Capital BLUE

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Benefit Highlights
PPO Plan
Northampton Area School District
Teachers and Police Officer Plan G
Effective 1/1/20

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program 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 Certificate of Coverage (COC). Refer to your COC for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:	
	Participating Providers	***Nonparticipating Providers***
Deductible (per benefit period)	$550 per member $850 per family	$1,000 per member $2,000 per family
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$25 copayment per visit	20% coinsurance after deductible
• **Virtual Visits** (*performed through the CBC Virtual Care platform or an approved virtual visit participating provider*)	$15 copayment per visit	Not Covered
• **Specialist Office Visit**	$25 copayment per visit	20% coinsurance after deductible
• **Emergency Room**	$100 copayment per visit, waived if admitted	
• **Urgent Care**	$45 copayment per visit	
• **Inpatient** (Per Admission)	Not Applicable	50% coinsurance after deductible
• **Outpatient Surgery Copayment** (facility)	Not Applicable	50% coinsurance after deductible
Coinsurance	Not Applicable	20% coinsurance after deductible
Out-of-Pocket Maximum *(includes Deductible, Copayments and Coinsurance for Medical (including ER)* for Participating Providers only).	$4,075 per member $8,150 per family	$6,000 per member $12,000 per family

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	***Nonparticipating Providers***
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full, waive deductible	20% coinsurance after deductible
• Adult Preventive Care		Covered in full, waive deductible	20% coinsurance after deductible
Immunizations		Covered in full, waive deductible	20% coinsurance, waive deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	20% coinsurance, waive deductible
• Diagnostic Mammogram		Covered in full after deductible	20% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	20% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board	120 days per disability	Covered in full after deductible	50% coinsurance after deductible
Acute Inpatient Rehabilitation	120 days/benefit period	Covered in full after deductible	50% coinsurance after deductible
Skilled Nursing Facility	360 days per disability	Covered in full after deductible	50% coinsurance after deductible
Surgery			
• Surgical Procedure & Anesthesia		Covered in full after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care		Covered in full after deductible	20% coinsurance after deductible
Diagnostic Services			
• Radiology		Covered in full after deductible	20% coinsurance after deductible
• Independent Laboratory		Covered in full, waive deductible	20% coinsurance after deductible
• Medical tests		Covered in full after deductible	20% coinsurance after deductible
Outpatient Surgery		Covered in full after deductible	20% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine		Copayment applies	20% coinsurance after deductible
• Occupational Therapy		Copayment applies	20% coinsurance after deductible
• Speech Therapy		Copayment applies	20% coinsurance after deductible
• Respiratory Therapy		Covered in full, waive deductible	20% coinsurance after deductible
• Manipulation Therapy	30 visits/benefit period	Copayment applies	20% coinsurance after deductible
• Acupuncture		Not Covered	Not Covered
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
Mental Health Care Services • Inpatient Services	120 days per disability	Covered in full after deductible	20% coinsurance after deductible
• Outpatient Services		Copayment applies	20% coinsurance after deductible
Substance Use Disorder Services • Rehabilitation – Inpatient	120 days per disability	Covered in full after deductible	20% professional and 50% facility coinsurance after deductible
• Rehabilitation – Outpatient		Copayment applies	20% professional and 50% facility coinsurance after deductible
Home Health Care Services	90 visits/benefit period	Covered in full after deductible	50% coinsurance after deductible
Durable Medical Equipment (DME)		Covered in full after deductible	20% coinsurance after deductible
Prosthetic Appliances		Covered in full after deductible	20% coinsurance after deductible
Orthotic Devices		Covered in full after deductible	20% coinsurance after deductible

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