

Luzerne County Courthouse Blue Care HMO

Effective Date: 1/1/2017
Renewal Date: 1/1/2018

Group numbers:

10208401-8402-8403-8404-8405-8406-8407-8408-8409-8410-8411-8412-8413-8414-8415-8416-8417-8418-8419-8420-8421-8422-8423-8424-8425-8426-8427-8428-8429-8430-8431-8432-8433-8434-8435-8436-8437-8438-8439-8440-8441-8442-8443-8444-8445-8446-8447-8448-8449-8450

On the chart below, you'll see what your plan pays for specific services. You are responsible for paying for non-emergency services received from an out-of-network provider. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network
General Provisions	
Benefit Period(1)	Calendar Year
Deductible (per benefit period)	
Individual	\$500
Family	\$1,000
Plan Pays – payment based on the plan allowance	100% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)	
Individual	none
Family	none
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.	
Individual	\$7,150
Family	\$14,300
Office/Clinic/Urgent Care Visits	
Retail Clinic Visits & Virtual Visits	100% after \$10 copay
Primary Care Provider Office Visits & Virtual Visits	100% after \$10 copay limit: 6 visits/benefit period
Specialist Office Visits & Virtual Visits	100% after \$20 copay
Virtual Visit Originating Site Fee	100% after deductible
Urgent Care Center Visits	100% after \$20 copay
Telemedicine Services (3)	100% after \$5 copay
Preventive Care (4)	
Routine Adult	
Physical Exams	100% (deductible does not apply)
Adult Immunizations	100% (deductible does not apply)
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)
Nutritional Counseling (6 visit maximum per member benefit period)	100% (deductible does not apply)
Routine Pediatric	
Physical Exams	100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)
Emergency Services	
Emergency Room Services	100% after \$100 copay (waived if admitted)
Ambulance	100% (deductible does not apply) for emergencies; 100% after deductible plus \$50 copay per trip; air, water and/or train transport: 100% after \$250 copay per trip, (deductible does not apply) for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)	
Hospital Inpatient	100% after deductible

Benefit	In Network
Hospital Outpatient	100% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible
Gender Reassignment Surgery	100% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible
Therapy and Rehabilitation Services	
Physical Medicine	100% after \$20 copay after deductible limit: 45 visits/benefit period aggregate with speech & occupational therapy
Respiratory Therapy	100% after deductible limit: 18 visits/benefit period
Speech Therapy	100% after \$20 copay after deductible limit: 45 visits/therapy, per benefit period aggregate with physical medicine and occupational therapy therapy
Occupational Therapy	100% after \$20 copay after deductible limit: 45 visits/therapy, per benefit period aggregate with physical medicine & speech therapy
Spinal Manipulations	100% after \$20 copay limit: 12 visits/benefit period
Cardiac Rehabilitation Therapy	100% after deductible limit: 36 visits/benefit period
Infusion Therapy	100% after deductible
Chemotherapy	100% after deductible
Radiation Therapy	100% after deductible
Dialysis	100% after deductible
Mental Health / Substance Abuse	
Inpatient Mental Health Services	100% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% (deductible does not apply)
Outpatient Substance Abuse Services	100% (deductible does not apply)
Other Services	
Allergy Extracts and Injections	100% (deductible does not apply)
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	100% after deductible
Dental Services Related to Accidental Injury	100% after deductible
Diagnostic Services	
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after \$75 copay
Outpatient Diagnostic Services	100% after deductible
Standard Imaging	100% (deductible does not apply)
Diagnostic Medical	100% (deductible does not apply)
Pathology/Laboratory	100% (deductible does not apply)
Allergy Testing	100% after deductible
Durable Medical Equipment , Orthotics,and Prosthetics	100% after deductible
Ostomy Supplies	50% after deductible limit: \$1,000 dollars/per participant per benefit period
Home Health Care	100% after \$20 copay after deductible
Hospice	100% after deductible limit: 180 days/ lifetime maximum of 18 days/ lifetime can be used for continuous or inpatient care
Prostate Cancer Screening	100% (deductible does not apply)
Infertility Counseling, Testing and Treatment	100% after deductible
Private Duty Nursing	not covered
Skilled Nursing Facility Care	100% after deductible limit: 60 days/benefit period
Transplant Services	100% after deductible
Precertification Requirements (6)	Yes

Benefit	In Network
Prescription Drugs	
Prescription Drug Deductible Individual Family	none none
Prescription Drug Program (7) Hard Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	<p style="text-align: center;">Retail Drugs (30-day Supply)</p> \$0 formulary low cost generic copay \$0 non-formulary low cost generic copay \$10 formulary generic copay \$10 non-formulary generic copay \$20 formulary brand copay \$35 non-formulary brand copay <p style="text-align: center;">Maintenance Drugs through Mail Order (90-day Supply)</p> \$0 formulary low cost generic copay \$0 non-formulary low cost generic copay \$20 formulary generic copay \$20 non-formulary generic copay \$40 formulary brand copay \$105 non-formulary brand copay

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. Effective with plan years beginning on or after January 1, 2017, the TMOOP cannot exceed \$7,150 for individual and \$14,300 for two or more persons.

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health.

(4) Services are limited to those listed on the Highmark Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).

(5) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.

(6) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

(7) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/program; including, any exclusion or limitation described in the benefit Booklet.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

CHỦ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deutsch schwetzsch, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આપેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ: បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នង កាតសម្គាល់របស់របស់លោកអ្នក (TTY: 711) ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyon tulog sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yánítí'go, language assistance services, éí t'áá níik'eh, bee níká a'doowól, éí bee ná'ahóót'i'. ID bee nééhózingo nanitínígíí bine'déé' (TTY: 711) jí' hodíílnih.

ध्यान दें: यदि आप हन्दी बोलते हैं, तो आपके लए नःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दए गए नंबर पर फोन करें। (TTY: 711).

توجه: فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడతే, లాగ్ వేళ్ల అసనంబనన సర్వీసెన, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాలి చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณ โดยไม่มีค่าใช้จ่าย โทรไปยัง หมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दनुहोस्: यदि तपाईं नेपाली भाषा बोलनुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू नःशुल्क उपलब्ध हुन्छन्। तपाईंको आइडी कार्डको पछाडी भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).