Shippensburg Area School District (Teachers)
Overview of PPO Qualified High Deductible Health Plan
Non-Grandfathered

BENEFIT	Qualified High Deductible Health Plan PPQSJ052/RXQSJ052 & PPQSJ053/RXQSJ053	
Summary of Cost Sharing	**Member Responsibilities**	
	In-Network	**Out-of-Network**
Benefit Period	January 1 - December 31	
Deductible (per benefit period) Deductible is combined to include medical & prescription drug benefits for in-network providers. If you enroll in a family plan, the overall family deductible must be met before the plan begins to pay.	$1,600 per member / $3,200 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 and prescription drug.	$3,000 per member $6,000 per family	$6,000 per member $12,000 per family
Office Visits / Urgent Care / Emergency Room Copayments		
Virtual Care Visits - delivered via the Capital BlueCross Virtual Care platform	No charge after deductible	Not covered
Office Visits & Consultations (In-person & Telehealth) performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	No charge after deductible	20% coinsurance after deductible
Specialist Office Visits (In-person & Telehealth)	No charge after deductible	20% coinsurance after deductible
Urgent Care Services	No charge after deductible	20% coinsurance after deductible
Emergency Room	No charge after deductible	
Preventive Care		
Pediatric & Adult Preventive Care	No charge waive deductible	20% coinsurance after deductible
Screening Gynecological Exam & 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 waive deductible	20% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room & 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 & Newborn Care	No charge after deductible	20% coinsurance after deductible
Surgical Procedure & Anesthesia (professional charges)	No charge after deductible	20% 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		
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 & Habilitative Services)		
Physical Therapy (25 visits per benefit period)	No charge after deductible	20% coinsurance after deductible
Occupational Therapy (12 visits per benefit period)	No charge after deductible	20% coinsurance after deductible
Speech Therapy (12 visits per benefit period)	No charge after deductible	20% coinsurance after deductible
Respiratory Therapy	No charge after deductible	20% coinsurance after deductible
Manipulation Therapy (25 visits per benefit period)	No charge after deductible	20% coinsurance after deductible
Acupuncture	Not covered	Not covered
Mental Health & Substance Use Disorder Services		
Mental Health Inpatient Services	No charge after deductible	20% professional, 50% facility coinsurance after deductible
Mental Health Outpatient Services	No charge after deductible	20% professional, 50% facility coinsurance after deductible
Substance Use Disorder Detoxification Inpatient	No charge after deductible	20% professional, 50% facility coinsurance after deductible
Substance Use Disorder Rehabilitation Outpatient	No charge after deductible	20% professional, 50% facility coinsurance after deductible
Additional Services		
Home Health Care Services (90 visits per benefit period)	No charge after deductible	20% coinsurance after deductible
Durable Medical Equipment	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

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Prescription Drug			
Highlights	**Member Responsibilities**		
	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)**
Deductible per benefit period* Deductible does not apply (copay applies) to preventive drugs listed on Capital's Rx Preventive Coverage List. However, copays apply. (Members can view the most current list by accessing the Capital BlueCross website at capbluecross.com)	Includes medical and prescription drug benefits		
Prescription Drug Tier			
Generic Preferred	$5 copayment after deductible	$10 copayment after deductible	$5 copayment after deductible
Generic Non-Preferred	$5 copayment after deductible	$10 copayment after deductible	$5 copayment after deductible
Brand Preferred	$10 copayment after deductible	$20 copayment after deductible	$20 copayment after deductible
Brand Non-Preferred	$25 copayment after deductible	$50 copayment after deductible	$35 copayment after deductible
Contraceptives (Self-Administered)			
Generic Preferred	$0 copayment after deductible	$0 copayment after deductible	Not covered
Select Brands (no generic equivalent available)	$0 copayment after deductible	$0 copayment after deductible	Not covered
Brand Preferred	$10 copayment after deductible	$20 copayment after deductible	Not covered
Brand Non-Preferred	$25 copayment after deductible	$50 copayment after deductible	Not covered
Additional Pharmacy Benefits/Details			
Network (for Specialty Pharmacy information please refer to the Guide to Rx Benefits at www.capbluecross.com)	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) unless the physician requests the brand be dispensed.		
Extended Supply Network (ESN)	Members have the ability to obtain covered drugs for up to a 90 day supply at in-network retail pharmacies.		

This is not a contract. Programs are subject to change. This information highlights benefits, limitations and exclusions of the prescription drug coverage and is not intended to be a complete list or complete description of available services. The terms and conditions of coverage shall be governed solely by the contract issued to the group. Contact your employer, marketing representative, or broker for additional benefit details.

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

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. *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.