge after deductible | 50% coinsurance after deductible |
| **Outpatient Surgery at Ambulatory Surgical Center** (facility charge only) | No charge after deductible | Not covered |
| **Outpatient Surgery at Acute Care Hospital** (facility charge only) | No charge after deductible | 50% coinsurance after deductible |
| **Diagnostic Services** | | |
| **Independent Radiology** | $75 copayment, waive deductible | 50% coinsurance after deductible |
| **Facility-Owned Radiology** | $75 copayment after deductible | 50% coinsurance after deductible |
| **Independent Laboratory** | $30 copayment, waive deductible | 50% coinsurance after deductible |
| **Facility-owned Laboratory** (i.e. Health System owned) | No charge after deductible | 50% coinsurance after deductible |
| **Therapy Services (Rehabilitative and Habilitative Services)** | | |
| **Physical Therapy** (30 visits per benefit period) | $40 copayment per visit | 50% coinsurance after deductible |
| **Occupational Therapy** (30 visits per benefit period) | $40 copayment per visit | 50% coinsurance after deductible |
| **Speech Therapy** (30 visits per benefit period) | $40 copayment per visit | 50% coinsurance after deductible |
| **Respiratory Therapy** (30 visits per benefit period) | $40 copayment per visit | 50% coinsurance after deductible |
| **Manipulation Therapy** (20 visits per benefit period) | $40 copayment per visit | 50% coinsurance after deductible |
| **Acupuncture** | Not covered | Not covered |
| **Mental Health (MH) and Substance Use Disorder Services (SUD)** | | |
| **MH Inpatient Services** | No charge after deductible | 50% coinsurance after deductible |
| **MH Outpatient Services** | $40 copayment per visit | 50% coinsurance after deductible |
| **SUD Detoxification Inpatient** | No charge after deductible | 50% coinsurance after deductible |
| **SUD Rehabilitation Outpatient** | $40 copayment per visit | 50% coinsurance after deductible |
| **Additional Services** | | |
| **Home Health Care Services** (90 visits per benefit period) | No charge after deductible | 50% coinsurance after deductible |
| **Durable Medical Equipment and Supplies** | No charge after deductible | 50% coinsurance after deductible |
| **Prosthetic Appliances** | No charge after deductible | 50% coinsurance after deductible |
| **Orthotic Devices** | No charge after deductible | 50% coinsurance after deductible |

**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 in-network** | **If provider is out-of-network** | |
| **Deductible** (per benefit period) | None | None | |
| | Retail Pharmacy (up to a 30 day supply) | Home Delivery (up to a 90 day supply) | Specialty Pharmacy (up to a 30 day supply) |
| **Prescription Drug Tier** | | | |
| Generic Preferred | $5 copayment | $10 copayment | $100 copayment |
| Generic Nonpreferred | $5 copayment | $10 copayment | $100 copayment |
| Brand Preferred | $35 copayment | $70 copayment | $100 copayment |
| Brand Nonpreferred | $70 copayment | $140 copayment | $100 copayment |
| **Contraceptives* (self-administered)** | | | |
| Generic | $0 copayment | $0 copayment | Not covered |
| Select Brands (no generic equivalent available) | $0 copayment | $0 copayment | Not covered |
| Brand Preferred | $35 copayment | $70 copayment | Not covered |
| Brand Nonpreferred | $70 copayment | $140 copayment | Not covered |
| **Additional Pharmacy Benefits/Details** | | | |
| **Network** (for Specialty Pharmacy information please refer to the Guide to Rx Benefits at CapitalBlueCross.com) | Broad Plus | | |
| **Formulary** | Value Plus | | |
| **$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) unless the physician requests the brand be dispensed. | | |

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 an in-network pharmacy with a valid prescription in accordance with Preventive Health Guidelines.

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