## BENEFIT HIGHLIGHTS

CapitalBlueCross.com

## PPO Plan

## Berks County School Districts Health Trust

**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 Benefits Booklet for complete details.

**Important notice for fully insured individual and employer group plans in Pennsylvania: Advertised health insurance policies or programs may not cover all your healthcare expenses. Read your contract or benefit booklet (certificate of coverage) carefully to determine which healthcare services are covered. Questions? Please call 800.962.2242 or the number on the back of your ID card (TTY: 711).**

| YOUR MEDICAL PLAN SUMMARY OF COST SHARING | | |
|---|---|---|
| | **Member Responsibilities** | |
| | **If provider is in-network** | **If provider is out-of-network** |
| **Deductible** (per benefit period) | $700 per member<br>$1,400 per family | $1,400 per member<br>$2,800 per family |
| **Coinsurance** (Percentage you pay after your deductible is met.) | No member coinsurance | 20% coinsurance after deductible |
| **Out-of-pocket maximum** | Overall in-network out-of-pocket maximum includes deductible, copayments, and coinsurance for medical and prescription drugs:<br>$10,600 per member<br>$21,200 per family | Out-of-network medical coinsurance-only maximum:<br>$1,500 per member<br>$3,000 per family<br><br>Overall out-of-network out-of-pocket not applicable |
| **Office Visit / Urgent Care / Emergency Room Copayments** | | |
| **VirtualCare (non-specialist) visits**—delivered via the Capital Blue Cross VirtualCare platform | $5 copayment per visit | Not applicable |
| **Office visits and consultations (in-person & telehealth)**—performed by a family practitioner, general practitioner, internist, pediatrician network retail clinic or in-person | $15 copayment per visit | 20% coinsurance after deductible |
| **Specialist office visits** (in-person, telehealth & via the Capital Blue Cross VirtualCare platform) | $30 copayment per visit<br>VirtualCare - $10 copayment per visit | 20% coinsurance after deductible<br>VirtualCare–Not applicable |
| **Urgent care services** | $40 copayment per visit | |
| **Emergency room** | $100 copayment per visit, waived if admitted | |
| **Preventive Care** | | |
| **Pediatric and adult preventive care** | No charge, deductible waived | 20% coinsurance after deductible |
| **Screening gynecological exam and pap smear** | No charge, deductible waived | 20% coinsurance, deductible waived |
| **Screening mammogram** | No charge, deductible waived | 20% coinsurance, deductible waived |
| **Facility / Surgical Services** | | |
| **Inpatient hospital room and board including maternity services and newborn care** | No charge after deductible | 20% coinsurance after deductible |
| **Acute inpatient rehabilitation** | No charge after deductible | 20% coinsurance after deductible |
| **Skilled nursing facility** (100 days per benefit period) | 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 | Not covered |
| **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, deductible waived | 20% coinsurance after deductible |
| **Facility-owned laboratory** (i.e. Health System owned) | No charge after deductible | 20% coinsurance after deductible |
| **Diagnostic mammogram** | 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** (12 visits per benefit period) | $30 copayment per visit | 20% coinsurance after deductible |
| **Speech therapy** (12 visits per benefit period) | $30 copayment per visit | 20% coinsurance after deductible |
| **Respiratory therapy** | $30 copayment per visit | 20% coinsurance after deductible |
| **Manipulation therapy** | $30 copayment per visit | 20% coinsurance after deductible |
| **Mental Health (MH) and Substance Use Disorder Services (SUD)** | | |
| **MH & SUD detoxification inpatient services** | No charge after deductible | 20% coinsurance after deductible |
| **MH rehabilitation outpatient services** | $30 copayment per visit | 20% coinsurance after deductible |
| **SUD rehabilitation outpatient services** | No charge, deductible waived | 20% coinsurance after deductible |
| **Additional Services** | | |
| **Home healthcare services** | No charge after deductible | 20% coinsurance after deductible |

| | | |
|---|---|---|
| **Durable medical equipment and supplies; prosthetic appliances and orthotic devices** | No charge after deductible | 20% coinsurance after deductible |

*Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital Blue Cross. An independent licensee of the Blue Cross Blue Shield Association.*

## COST SHARING FOR PRESCRIPTION DRUGS DOES NOT APPLY TO THE MEDICAL DEDUCTIBLE SHOWN ON PAGE ONE

### YOUR PRESCRIPTION DRUG SUMMARY OF COST-SHARING

| | Member Responsibilities | | |
|---|---|---|---|
| | **If provider is in-network** | **If provider is out-of-network** | |
| **Deductible** (per benefit period) | $200 per member (Retail & Specialty) | Not covered | |
| | Retail pharmacy (up to a 30-day supply) | Home delivery/Extended supply network (ESN) (up to a 90-day supply) | Specialty pharmacy (up to a 30-day supply) |
| **Prescription drug tier** | | | |
| Generic preferred | $5 copayment | $10 copayment | $5 copayment |
| Generic nonpreferred | $5 copayment | $10 copayment | $5 copayment |
| Brand preferred | $35 copayment | $70 copayment | $35 copayment |
| Brand nonpreferred | $70 copayment | $140 copayment | $70 copayment |
| **Contraceptives* (self-administered)** | | | |
| Generic | $0 copayment | $0 copayment | Not covered |
| Select brands (no generic equivalent available) | $0 copayment | $0 copayment | Not covered |
| Brand preferred | $35 copayment | $70 copayment | Not covered |
| Brand nonpreferred | $70 copayment | $140 copayment | Not covered |
| **Additional pharmacy benefits/details** | | | |
| **Network** (for specialty pharmacy information please refer to the guide to Rx benefits at CapitalBlueCross.com) | Broad Plus | | |
| **Formulary** | Advantage | | |
| **$0 preventive Rx coverage** | No charge | | |
| **Weight Loss Drugs** | Not covered | | |
| **Generic substitution program** | Voluntary generic substitution program—The member pays the applicable copayment/coinsurance for a generic drug and for a brand drug, even if an approved generic drug equivalent is available and regardless of whether the physician or member requested such brand drug 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. | | |

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.

*Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.*