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BENEFIT HIGHLIGHTS

CapitalBlueCross.com

PPO 375 Plan

City of Easton – Police

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)	$375 per member $625 per family	$500 per member $1,000 per family
Coinsurance (percentage you pay after your deductible is met)	No member coinsurance	20% coinsurance
Coinsurance Out-of-Pocket Maximum (includes coinsurance amounts; when this amount is satisfied, no further coinsurance is applied).	None	$2,000 per member $6,000 per family.
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 medical including ER and prescription drug, for in-network providers only.)	$6,850 per member $13,700 per family	Not Applicable
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist) Visits – delivered via the Capital Blue Cross Virtual Care platform	$25 copayment per visit $30 copayment per visit/Specialist	Not covered
Office Visit Plus – Total Care	$25 copayment per visit	20% coinsurance after deductible
Office Visits and Consultations (In-person & Telehealth) - performed by a family practitioner, general practitioner, internist, pediatrician network retail clinic or in-	$25 copayment per visit	20% coinsurance after deductible
Specialist Office Visits (In-person, Telehealth & via the Capital Blue Cross Virtual Care platform)	$30 copayment per visit	20% coinsurance after deductible Virtual Care – Not covered
Urgent Care Services	$50 copayment per visit	20% coinsurance after deductible
Emergency Room	$100 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and Adult Preventive Care	No charge	20% coinsurance after deductible
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge	20% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge	20% coinsurance, waive deductible
Diagnostic Mammogram	No charge after deductible	20% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	No charge after deductible	20% coinsurance after deductible
Acute Inpatient Rehabilitation (60 days per benefit period)	No charge after deductible	20% coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	No charge after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care	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 after deductible	20% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	No charge after deductible	20% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (30 visits per benefit period)	$30 copayment per visit	20% coinsurance after deductible
Occupational Therapy (30 visits per benefit period)	$30 copayment per visit	20% coinsurance after deductible
Speech Therapy (30 visits per benefit period)	$30 copayment per visit	20% coinsurance after deductible
Respiratory Therapy	No charge after deductible	20% coinsurance after deductible
Manipulation Therapy (20 visits per benefit period)	$30 copayment per visit	20% coinsurance after deductible
Acupuncture	Not Covered	Not Covered
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	No charge after deductible	20% coinsurance after deductible
MH Outpatient Services	$30 copayment per visit	20% coinsurance after deductible
SUD Detoxification Inpatient	No charge after deductible	20% coinsurance after deductible
SUD Rehabilitation Outpatient	$30 copayment per visit	20% coinsurance after deductible
Additional Services		
Home Health Care Services (100 visits per benefit period)	No charge after deductible	20% coinsurance after deductible
Durable Medical Equipment and Supplies	No charge after deductible	20% coinsurance after deductible
Prosthetic Appliances	No charge after deductible	20% coinsurance after deductible

Orthotic Devices	No charge after deductible	20% coinsurance after deductible

COST SHARING FOR PRESCRIPTION DRUGS DOES NOT APPLY TO THE MEDICAL DEDUCTIBLE SHOWN ON PAGE 1

YOUR PRESCRIPTION DRUG SUMMARY OF COST-SHARING

	Member Responsibilities		
	If provider is in-network	**If provider is out-of-network**	
Deductible (per benefit period)	Not Applicable		
	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	Not Applicable	Not Applicable	Not Applicable
Generic Non-preferred	Not Applicable	Not Applicable	Not Applicable
Brand Preferred	Not Applicable	Not Applicable	Not Applicable
Brand Non-preferred	Not Applicable	Not Applicable	Not Applicable
Contraceptives* (self-administered)			
Generic	Not Applicable	Not Applicable	Not Applicable
Select Brands (no generic equivalent available)	Not Applicable	Not Applicable	Not Applicable
Brand Preferred	Not Applicable	Not Applicable	Not Applicable
Brand Non-preferred	Not Applicable	Not Applicable	Not Applicable
Additional Pharmacy Benefits/Details			
Network (for Specialty Pharmacy information please refer to the Guide to Rx Benefits at CapitalBlueCross.com)	Not Applicable		
Formulary	Not Applicable		

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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BENEFIT HIGHLIGHTS

