

BENEFIT HIGHLIGHTS

CapitalBlueCross.com



HSA 1700 P PLAN

Chambersburg Area 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) Deductible is combined to include medical and 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.	\$1,700 single coverage \$3,400 family coverage	
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: \$3,000 single coverage \$6,000 family coverage	Out-of-network medical coinsurance-only maximum: \$4,000 per member with an embedded amount of \$3,600 \$8,000 family coverage 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	No charge after deductible	Not applicable
Office visits and 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 & via the Capital Blue Cross VirtualCare platform)	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 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	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
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 after deductible	20% coinsurance after deductible
Facility-owned laboratory (i.e. Health System owned)	No charge after deductible	50% coinsurance after deductible
Diagnostic mammogram	No charge after deductible	20% coinsurance after deductible
Therapy Services (Rehabilitative and 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
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH & SUD detoxification inpatient services	No charge after deductible	50% coinsurance after deductible
MH & SUD rehabilitation outpatient services	No charge after deductible	20% coinsurance after deductible
Additional Services		
Home healthcare services (90 visits per benefit period)	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.

YOUR PRESCRIPTION DRUG SUMMARY OF COST-SHARING

	Member Responsibilities		
	If provider is in-network	If provider is out-of-network	
Deductible (includes medical and prescription drug benefits for in-network providers)	\$1,700 single coverage \$3,400 family coverage	Not covered	
	Retail pharmacy (up to a 30-day supply)	Home delivery (up to a 90-day supply)	Specialty pharmacy (up to a 30-day supply)
Prescription drug tier			
Generic preferred	\$5 copayment after deductible	\$10 copayment after deductible	\$5 copayment after deductible
Generic nonpreferred	\$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 nonpreferred	\$25 copayment after deductible	\$50 copayment after deductible	\$35 copayment after deductible
Contraceptives* (self-administered)			
Generic	\$0 copayment	\$0 copayment	Not covered
Select brands (no generic equivalent available)	\$0 copayment	\$0 copayment	Not covered
Brand preferred	\$10 copayment after deductible	\$20 copayment after deductible	Not covered
Brand nonpreferred	\$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 CapitalBlueCross.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) <u>unless</u> the physician requests the brand be dispensed.		

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.

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