Capital BLUE

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# *Benefit Highlights*
# *PPO $500 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: | |
|---|---|---|
| | ***Participating Providers*** | ***Non-Participating Providers*** |
| **Deductible** (per benefit period) | $500 per member<br>$1,000 per family | $1,000 per member<br>$1,500 per family |
| **Copayments** | | |
| • **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*) | $25 copayment per visit | 20% coinsurance |
| • **Specialist Office Visit** | $30 copayment per visit | 20% coinsurance |
| • **Emergency Room** | $125 copayment per visit, waived if admitted | |
| • **Urgent Care** | $50 copayment per visit | |
| • **Inpatient** (Per Admission) | Not Applicable | 20% coinsurance |
| • **Outpatient Surgery Copayment** (facility) | Not Applicable | 20% coinsurance |
| **Coinsurance** | Not Applicable | 20% coinsurance |
| **Out-of-Pocket Maximum** (includes Deductible, Copayments and Coinsurance for Medical (including ER), and Prescription Drug for Participating Providers only). | $6,350, per member<br>$12,700 per family | $3,000 per member<br>$6,000 per family |

| SUMMARY OF BENEFITS | Limits and Maximums | Amounts *Members* Are Responsible For: | |
|---|---|---|---|
| | | ***Participating Providers*** | ***Non-Participating Providers*** |
| **PREVENTIVE CARE:** *Administered in accordance with Preventive Health Guidelines and PA state mandates* | | | |
| **Preventive Care Services** | | | |
| • Pediatric Preventive Care | | Covered in full, waive deductible | 20% coinsurance after deductible |
| • Adult Preventive Care | | Covered in full, waive deductible | 20% coinsurance after deductible |
| **Immunizations** | | Covered in full, waive deductible | 20% coinsurance waive deductible |
| **Mammograms** | | | |
| • Screening Mammogram | One per benefit period | Covered in full, waive deductible | 20% coinsurance waive deductible |
| • Diagnostic Mammogram | | Covered in full after deductible | 20% coinsurance after deductible |
| **Gynecological Services** | | | |
| • Screening Gynecological Exam & Pap Smear | One per benefit period | Covered in full, waive deductible | 20% coinsurance after deductible |
| **BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET** | | | |
| **Acute Care Hospital Room & Board** | | Covered in full after deductible | 20% coinsurance after deductible |
| **Acute Inpatient Rehabilitation** | 60 days/benefit period | Covered in full after deductible | 20% coinsurance after deductible |
| **Skilled Nursing Facility** | 100 days/benefit period | Covered in full after deductible | 20% coinsurance after deductible |
| **Surgery** | | Covered in full after deductible | |
| • Surgical Procedure & Anesthesia | | Covered in full after deductible | 20% coinsurance after deductible |
| **Maternity Services and Newborn Care** | | Covered in full after deductible | 20% coinsurance after deductible |
| **Diagnostic Services** | | | |
| • Radiology | | Covered in full after deductible | 20% coinsurance after deductible |
| • Laboratory | | Covered in full after deductible | 20% coinsurance after deductible |
| • Medical tests | | Covered in full after deductible | 20% coinsurance after deductible |
| **Outpatient Surgery** | | Covered in full after deductible | 20% coinsurance after deductible |
| **Outpatient Therapy Services** | | | |
| • Physical Medicine | Unlimited visits/benefit period | $30 copayment per visit | 20% coinsurance after deductible |
| • Occupational Therapy | 12 visits/benefit period | $30 copayment per visit | 20% coinsurance after deductible |
| • Speech Therapy | 12 visits/benefit period | $30 copayment per visit | 20% coinsurance after deductible |
| • Respiratory Therapy | 30 visits/benefit period | $30 copayment per visit | 20% coinsurance after deductible |
| • Manipulation Therapy | Unlimited visits/benefit period | $30 copayment per visit | 20% coinsurance after deductible |
| **Emergency Services** | | Covered in full, waive deductible<br>Emergency room copayment applies, waived if admitted inpatient | |
| **Mental Health Care Services**<br>• Inpatient Services | | Covered in full after deductible | 20% coinsurance after deductible |
| • Outpatient Services | | $30 copayment per visit | 20% coinsurance after deductible |
| **Substance Abuse Services**<br>• Rehabilitation – Inpatient | | Covered in full after deductible | 20% coinsurance after deductible |
| • Rehabilitation – Outpatient | | $30 copayment per visit | 20% coinsurance after deductible |
| **Home Health Care Services** | 90 visits/benefit period | Covered in full after deductible | 20% coinsurance after deductible |
| **Durable Medical Equipment (DME)** | | Covered in full after deductible | 20% coinsurance after deductible |
| **Prosthetic Appliances** | | Covered in full after deductible | 20% coinsurance after deductible |
| **Orthotic Devices** | | Covered in full after deductible | 20% coinsurance after deductible |

***Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. Independent licensee of the BlueCross BlueShield Association.*** *Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.*

| SUMMARY OF BENEFITS | Amounts Members Are Responsible For: | | |
|---|---|---|---|
| **PRESCRIPTION DRUG DEDUCTIBLE**<br>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** | **BENEFIT** | | |
| Generic Preferred Prescription Drugs | $5 copayment | $10 copayment | $3.33 copayment |
| Generic Non-Preferred Prescription Drugs | $5 copayment | $10 copayment | $3.33 copayment |
| Brand Preferred Prescription Drugs | $40 copayment | $80 copayment | $26.67 copayment |
| Brand Non-Preferred Prescription Drugs | $60 copayment | $120 copayment | $40 copayment |
| **Lifestyle Prescription Drugs** | Same as above | | |
| **Network** | CVS Caremark National Pharmacy Network with Voluntary Maintenance Choice | | |
| **PRESCRIPTION DRUG TIER (Contraceptives)** | **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 copayment | $80 copayment | Not covered |
| Brand Non-Preferred Prescription Drugs | $60 copayment | $120 copayment | 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 drug and generic drug price (when there is a generic drug alternative) unless the prescribing physician requests that the brand drug 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.** | | |

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

*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.*

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

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

**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.**

For more information or to locate a participating provider, visit www.capbluecross.com.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size >51.