CapitalBlueCross.com

QHDHP PPO 2000 PLAN

City of Easton - Police

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.	$2,000 single coverage $4,000 family coverage	$4,000 single coverage $8,000 family coverage
Coinsurance (percentage you pay after your deductible is met)	10% coinsurance	20% coinsurance
Coinsurance Out-of-Pocket Maximum (includes coinsurance amounts; when this amount is satisfied, no further coinsurance is applied)	Not Applicable	$2,000 per member $6,000 per family
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 medical including ER and prescription drug for in-network providers only.)	$3,000 single coverage $6,000 family coverage	Not Applicable
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist) Visits – delivered via the Capital Blue Cross Virtual Care platform	10% coinsurance after deductible	Not covered
Office Visits and Consultations (In-person & Telehealth) - performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	10% coinsurance after deductible	20% coinsurance after deductible
Specialist Office Visits (In-person, Telehealth & via the Capital Blue Cross Virtual Care platform)	10% coinsurance after deductible	20% coinsurance after deductible
Urgent Care Services	10% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	10% coinsurance after deductible	
Preventive Care		
Pediatric and Adult Preventive Care	No charge, waive deductible	20% coinsurance after deductible
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge, waive deductible	20% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge, waive deductible	20% coinsurance, waive deductible
Diagnostic Mammogram	10% coinsurance after deductible	20% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	10% coinsurance after deductible	20% coinsurance after deductible
Acute Inpatient Rehabilitation (60 days per benefit period)	10% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	10% coinsurance after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care	10% coinsurance after deductible	20% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	10% coinsurance after deductible	Not covered
Outpatient Surgery at Acute Care Hospital (facility charge only)	10% coinsurance after deductible	20% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	10% coinsurance after deductible	20% coinsurance after deductible
Radiology (other than high tech imaging)	10% coinsurance after deductible	20% coinsurance after deductible
Independent Laboratory	10% coinsurance after deductible	20% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	10% coinsurance after deductible	20% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (30 visits per benefit period)	10% coinsurance after deductible	20% coinsurance after deductible
Occupational Therapy (30 visits per benefit period)	10% coinsurance after deductible	20% coinsurance after deductible
Speech Therapy (30 visits per benefit period)	10% coinsurance after deductible	20% coinsurance after deductible
Respiratory Therapy (Unlimited visits per benefit period)	10% coinsurance after deductible	20% coinsurance after deductible
Manipulation Therapy (20 visits per benefit period)	10% coinsurance after deductible	20% coinsurance after deductible
Acupuncture (15 visits per benefit period)	Not Covered	Not Covered
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	10% coinsurance after deductible	20% coinsurance after deductible
MH Outpatient Services	10% coinsurance after deductible	20% coinsurance after deductible
SUD Detoxification Inpatient	10% coinsurance after deductible	20% coinsurance after deductible
SUD Rehabilitation Outpatient	10% coinsurance after deductible	20% coinsurance after deductible
Additional Services		

Home Health Care Services (100 visits per benefit period)	10% coinsurance after deductible	20% coinsurance after deductible
Durable Medical Equipment and Supplies	10% coinsurance after deductible	20% coinsurance after deductible
Prosthetic Appliances	10% coinsurance after deductible	20% coinsurance after deductible
Orthotic Devices	10% coinsurance 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)	Not Applicable		Not Applicable
	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	Not Applicable	Not Applicable	Not Applicable
Generic Non-preferred	Not Applicable	Not Applicable	Not Applicable
Brand Preferred	Not Applicable	Not Applicable	Not Applicable
Brand Non-preferred	Not Applicable	Not Applicable	Not Applicable
Contraceptives* (self-administered)			
Generic	Not Applicable	Not Applicable	Not Applicable
Select Brands (no generic equivalent available)	Not Applicable	Not Applicable	Not Applicable
Brand Preferred	Not Applicable	Not Applicable	Not Applicable
Brand Non-preferred	Not Applicable	Not Applicable	Not Applicable
Additional Pharmacy Benefits/Details			
Network (for Specialty Pharmacy information please refer to the Guide to Rx Benefits at CapitalBlueCross.com)	Not Applicable		
Formulary	Not Applicable		

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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Capital Blue Cross Vision
Vision Plan 1

CITY OF EASTON

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.

HIGHLIGHTS	PLAN ALLOWANCES	
Benefit frequencies are based on date of service	**In-network Providers**	**Out-of-network Providers**
EXAMINATION Once every 12 months for Employees	100%	$32
FRAMES [1] Once every 12 months for Employees	$200 plus 30% off the retail balance[2]	$200
EYEGLASS LENSES (per pair)[1 & 3] Once every 12 months for Employees		
Single Vision Standard Lenses	100%	$25
Bifocal Standard Lenses	100%	$36
Trifocal Standard Lenses	100%	$46
Aphakic/Lenticular Standard Lenses	100%	$72
Polycarbonate Standard Lenses (under age 19)	100%	Not covered
Polycarbonate Standard Lenses adults – Copayment is waived for monocular patients and patients with prescriptions +/-6.00 diopters or greater. Prior approval required.	$30 copay	Not covered
Tint (Solid & Gradient)	$11 copay	Not covered
Standard Anti-reflective Coating	$35 copay	Not covered
Premium Anti-reflective Coating	$48 copay	Not covered
Ultra Anti-Reflective Coating	$60 copay	Not covered
Premium Progressive Lenses [5]	$90 copay	Not covered
Ultra Progressive Lenses [5]	$140 copay	Not Covered
Intermediate Vision Lenses	$30 copay	Not covered
Transitions	$65 copay	Not covered
Oversized Lenses	100%	Not covered
Scratch protection plan (single/multifocal lenses)[7]	$20/$40 copay	Not covered
CONTACT LENSES[1 & 3] Once every 12 months for Employees		
Disposable (unlimited boxes)	$200, plus 25% off the retail balance [2 & 4]	$200
Conventional including, but not limited to: Hard/soft daily wear and spherical	$200, plus 25% off the retail balance [2 & 4]	$200
Specialty lenses including but not limited to: Bifocal, toric or gas permeable	$200, plus 25% off the retail balance [2 & 4]	$200
Medically necessary (per pair) (Prior approval required)	100%	$225
CONTACT LENS FITTING & FOLLOW UP Once every 12 months for Employees		
Daily wear	100%	$20
Extended wear	100%	$30
Specialty	100%	Not covered

