

# Shippensburg Area School District (Support Staff)

## Overview of PPO High Deductible Health Plan Including HRA Non-Grandfathered

BENEFIT	PPO High Deductible Health Plan Including HRA PPOSJ061/RXRSJ061	
Summary of Cost Sharing	Member Responsibilities	
	In-Network	Out-of-Network
<b>Benefit Period</b>	January 1 - December 31	
<b>Deductible</b> (per benefit period) Deductible is combined to include medical & prescription drug benefits.	\$1,650 per member \$3,300 per family	\$3,300 per member \$6,600 per family
<b>Coinsurance</b> (percentage you pay after your deductible is met)	No member coinsurance	20% coinsurance
<b>Out-of-Pocket Maximum</b> 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		
<b>Virtual Care Visits</b> - delivered via the Capital BlueCross Virtual Care platform	\$10 PCP/ \$25 Specialist copayment per visit after deductible	Not covered
<b>Office Visits &amp; Consultations (In-person &amp; Telehealth)</b> performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	\$25 copayment per visit after deductible	20% coinsurance after deductible
<b>Specialist Office Visits (In-person &amp; Telehealth)</b>	\$25 copayment per visit after deductible	20% coinsurance after deductible
<b>Urgent Care Services</b>	\$35 copayment per visit after deductible	
<b>Emergency Room</b>	\$100 copayment per visit after deductible, waived if admitted	
Preventive Care		
<b>Pediatric &amp; Adult Preventive Care</b>	No charge waive deductible	20% coinsurance after deductible
<b>Screening Gynecological Exam &amp; Pap Smear</b> (One per benefit period)	No charge waive deductible	20% coinsurance waive deductible
<b>Screening Mammogram</b> (One per benefit period)	No charge waive deductible	20% coinsurance waive deductible
<b>Diagnostic Mammogram</b>	No charge after deductible	20% coinsurance after deductible
Facility / Surgical Services		
<b>Inpatient Hospital Room &amp; Board</b>	No charge after deductible	50% coinsurance after deductible
<b>Acute Inpatient Rehabilitation</b> (60 days per benefit period)	No charge after deductible	50% coinsurance after deductible
<b>Skilled Nursing Facility</b> (100 days per benefit period)	No charge after deductible	50% coinsurance after deductible
<b>Maternity Services &amp; Newborn Care</b>	No charge after deductible	20% coinsurance after deductible
<b>Surgical Procedure &amp; Anesthesia</b> (professional charges)	No charge after deductible	20% coinsurance after deductible
<b>Outpatient Surgery at Ambulatory Surgical Center</b> (facility charge only)	No charge after deductible	Not covered
<b>Outpatient Surgery at Acute Care Hospital</b> (facility charge only)	No charge after deductible	50% coinsurance after deductible
Diagnostic Services		
<b>High Tech Imaging</b> (such as MRI, CT, PET)	No charge after deductible	20% coinsurance after deductible
<b>Radiology</b> (other than high tech imaging)	No charge after deductible	20% coinsurance after deductible
<b>Independent Laboratory</b>	No charge after deductible	20% coinsurance after deductible
<b>Facility-Owned Laboratory</b> (i.e. Health System owned)	No charge after deductible	20% coinsurance after deductible
Therapy Services (Rehabilitative & Habilitative Services)		
<b>Physical Therapy</b> (25 visits per benefit period)	\$25 copayment per visit after deductible	20% coinsurance after deductible
<b>Occupational Therapy</b> (12 visits per benefit period)	\$25 copayment per visit after deductible	20% coinsurance after deductible
<b>Speech Therapy</b> (12 visits per benefit period)	\$25 copayment per visit after deductible	20% coinsurance after deductible
<b>Respiratory Therapy</b>	\$25 copayment per visit after deductible	20% coinsurance after deductible
<b>Manipulation Therapy</b> (25 visits per benefit period)	\$25 copayment per visit after deductible	20% coinsurance after deductible
<b>Acupuncture</b>	Not covered	Not covered
Mental Health & Substance Use Disorder Services		
<b>Mental Health Inpatient Services</b>	No charge after deductible	20% professional, 50% facility coinsurance after deductible
<b>Mental Health Outpatient Services</b>	\$25 copayment per visit after deductible	20% professional, 50% facility coinsurance after deductible
<b>Substance Use Disorder Detoxification Inpatient</b>	No charge after deductible	20% professional, 50% facility coinsurance after deductible
<b>Substance Use Disorder Rehabilitation Outpatient</b>	No charge after deductible	20% professional, 50% facility coinsurance after deductible

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<b>Additional Services</b>			
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	
<b>Prescription Drug</b>			
<b>Highlights</b>	<b>Member Responsibilities</b>		
	<b>Retail Pharmacy (up to a 30-day supply)</b>	<b>Mail Service Pharmacy (up to a 90-day supply)</b>	<b>Specialty Pharmacy (up to a 30-day supply)</b>
Deductible per benefit period	Includes medical and prescription drug benefits		
<b>Prescription Drug Tier</b>			
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
<b>Contraceptives (Self-Administered)</b>			
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
<b>Additional Pharmacy Benefits/Details</b>			
Network (for Specialty Pharmacy information please refer to the Guide to Rx Benefits at <a href="http://www.capbluecross.com">www.capbluecross.com</a> )	Broad Plus		
Formulary	Advantage		
\$0 Preventive Rx Coverage	No charge		
Generic Substitution Program	<b>Restrictive Generic Substitution</b> – In addition to the coinsurance/ copayment, the member pays the difference between the brand and generic drug price (when there is a generic alternative) <u>unless</u> 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.