Capital BLUE

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BENEFIT HIGHLIGHTS

QHDHP 3500 PLAN

Lafayette College

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 Certificate of Coverage (also known as "benefit booklet"). Refer to your benefit 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.	$3,500 per member $7,000 per family	$7,000 per member $14,000 per family
Coinsurance (percentage you pay after your deductible is met)	20% coinsurance	40% coinsurance
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.)	$5,000 per member $10,000 per family	$10,000 per member $20,000 per family
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care Visits – delivered via the Capital BlurCross Virtual Care platform	20% 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	20% coinsurance after deductible	40% coinsurance after deductible
Specialist Office Visits (In-person & Telehealth)	20% coinsurance after deductible	40% coinsurance after deductible
Urgent Care Services	20% coinsurance after deductible	40% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	
Preventive Care		
Pediatric and Adult Preventive Care	No charge, waive deductible	40% coinsurance after deductible
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge, waive deductible	40% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge, waive deductible	50% coinsurance after deductible
Diagnostic Mammogram	No charge after deductible	40% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	20% coinsurance after deductible	40% coinsurance after deductible
Acute Inpatient Rehabilitation (60 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Maternity Services and Newborn Care	20% coinsurance after deductible	40% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	20% coinsurance after deductible	Not covered
Outpatient Surgery at Acute Care Hospital (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible
Radiology (other than high tech imaging)	20% coinsurance after deductible	40% coinsurance after deductible
Independent Laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	20% coinsurance after deductible	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy	20% coinsurance after deductible	40% coinsurance after deductible
Occupational Therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Speech Therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Respiratory Therapy	20% coinsurance after deductible	40% coinsurance after deductible
Manipulation Therapy (20 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	20% coinsurance after deductible	40% coinsurance after deductible
MH Outpatient Services	20% coinsurance after deductible	40% coinsurance after deductible
SUD Detoxification Inpatient	20% coinsurance after deductible	40% coinsurance after deductible
SUD Rehabilitation Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
Additional Services		
Home Health Care Services (90 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Durable Medical Equipment and Supplies	20% coinsurance after deductible	40% coinsurance after deductible
Prosthetic Appliances	20% coinsurance after deductible	40% coinsurance after deductible
Orthotic Devices	20% coinsurance after deductible	40% coinsurance after deductible

YOUR PRESCRIPTION DRUG SUMMARY OF COST-SHARING			
	Member Responsibilities		
Deductible (includes medical and prescription drug benefits for in-network providers)	Retail Pharmacy (up to a 31 day supply)	Home Delivery (up to a 90 day supply)	Specialty Pharmacy (up to a 30 day supply)
Prescription Drug Tier			
Generic Preferred	$20 copayment after deductible	$40 copayment after deductible	$20 copayment after deductible
Generic Nonpreferred	$20 copayment after deductible	$40 copayment after deductible	$20 copayment after deductible
Brand Preferred	$45 copayment after deductible	$90 copayment after deductible	$45 copayment after deductible
Brand Nonpreferred	$60 copayment after deductible	$120 copayment after deductible	$60 copayment after deductible
Contraceptives* (self-administered)			
Generic	$0 copayment	$0 copayment	Not covered
Select Brands (no generic equivalent available)	$0 copayment	$0 copayment	Not covered
Brand Preferred	$45 copayment after deductible	$90 copayment after deductible	Not covered
Brand Nonpreferred	$60 copayment after deductible	$120 copayment after deductible	Not covered
Additional Pharmacy Benefits/Details			
Network (for Specialty Pharmacy information please refer to the Guide to Rx Benefits at www.capbluecross.com)	Broad Plus		
Formulary	Advantage		
$0 Preventive Rx Coverage	No charge		
Generic Substitution Program	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.		
Extended Supply Network (ESN)	Members have the ability to obtain covered drugs for up to a 90 day supply at participating retail pharmacies.		

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.

Voice activated paper.

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