Capital BLUE

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Benefit Highlights

CareConnect 350 Plan

Harrisburg Area Community College

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program 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 (COC). Refer to your COC for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:		
	PCP-Directed Care	***Self-Directed Care***	***Out-of-Network Care***
Deductible (per benefit period) **Deductible may be waived for certain services related to chronic condition management.**	$350 per member $700 per family	$500 per member $1,000 per family	$3,000 per member $6,000 per family
Copayments			
• **Office Visits** (*Family Practitioner, General Practitioner, Internist, Pediatrician)*	$25 copayment per visit	$25 copayment per visit	50% coinsurance
• **Specialist Office Visit**	$30 copayment per visit	$30 copayment per visit	50% coinsurance
• **Emergency Room**	$125 copayment per visit, waived if admitted		
• **Urgent Care**	$50 copayment per visit		
• **Inpatient** (Per Admission)	Not Applicable	10% coinsurance	50% coinsurance
• **Outpatient Surgery Copayment** (facility)	Not Applicable	10% coinsurance	50% coinsurance
• **High Tech Imaging**	Not Applicable	10% coinsurance	50% coinsurance
Coinsurance	Not Applicable	10% coinsurance	50% coinsurance
Coinsurance Out-of-Pocket Maximum (includes coinsurance amounts; when this amount is satisfied, no further coinsurance is applied).	Not Applicable	$1,500 per member $3,000 per family	$6,350 per member $12,700 per family
Maximum Out-of-Pocket Liability (includes deductible, copayments and coinsurance for medical (including ER), and prescription drug for participating providers only).	$6,350 per member $12,700 per family		Not Applicable

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:		
		PCP-Directed Care	***Self-Directed Care***	***Out-of-Network Care***
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*				
Preventive Care Services				
• Pediatric Preventive Care		Covered in full, waive deductible	Covered in full, waive deductible	50% coinsurance after deductible
• Adult Preventive Care		Covered in full, waive deductible	Covered in full, waive deductible	50% coinsurance after deductible
Immunizations		Covered in full, waive deductible	Covered in full, waive deductible	50% coinsurance, waive deductible
Mammograms				
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	Covered in full, waive deductible	50% coinsurance, waive deductible
• Diagnostic Mammogram		Covered in full after deductible	Covered in full after deductible	50% coinsurance after deductible
Gynecological Services				
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	Covered in full, waive deductible	50% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET				
Acute Care Hospital Room & Board		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Acute Inpatient Rehabilitation	60 days/benefit period	Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility	100 days/benefit period	Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Surgery				
• Surgical Procedure & Anesthesia		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Maternity Services and Newborn Care		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Diagnostic Services		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
• Radiology		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
• Laboratory		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
• Medical tests		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient Therapy Services				
• Physical Medicine	20 visits/benefit period	$30 copayment per visit	$30 copayment per visit	50% coinsurance after deductible
• Occupational Therapy	20 visits/benefit period	$30 copayment per visit	$30 copayment per visit	50% coinsurance after deductible
• Speech Therapy	12 visits/benefit period	$30 copayment per visit	$30 copayment per visit	50% coinsurance after deductible
• Respiratory Therapy	20 visits/benefit period	$30 copayment per visit	$30 copayment per visit	50% coinsurance after deductible
• Manipulation Therapy	20 visits/benefit period	$30 copayment per visit	$30 copayment per visit	50% coinsurance after deductible

SUMMARY OF BENEFITS (CONTINUED)	Limits and Maximums	Amounts Members Are Responsible For:		
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient		
Mental Health Care Services • Inpatient Services		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
• Outpatient Services		$30 copayment per visit	$30 copayment per visit	50% coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
• Rehabilitation – Outpatient		$30 copayment per visit	$30 copayment per visit	50% coinsurance after deductible
Home Health Care Services	90 visits/benefit period	Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Durable Medical Equipment (DME)		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Prosthetic Appliances		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Orthotic Devices		Covered in full after deductible	10% coinsurance after deductible	50% coinsurance after deductible

BENEFITS LISTED BELOW DO NOT APPLY BENEFIT PERIOD MEDICAL DEDUCTIBLE

PRESCRIPTION DRUG DEDUCTIBLE Per benefit period	**None**					
	Retail Pharmacy (up to a 30-day supply)		**Mail Service Pharmacy (up to a 90-day supply)**		**Specialty Pharmacy (up to a 30-day supply)**	
PRESCRIPTION DRUG TIER	**Copay**	**Healthy Rewards Copay**	**Copay**	**Healthy Rewards Copay**	**Copay**	**Healthy Rewards Copay**
Generic Preferred Prescription Drugs	$5 copay	$2.50 copay	$10 copay	$5 copay	$3.33 copay	N/A
Generic Non-Preferred Prescription Drugs	$5 copay	$2.50 copay	$10 copay	$5 copay	$3.33 copay	N/A
Brand Preferred Prescription Drugs	$40 copay	$20 copay	$80 copay	$40 copay	$26.67 copay	N/A
Brand Non-Preferred Prescription Drugs	$60 copay	$30 copay	$120 copay	$60 copay	$40 copay	N/A
Preventive Coverage	Covered in full, waive deductible					
Network	CVS Caremark National Pharmacy Network, Include Voluntary Maintenance Choice					
PRESCRIPTION DRUG TIER (Contraceptives)-Limited Coverage*	**BENEFIT**					
Generic Prescription Drugs	$0 copayment		$0 copayment		Not covered	
Select Brand Prescription Drugs**	$0 copayment		$0 copayment		Not covered	
Brand Preferred Prescription Drugs	$40 copay		$80 copay		Not covered	
Brand Non-Preferred Prescription Drugs	$60 copay		$120 copay		Not covered	
FORMULARY SYSTEM	Open					
UTILIZATION PROGRAM	**BENEFIT**					
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**.**					
Voluntary Maintenance Choice	The dispensing of maintenance covered drugs for up to a 90 day supply is available through Mail Service or at CVS Pharmacies					
Specialty Pharmacy	**For most specialty medications, coverage is available only when dispensed by Accredo Health Group, Inc.**					
Quantity Level Limits (per prescription, day supply or copayment)	**Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com.**					
Prior Authorization and Enhanced Prior Authorization	**Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com.**					

Benefits are underwritten by Capital Advantage Insurance 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.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

***Some** contraceptive services are not covered by this group contract. Members may receive contraceptive benefits directly from Capital BlueCross due to the Affordable Care Act's mandate on women's preventive services.

**Select Brands include contraceptives for which there is no generic equivalent.

Under CareConnect Select, you should designate a CareConnect primary care physician (PCP) from the list of PCPs in Capital's Provider Directory. The CareConnect Select program provides the highest level of coverage when care is provided or coordinated by your PCP. To locate a PCP or other participating provider, visit www.capbluecross.com.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered.

Refer to your Certificate of Coverage or contact your employer for the applicable benefit period.

This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. Please call the Customer Service number on the back of your identification card if you have any questions regarding your coverage.

On behalf of Capital BlueCross, CVS/Caremark assists in the administration of our prescription drug program. CVS/Caremark is an independent pharmacy benefit manager. Accredo Health Group, Inc. is the exclusive vendor for specialty prescription drugs. On behalf of Capital BlueCross, Accredo Health Group, Inc. assists in the delivery of specialty medications directly to our Members. Accredo Health Group, Inc. is an independent company.

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