## BENEFIT HIGHLIGHTS

CapitalBlueCross.com

## QHDHP PPO PLAN

## Pennsylvania State Employees Credit Union

**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<br>$3,400 family coverage | $3,000 single coverage<br>$6,000 family coverage |
| **Coinsurance** (Percentage you pay after your deductible is met) | No member coinsurance | 30% 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>$6,750 per member<br>$13,500 per family | Out-of-network medical coinsurance-only maximum:<br>$6,750 per member<br>$13,500 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 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 | $20 copayment per visit after deductible | 30% coinsurance after deductible |
| **Specialist office visits** (in-person, telehealth & via the Capital Blue Cross VirtualCare platform) | $30 copayment per visit after deductible | 30% coinsurance after deductible<br>VirtualCare–Not applicable |
| **Urgent care services** | $50 copayment per visit after deductible | 30% coinsurance after deductible |
| **Emergency room** | $100 copayment per visit after deductible, waived if admitted | |
| **Preventive Care** | | |
| **Pediatric and adult preventive care** | No charge, deductible waived | 30% coinsurance after deductible |
| **Screening gynecological exam and pap smear** | No charge, deductible waived | 30% coinsurance, deductible waived |
| **Screening mammogram** | No charge, deductible waived | 30% 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 | 30% 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 | 30% coinsurance after deductible |
| **Diagnostic Services** | | |
| **High tech imaging** (such as MRI, CT, PET) | No charge after deductible | 30% coinsurance after deductible |
| **Radiology** (other than high tech imaging) | No charge after deductible | 30% coinsurance after deductible |
| **Independent laboratory** | No charge after deductible | 30% coinsurance after deductible |
| **Facility-owned laboratory** (i.e. Health System owned) | No charge after deductible | 30% coinsurance after deductible |
| **Diagnostic mammogram** | No charge after deductible | 30% coinsurance after deductible |
| **Therapy Services (Rehabilitative and Habilitative Services)** | | |
| **Physical therapy** (30 visits per benefit period) | $30 copayment after deductible | 30% coinsurance after deductible |
| **Occupational therapy** (30 visits per benefit period) | $30 copayment after deductible | 30% coinsurance after deductible |
| **Speech therapy** (30 visits per benefit period) | $30 copayment after deductible | 30% coinsurance after deductible |
| **Respiratory therapy** (30 visits per benefit period) | $30 copayment after deductible | 30% coinsurance after deductible |
| **Manipulation therapy** (20 visits per benefit period) | $30 copayment after deductible | 30% coinsurance after deductible |
| **Acupuncture** (15 visits per benefit period) | $30 copayment after deductible | 30% coinsurance after deductible |
| **Mental Health (MH) and Substance Use Disorder Services (SUD)** | | |
| **MH & SUD detoxification inpatient services** | No charge after deductible | 30% coinsurance after deductible |
| **MH & SUD rehabilitation outpatient services** | $30 copayment after deductible | 30% coinsurance after deductible |
| **Additional Services** | | |
| **Home healthcare services** (90 visits per benefit period) | No charge after deductible | 30% coinsurance after deductible |
| **Durable medical equipment and supplies; prosthetic appliances and orthotic devices** | No charge after deductible | 30% coinsurance after deductible |

| 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<br>$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 | 2% coinsurance ($50 minimum to $150 maximum) |
| Generic nonpreferred | $5 copayment after deductible | $10 copayment after deductible | 2% coinsurance ($50 minimum to $150 maximum) |
| Brand preferred | $35 copayment after deductible | $70 copayment after deductible | 2% coinsurance ($50 minimum to $150 maximum) |
| Brand nonpreferred | $50 copayment after deductible | $100 copayment after deductible | 2% coinsurance ($50 minimum to $150 maximum) |
| **Diabetic Supplies** | | | |
| Generic preferred/ Generic Nonpreferred | No charge | No charge | 2% coinsurance ($50 minimum to $150 maximum) |
| Brand Preferred | $17.50 copayment | $35 copayment | 2% coinsurance ($50 minimum to $150 maximum) |
| **Value- Based Benefit Program (VBB), Subscriber Only- Enhanced Rx for certain condition management drugs** | | | |
| | No charge | No charge | 2% coinsurance ($50 minimum to $150 maximum) |
| **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 after deductible | $70 copayment after deductible | Not covered |
| Brand nonpreferred | $50 copayment after deductible | $100 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) unless the physician requests the brand be dispensed. | | |
| **90DayMyWay** | Members can choose to fill their maintenance medicines through home delivery or at an in-network extended supply network (ESN) retail pharmacy. | | |

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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