[1] Walmart/Sam's Club: To maintain comparable values with Walmart's pricing structure, your frame allowance will be 50% of the allowance shown above with no additional retail discounts. Your contact lens allowance will be 75% of the allowance shown above with no additional retail discount. Walmart/Sam's Club stores accept BlueCross Vision for materials, not Lens Options. Doctors affiliated with Walmart/Sam's Club are not Walmart employees; therefore, participation for exams varies.

[2] Discounted amounts may vary and may not be honored at all optical retailers

[3] Payment will be made for either lenses or contact lenses within a benefit period. Payment will not be made for both.

[4] Retail discounts do not apply to Contact Fill.

VALUE ADDED DISCOUNTS[5]

Costs associated with the services and materials listed below are the responsibility of the member. Valid at in-network providers only.

LENS OPTIONS AND ADDITIONAL SERVICES	MEMBER RESPONSIBILITY	LENS OPTIONS AND ADDITIONAL SERVICES	MEMBER RESPONSIBILITY
Solid Tint	$10	Progressives – Tier 1	$50
Fashion / Gradient Tint	$12	Progressives – Tier 2	$80
Standard Scratch-Resistant Coating	$10	Progressives – Tier 3	$100
Ultraviolet Coating	$12	Progressives – Tier 4	$120
Glass Photogrey	$20 (SV); $30 (bifocal/trifocal)	Progressives – Tier 5	$140
Polarized	$75	Progressives – Tier 6	$165
Anti-Reflective Coatings – Tier 1	$40	Progressives – Tier 7	$190
Anti-Reflective Coatings – Tier 2	$50	Progressives – Tier 8	20% discount off U&C
Anti-Reflective Coatings – Tier 3	$65	Blue Blockers	Standard $40, Premium $60, Ultra $150

Anti-Reflective Coatings – Tier 4	$80	High Index	$55
Anti-Reflective Coatings – Tier 5	20% discount off U&C	Retinal Imaging	$39
Polycarbonate Standard Lenses (age 19 and older)	$25 (SV); $30 (bifocal/trifocal)	Additional supplies (excluding contact lenses)	20% discount off U&C
Blended Bifocal (Segment)	$30	Transitions	$65 (SV);$70 (bifocal/trifocal)
LASIK SURGERY	Retail Discount		

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VALUE ADDED PLUS [5]

Value Added Plus provides discounts on additional purchases during the benefit period after the insured benefits have been exhausted. Costs associated with the services and materials listed below are the responsibility of the member. Valid at in-network providers only.

Benefit frequencies are unlimited	
SERVICE AND MATERIALS	MEMBER RESPONSIBILITY
EXAMINATION	Balance after $10 Discount
FRAMES	35% off retail
EYEGLASS LENSES (per pair)	
Single Vision Standard Lenses	$35
Bifocal Standard Lenses	$55
Trifocal Standard Lenses	$70
Aphakic/Lenticular Standard Lenses	$70
CONTACT LENSES[4]	
Disposable (unlimited boxes)	10% off retail
Conventional including, but not limited to: Hard/soft daily wear and spherical	15% off retail
Fitting & Follow up	10% off retail
LENS OPTIONS	
Ultraviolet Coating	$12
Tint (Solid & Gradient)	$12
Scratch-Resistant Coating (Standard)	$15
Polycarbonate (Standard)	$35
Anti-Reflective Coating (Standard)	$45
Polarized	$75
Transitions (Standard)	$65 (Single vision)
	$70 (bifocal or trifocal)
Blue Blockers	Standard $40, Premium $60, Ultra $150 or 20% off U&C
Standard Progressive Lenses[6]	$50+ Bifocal or trifocal lens charge
Additional supplies	20% off retail

[5]Value Added Discounts & Value Added Plus are not part of the insured benefits. Value Added Discounts & Value Added Plus are a reduced fee-for-service discount program. Members pay a discounted amount for listed services by in-network providers. Capital Blue Cross does not pay the in-network providers for these services. Discounted pricing does not apply at Walmart, Sam's Club and select retailers. Discounted amounts may vary and may not be honored at all in-network provider locations. Contact your provider's office to verify their participation in this program.

[6] Fixed discounted pricing is not available on all brands.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments described in your company's other health benefits coverage. *1/01/2022*