

Lafayette College – PPO Low – Customized PPO Blue Benefit Summary

On the chart below, you'll see what your plan pays for specific services. 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 | Network | Out-of-Network |
|---|--|---------------------------------|
| General Provisions | | |
| Benefit Period(1) | Contract Year | |
| Deductible (per benefit period) | | |
| Individual | \$300 | \$1,200 |
| Family | \$900 | \$3,600 |
| Plan Pays – payment based on the plan allowance | 90% after deductible | 75% after deductible |
| Out-of-Pocket Limit - Coinsurance (Once met, plan pays 100% coinsurance for the rest of the benefit period) | | |
| Individual | \$1,200 | \$2,250 |
| Family | \$3,600 | \$6,750 |
| 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 | \$6,600 | Not Applicable |
| Family | \$13,200 | Not Applicable |
| Office/Clinic/Urgent Care Visits | | |
| Retail Clinic Visits & Virtual Visits | 100% after \$10 copay | 75% after deductible |
| Primary Care Provider Office Visits & Virtual Visits | 100% after \$10 copay | 75% after deductible |
| Specialist Office & Virtual Visits | 100% after \$20 copay | 75% after deductible |
| Virtual Visit Originating Site Fee | 90% after deductible | 75% after deductible |
| Urgent Care Center Visits | 100% after \$50 copay | 75% after deductible |
| Telemedicine Services(3) | 100% after \$5 copay | Not Covered |
| Preventive Care(4) | | |
| Routine Adult Physical exams | 100% (deductible does not apply) | 75% after deductible |
| Adult immunizations | 100% (deductible does not apply) | 75% after deductible |
| Routine gynecological exams, including a Pap Test | 100% (deductible does not apply) | 75% (deductible does not apply) |
| Mammograms, annual routine | 100% (deductible does not apply) | 75% after deductible |
| Mammograms, medically necessary | 100% (deductible does not apply) | 75% after deductible |
| Diagnostic services and procedures | 100% (deductible does not apply) | 75% after deductible |
| Routine Pediatric Physical exams | 100% (deductible does not apply) | 75% after deductible |
| Pediatric immunizations | 100% (deductible does not apply) | 75% (deductible does not apply) |
| Diagnostic services and procedures | 100% (deductible does not apply) | 75% after deductible |
| Emergency Services | | |
| Emergency Room Services | 100% after \$100 copay (waived if admitted) | |
| Ambulance – Emergency | 90% after network deductible | |
| Ambulance – Non-Emergency | 90% after deductible | 75% after deductible |
| Hospital and Medical/Surgical Expenses (including maternity) | | |
| Hospital Inpatient | 90% after deductible | 75% after deductible |
| Hospital Outpatient | 90% after deductible | 75% after deductible |
| Maternity (non-preventive facility & professional services) including dependent daughter | 90% after deductible | 75% after deductible |
| Medical Care (including inpatient visits and consultations)/Surgical Expenses | 90% after deductible | 75% after deductible |
| Therapy and Rehabilitation Services | | |
| Physical Medicine | 100% after \$20 copay | 75% after deductible |
| | Limit: Unlimited visits per therapy/benefit period | |
| Respiratory Therapy | 90% after deductible | 75% after deductible |
| Speech Therapy & Occupational Therapy | 100% after \$20 copay | 75% after deductible |
| | Limit: 30 visits/benefit period | |
| Spinal Manipulations | 100% after \$20 copay | 75% after deductible |
| | Limit: 20 visits/benefit period | |
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 90% after deductible | 75% after deductible |

| Benefit | Network | Out-of-Network |
|--|---------------------------------|---|
| Mental Health/Substance Abuse | | |
| Inpatient Mental Health Services | 90% after deductible | 75% after deductible |
| Inpatient Detoxification / Rehabilitation | 90% after deductible | 75% after deductible |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | 100% after \$20 copay | 75% after deductible |
| Outpatient Substance Abuse Services | 100% after \$20 copay | 75% after deductible |
| Other Services | | |
| Allergy Extracts and Injections | 90% after deductible | 75% after deductible |
| Autism Spectrum Disorder including Applied Behavior Analysis(5) | 90% after deductible | 75% after deductible |
| Assisted Fertilization Procedures | Not Covered | Not Covered |
| Dental Services Related to Accidental Injury | Not Covered | Not Covered |
| Diagnostic Services | | |
| Advanced Imaging (MRI, CAT, PET scan, etc.) | 90% after deductible | 75% after deductible |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 90% after deductible | 75% after deductible |
| Durable Medical Equipment, Orthotics and Prosthetics | 90% after deductible | 75% after deductible |
| Home Health Care | 90% after deductible | 75% after deductible |
| | Limit: 90 visits/benefit period | |
| Hospice | 90% after deductible | 75% after deductible |
| Infertility Counseling, Testing and Treatment(6) | 90% after deductible | 75% after deductible |
| Private Duty Nursing | 90% after deductible | 75% after deductible |
| | Limit: 240 hours/benefit period | |
| Skilled Nursing Facility Care | 90% after deductible | 75% after deductible |
| | Limit: 100 days/benefit period | |
| Transplant Services | 90% after deductible | 75% after deductible |
| Precertification Requirements(7) | Yes | |
| Prescription Drugs | | |
| Prescription Drug Deductible | | |
| Individual | | \$150 |
| Family | | \$450 |
| Prescription Drug Out-of-Pocket Maximum | | \$5,400 Individual/benefit period \$9,600 Family/benefit period |
| Prescription Drug Program(8) 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. | | Retail Drugs (31/60/90-day Supply) \$10/\$20/\$30 generic copay \$30/\$60/\$90 formulary brand copay \$45/\$90/\$135 non-formulary brand copay Maintenance Drugs through Mail Order (90-day Supply) \$20 generic copay \$60 formulary brand copay \$90 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 Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- (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.
- (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 benefit.
- (4) Services are limited to those listed on the Highmark Preventive Schedule (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) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (7) 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.
- (8) 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.