

Medical & Prescription Benefits
PPO 750 Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-802-4711. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$750 individual / \$1,500 two party and \$2,250 family Out-of-Network: \$1,500 individual / \$3,000 two party and \$4,500 family RX: \$0/individual or \$0/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan ?	Maximum Out-of-Pocket-Limit : Medical: In Network: \$6,600 / individual \$13,200 / family; Out of Network: \$8,150 / individual \$16,300 / family RX: In Network: \$4,350 / individual \$8,700 / family	This out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in the plan , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit ?	Copayments , deductibles , premiums , balance-billed charges , and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket-limit .
Will you pay less if you use a network provider ?	Yes. See www.capbluecross.com or call 1-800-962-2242 for a list of network providers	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	20% coinsurance	You may have to pay for services that are preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	\$50 copay/visit	20% coinsurance	
	Preventive care/screening/immunization	No charge	20% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	\$75 copay/visit	20% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-800-552-8159.	Generic drugs (Tier 1)	\$20 copay/retail \$40 copay/mail order	Not covered	Up to 30-day supply retail pharmacy.
	Preferred brand drugs (Tier 2)	\$40 copay/retail \$80 copay/mail order	Not covered	Up to 90-day supply maintenance prescription drugs through mail order.
	Non-preferred brand drugs (Tier 3)	\$80 copay/retail \$160 copay/mail order	Not covered	Select Specialty Drugs are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$30 copay/visit; not subject to deductible	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	\$180 copay/visit	\$180 copay/visit	Copay waived if admitted as inpatient. Deductible does not apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	No charge	No charge	Deductible does not apply.
	Urgent care	\$75 copay/visit	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 copay/visit	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental Health, \$50 copayment ; Substance Abuse, covered in full, waive deductible .	20% coinsurance	Precertification may be required.
	Inpatient services	\$200 copay/visit	50% coinsurance	
If you are pregnant	Office visits	\$50 copay/for the 1 st initial visit	20% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	\$200 copay / per admission	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Precertification may be required
	Rehabilitation services	\$50 copay/visit	20% coinsurance	Combined network and out-of-network: unlimited physical therapy and chiropractic visits. 10 speech therapy and 10 occupational therapy visits per benefit period.
	Habilitation services	\$50 copay/visit	Not covered	
	Skilled nursing care	\$200 copay / per admission	20% coinsurance	Precertification may be required.
	Durable medical equipment	No charge	20% coinsurance	Precertification may be required.
	Hospice services	No charge	30% coinsurance	Precertification may be required.
	Children's eye exam	Not covered	Not covered	-----none-----

If your child needs dental or eye care	Children's glasses	Not covered	Not covered	-----none-----
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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic Surgery • Dental care (Adult) • Hearing Aids | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S • Private Duty Nursing | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight Loss Programs |
|--|---|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|----------------------------|---------------------|-------------------------|
| • Autism Spectrum Disorder | • Bariatric Surgery | • Infertility Treatment |
|----------------------------|---------------------|-------------------------|

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Carbon Career & Technical Institute at 570-325-8580 or www.carboncti.org. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

To access our Language helpline, please call the Customer Service toll free number on the back of your medical and/or prescription identification card.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$750
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,800
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$950

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$750
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$7,400
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$750
Copayments (Primary Care \$25)	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$950

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$750
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$1,900
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$750
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$1,260

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

BENEFIT HIGHLIGHTS

CapitalBlueCross.com



PPO 750 ER \$180

Saucon Valley School District

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.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is in-network	If provider is out-of-network
Deductible (per benefit period)	\$750 per member \$1,500 2-party \$2,250 per family	\$1,500 per member \$3,000 2-party \$4,500 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: \$6,600 per member \$13,200 2-party \$13,200 per family	Out-of-network medical coinsurance-only maximum: \$8,150 per member \$16,300 2-party \$16,300 per family Overall out-of-network out-of-pocket not applicable
Office Visit / Urgent Care / Emergency Room Copayments		
Office visits and consultations (in-person & telehealth)—performed by a family practitioner, general practitioner, internist, pediatrician network retail clinic or in-person	\$25 copayment per visit	20% coinsurance after deductible
Specialist office visits (in-person, telehealth & via Capital Blue Cross VirtualCare)	\$50 copayment per visit	20% coinsurance after deductible
Urgent care services	\$75 copayment per visit	20% coinsurance after deductible
Emergency room	\$180 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	\$200 copayment per admission	20% coinsurance after deductible
Acute inpatient rehabilitation (60 days per benefit period)	\$200 copayment per admission	20% coinsurance after deductible
Skilled nursing facility	\$200 copayment per admission	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)	\$30 copayment per visit	Not covered
Outpatient surgery at acute care hospital (facility charge only)	\$30 copayment per visit	20% coinsurance after deductible
Diagnostic Services		
High tech imaging (such as MRI, CT, PET)	\$75 copayment 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
Diagnostic mammogram	No charge after deductible	20% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical therapy	\$50 copayment per visit	20% coinsurance after deductible
Occupational therapy (10 visits per benefit period)	\$50 copayment per visit	20% coinsurance after deductible
Speech therapy (10 visits per benefit period)	\$50 copayment per visit	20% coinsurance after deductible
Respiratory therapy	\$50 copayment per visit	20% coinsurance after deductible
Manipulation therapy	\$50 copayment per visit	20% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH & SUD detoxification inpatient services	\$200 copayment per admission	20% coinsurance after deductible
MH rehabilitation outpatient services	\$50 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.

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. In-network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider's charges and the allowed amount. Out-of-network providers may balance bill the member. Some out-of-network facility providers are not covered. 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.



Prescription Services		
For questions regarding prescription coverage, please contact CVS Health at 800-552-8159.	Member Responsibilities	
	If provider is in-network	If provider is out-of-network
Deductible (per benefit period)	\$0 per member \$0 per family	No out of network coverage available Global coverage is available on an as needed emergency basis.
Coinsurance	No member 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 prescription drug, for in-network providers only.)	\$4,350 per member \$8,700 per 2-party \$8,700 per family	
Retail – up to 30-day supply*		
Generic	\$20 copayment	
Preferred Brand	\$40 copayment	
Non-Preferred Brand	\$80 copayment	
Mail Order – up to 90-day supply*		
Generic	\$40 copayment	
Preferred Brand	\$80 copayment	
Non-Preferred Brand	\$160 copayment	

*Specialty Drugs are limited to a 31-day supply.