Capital BLUE

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BENEFIT HIGHLIGHTS

PPO Plan

Tamaqua Area School District

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 benefit 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)	$250 per member $500 per family	$500 per member $1,000 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 for in-network providers only.)	$3,000 per member $6,000 per family	$3,000 per member $6,000 per family
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist) Visits – delivered via The Capital BlueCross Virtual Care platform	$15 copayment per visit	Not covered
Virtual Care (specialist) Visits – delivered via The Capital BlueCross 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	$30 copayment per visit	20% coinsurance after deductible
Specialist Office Visits (In-person & Telehealth)	$30 copayment per visit	20% coinsurance after deductible
Urgent Care Services	$40 copayment per visit	20% coinsurance after deductible
Emergency Room	$100 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and Adult Preventive Care	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, waive deductible
Diagnostic Mammogram	No charge after deductible	20% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	No charge after deductible	50% coinsurance after deductible
Acute Inpatient Rehabilitation	No charge after deductible	50% coinsurance after deductible
Skilled Nursing Facility	No charge after deductible	50% coinsurance after deductible
Maternity Services and Newborn Care (professional charges)	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	50% coinsurance after deductible
Outpatient Surgery at Acute Care Hospital (facility charge only)	No charge after deductible	20% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	No charge after deductible	20% coinsurance after deductible
Radiology (other than high tech imaging)	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	$30 copayment per visit	20% coinsurance after deductible
Occupational Therapy	$30 copayment per visit	20% coinsurance after deductible
Speech Therapy	$30 copayment per visit	20% coinsurance after deductible
Respiratory Therapy	$30 copayment per visit	20% coinsurance after deductible
Manipulation Therapy (20 visits per benefit period)	$30 copayment per visit	Not covered
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	No charge after deductible	20% coinsurance and 50% facility coinsurance after deductible
MH Outpatient Services	$30 copayment per visit	20% coinsurance and 50% facility coinsurance after deductible
SUD Detoxification Inpatient	No charge after deductible	20% coinsurance and 50% facility coinsurance after deductible
SUD Rehabilitation Outpatient	$30 copayment per visit	20% coinsurance and 50% facility 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	20% coinsurance after deductible
Prosthetic Appliances	No charge after deductible	20% coinsurance after deductible
Orthotic Devices	No charge after deductible	20% coinsurance after deductible

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

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