# Health Insurance as of January 1, 2021
## Capital Blue Cross PPO

| Coverage | In Network | Out of Network |
|---|---|---|
| **Office Visits** | $15 Primary Physician, $30 Specialist | 80%* of PRC |
| **Preventative Care** | 100% (deductible does not apply) | 80% (deductible may apply) |
| **Outpatient Surgery** | 100%* | 80%* of PRC |
| **Emergency Room** (waived if admitted) | 100% after $150 copay (waived if admitted) | 80% after $150 copay (waived if admitted) |
| **Retail Clinic Visit** | $10 | 80%* of PRC |
| **Urgent Care Visit** | $40 | 80%* of PRC |
| **Virtual Visits** (services provided by AmWell) | No charge | N/A |
| **Outpatient Diagnostic Tests** (x-rays, etc.) | 100%* | 80% |
| **Inpatient Hospital Services** | 100%* | 80%* of PRC |
| **Mental Health/Substance Abuse:** | | |
| *Inpatient* | 100%* | 80%* of PRC |
| *Inpatient Detoxification/Rehabilitation* | 100%* | 80%* of PRC |
| *Outpatient* | 100% after $25 copay* | 80%* of PRC |
| **Co-Insurance** | N/A | 80% / 20% |
| **Annual Deductible** | $350 individual / $700/family | $1,000 individual / $2,000 family |
| **Maximum Out of Pocket** *(once met, plan pays 100%)* | $8,150 individual / $16,300 family | |
| **Prescription Drugs** *Mandatory generic plan* ** | Up to 30-day supply at Pharmacy: $10 generic, $35 preferred brand, $50 non-preferred brand | |
| **Mandatory Mail Order** *Required after 2 refills of a 30-day Rx* | Maintenance Rx must be filled by mail, with a 90-day supply provided at the following rates: $25 Generic, $85 Preferred Brand, $125 non-preferred brand | |

| RATES (NO Vision) - Non-Tobacco/Smoke/Vape Users | RATES (NO Vision) - Tobacco/Smoke/Vape Users |
|---|---|
| **Employee only:** $129 per month / $59.54 biweekly | **Employee only:** $229 per month / $105.69 biweekly |
| **Employee+Child:** $224 per month / $103.38 biweekly | **Employee+Child:** $324 per month / $149.54 biweekly |
| **Employee+Spouse:** $296 per month / $136.62 biweekly | **Employee+Spouse:** $396 per month / $182.77 biweekly |
| **Employee+Children:** $365 per month / $168.46 biweekly | **Employee+Children:** $465 per monthly / $214.62 biweekly |
| **Employee+Spouse+Child(ren):** $403 per month / $186 biweekly | **Employee+Spouse+Child(ren):** $503 per month / $232.15 biweekly |

**SPOUSAL SURCHARGE:**
**Additional $75 per month surcharge applies if covering a spouse who has other coverage available (through an employer or Medicare).**

**Vision Rates (Highmark/Davis Vision):** Employee only: $3.60 per month/ $1.66 biweekly; Employee plus dependent(s): $10.40 per month, $4.80 biweekly

**LEGEND**

+= Up to **$350** of Individual in-network deductible expense is reimbursable for employees earning **$32,000** or less annually.
*= After satisfying the deductible; subject to maximum out-of-pocket limit.
N/A = Not Applicable
PRC = Provider's Reasonable Charge

** **Mandatory Generic:** If there is a generic equivalent and you obtain the brand name drug instead, even if this is at your doctor's request, you pay the difference between the cost of the generic and the brand name PLUS the brand co-pay. If there is no generic available, you pay just the brand name co-pay for the brand name drug.

***Please Note:** This summary is not intended to replace or supersede the insurer's certificate of coverage. Be sure to examine the handbook provided by **the insurer for complete details, restrictions and exclusions.***