### Benefit Highlights
**PPO Low**

**T51945**
01/2017

**Lafayette College**

**www.capblu-cross.com**

**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

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (per benefit period)</td>
<td>$300 per member</td>
<td>$1,200 per member</td>
</tr>
<tr>
<td></td>
<td>$900 per family</td>
<td>$3,600 per family</td>
</tr>
</tbody>
</table>

### Summary of Benefits

#### Preventive Care
- **Preventive Services**
  - Pediatric Preventive Care
  - Adult Preventive Care
- Immunizations
- Mammograms
- Screening Mammogram
- Diagnostic Mammogram
- Gynecological Services
- Screening Gynecological Exam & Pap Smear

#### Acute Care
- **Care Hospital Room & Board**
- **Inpatient Rehabilitation**
  - 60 days/benefit period
- **Skilled Nursing Facility**
  - 100 days/benefit period
- **Emergency Services**
  - Covered in full, waive deductible
  - Emergency room copayment applies, waived if admitted inpatient

#### Diagnostic Services
- **Radiology**
- **Laboratory**
- **Medical tests**

#### Outpatient Surgery
- **Physical Medicine**
- **Occupational Therapy**
  - 30 visits/benefit period
- **Speech Therapy**
  - 30 visits/benefit period
- **Respiratory Therapy**
- **Manipulation Therapy**
  - 20 visits/benefit period

#### Outpatient Therapy Services
- **Physical Medicine**
- **Occupational Therapy**
- **Speech Therapy**
- **Respiratory Therapy**
- **Manipulation Therapy**

#### Mental Health Care Services
- **Inpatient Services**
- **Outpatient Services**

#### Substance Abuse Services
- **Rehabilitation – Inpatient**
- **Rehabilitation – Outpatient**

#### Home Health Care Services
- **90 visits/benefit period**

#### Durable Medical Equipment (DME)
- **Prosthetic Appliances**
- **Orthotic Devices**

### Summary of Benefits

<table>
<thead>
<tr>
<th>Providers</th>
<th>Limits and Maximums</th>
<th>Amounts Members Are Responsible For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Providers</td>
<td>Non-Participating Providers</td>
<td></td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Covered in full, waive deductible</td>
<td>25% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered in full, waive deductible</td>
<td>25% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered in full, waive deductible</td>
<td>25% coinsurance after deductible</td>
</tr>
<tr>
<td>Mammograms</td>
<td>One per benefit period</td>
<td>Covered in full, waive deductible</td>
</tr>
<tr>
<td>Gynecological Services</td>
<td>One per benefit period</td>
<td>Covered in full, waive deductible</td>
</tr>
</tbody>
</table>

### Benefits Listed Below Apply Only After Benefit Period Deductible is Met

- **Acute Care Hospital Room & Board**
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible
- **Inpatient Rehabilitation**
  - 60 days/benefit period
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible
- **Skilled Nursing Facility**
  - 100 days/benefit period
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible
- **Emergency Services**
  - Covered in full, waive deductible
  - Emergency room copayment applies, waived if admitted inpatient
- **Mental Health Care Services**
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible
- **Outpatient Services**
  - $20 copayment per visit
  - 25% coinsurance after deductible
- **Substance Abuse Services**
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible
- **Rehabilitation – Inpatient**
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible
- **Rehabilitation – Outpatient**
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible
- **Home Health Care Services**
  - 90 visits/benefit period
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible
- **Durable Medical Equipment (DME)**
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible
- **Prosthetic Appliances**
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible
- **Orthotic Devices**
  - 10% coinsurance after deductible
  - 25% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. Independent licensee of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.
<table>
<thead>
<tr>
<th>SUMMARY OF BENEFITS</th>
<th>Amounts Members Are Responsible For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESCRIPTION DRUG DEDUCTIBLE</td>
<td><strong>Amounts Members Are Responsible For:</strong></td>
</tr>
<tr>
<td>Per benefit period*</td>
<td><strong>$150 per member</strong> <strong>$450 per family</strong></td>
</tr>
<tr>
<td>PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</td>
<td><strong>$5,400 per member</strong> <strong>$9,600 per family</strong></td>
</tr>
<tr>
<td>When the out-of-pocket maximum is reached, the Plan pays 100% until the end of the benefit period.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG TIER (up to a 31-day supply)</th>
<th>Mail Service Pharmacy (up to a 90-day supply)</th>
<th>Specialty Pharmacy (up to a 30-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Preferred Prescription Drugs</td>
<td>$10 copayment</td>
<td>$20 copayment</td>
</tr>
<tr>
<td>Generic Non-Preferred Prescription Drugs</td>
<td>$10 copayment</td>
<td>$20 copayment</td>
</tr>
<tr>
<td>Brand Preferred Prescription Drugs</td>
<td>$30 copayment</td>
<td>$60 copayment</td>
</tr>
<tr>
<td>Brand Non-Preferred Prescription Drugs</td>
<td>$45 copayment</td>
<td>$90 copayment</td>
</tr>
</tbody>
</table>

Network: CVS Caremark National Pharmacy Network

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG TIER (Contraceptives)</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Prescription Drugs</td>
<td>$0 copayment</td>
</tr>
<tr>
<td>Select Brand Prescription Drugs**</td>
<td>$0 copayment</td>
</tr>
<tr>
<td>Brand Preferred Prescription Drugs</td>
<td>$30 copayment</td>
</tr>
<tr>
<td>Brand Non-Preferred Prescription Drugs</td>
<td>$45 copayment</td>
</tr>
</tbody>
</table>

FORMULARY SYSTEM: Open

<table>
<thead>
<tr>
<th>UTILIZATION PROGRAM</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Substitution Program</td>
<td>Mandatory Generic Substitution – In addition to the coinsurance/copayment, the member pays the difference between the brand drug and generic drug price (when there is a generic drug alternative) regardless of whether the prescribing physician requests that the brand drug be dispensed.</td>
</tr>
<tr>
<td>Specialty Pharmacy</td>
<td>For most specialty medications, coverage is available only when dispensed by a Capital BlueCross Preferred Specialty Network. For a list of Preferred Specialty Networks, please refer to the Specialty Pharmacy information located in The Guide to Rx Benefits at <a href="http://www.capbluecross.com">www.capbluecross.com</a>.</td>
</tr>
<tr>
<td>Quantity Level Limits (per prescription, day supply or copayment)</td>
<td>Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to <a href="http://www.capbluecross.com">www.capbluecross.com</a>.</td>
</tr>
</tbody>
</table>

Inpatient admissions as well as certain other services and equipment may require Preauthorization.

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.

**Select Brands include contraceptives for which there is no generic equivalent.

Participating providers and pharmacies agree to accept our allowance as payment in full—often less than their normal charge. If you visit a non-participating provider or pharmacy, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider’s or non-participating pharmacy’s charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered. Deductibles, any differences paid between brand drug and generic drug prices, and any balances paid to non-participating 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.

On behalf of Capital BlueCross, CVS/caremark™ assists in the administration of our prescription drug program. CVS/caremark is an independent pharmacy benefit manager.

For more information or to locate a participating provider, visit www.capbluecross.com. Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size >51.
Capital BlueCross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you, or someone you’re helping, has questions about your health plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800.962.2242 (TTY: 711).

Spanish—Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de su plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800.962.2242 (TTY: 711).

Chinese—如果您，或是您正在協助的對象，有關於您的健康計劃方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話在此插入數字800.962.2242 (TTY: 711)。