

# BENEFIT HIGHLIGHTS

CapitalBlueCross.com



## PPO 1500 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 Benefits Booklet (also known as "Certificate of Coverage"). Refer to your Benefits Booklet for complete details.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is in-network	If provider is out-of-network
<b>Deductible</b> (per benefit period)	\$1,500 per member \$4,500 per family	\$3,000 per member \$8,000 per family
<b>Coinsurance</b> (Percentage you pay after your deductible is met.)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Out-of-pocket maximum</b> (The most you pay per benefit period, after which benefits are paid at 100%).	Overall in-network out-of-pocket maximum includes deductible, copayments, and coinsurance for medical and prescription drugs: \$5,000 per member \$10,000 per family	Out-of-network medical coinsurance-only maximum: \$10,000 per member \$20,000 per family  Overall out-of-network out-of-pocket not applicable
Office Visit / Urgent Care / Emergency Room Copayments		
<b>VirtualCare (non-specialist) visits</b> —delivered via the Capital Blue Cross VirtualCare platform	\$10 copayment per visit	Not applicable
<b>VirtualCare (specialist) visits</b> —delivered via the Capital Blue Cross VirtualCare platform	\$10 copayment per visit	Not applicable
<b>Office visits and consultations (in-person &amp; telehealth)</b> —performed by a family practitioner, general practitioner, internist, pediatrician network retail clinic or in-person	\$25 copayment per visit	40% coinsurance after deductible
<b>Specialist office visits</b> (in-person, telehealth & via the Capital Blue Cross VirtualCare platform)	\$40 copayment per visit	40% coinsurance after deductible
<b>Urgent care services</b>	\$50 copayment per visit	40% coinsurance after deductible
<b>Emergency room</b>	\$200 copayment per visit, waived if admitted	
Preventive Care		
<b>Pediatric and adult preventive care</b>	No charge, deductible waived	40% coinsurance after deductible
<b>Screening gynecological exam and pap smear</b>	No charge, deductible waived	40% coinsurance, deductible waived
<b>Screening mammogram</b>	No charge, deductible waived	40% coinsurance after deductible
Facility / Surgical Services		
<b>Inpatient hospital room and board including maternity services and newborn care</b>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Acute inpatient rehabilitation</b> (60 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Skilled nursing facility</b> (100 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Surgical procedure and anesthesia</b> (professional charges)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Outpatient surgery at ambulatory surgical center</b> (facility charge only)	20% coinsurance after deductible	Not covered
<b>Outpatient surgery at acute care hospital</b> (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Services		
<b>High tech imaging</b> (such as MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Radiology</b> (other than high tech imaging)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Independent laboratory</b>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Facility-owned laboratory</b> (i.e. Health System owned)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Diagnostic mammogram</b>	No charge, deductible waived	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
<b>Physical therapy</b>	\$40 copayment per visit	40% coinsurance after deductible
<b>Occupational therapy</b> (30 visits per benefit period)	\$40 copayment per visit	40% coinsurance after deductible
<b>Speech therapy</b> (30 visits per benefit period)	\$40 copayment per visit	40% coinsurance after deductible
<b>Respiratory therapy</b>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Manipulation therapy</b> (20 visits per benefit period)	\$40 copayment per visit	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
<b>MH &amp; SUD detoxification inpatient services</b>	20% coinsurance after deductible	40% coinsurance after deductible
<b>MH &amp; SUD rehabilitation outpatient services</b>	\$40 copayment per visit	40% coinsurance after deductible
Additional Services		
<b>Home healthcare services</b> (90 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Durable medical equipment and supplies; prosthetic appliances and orthotic devices</b>	20% coinsurance after deductible	40% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital Blue Cross. An independent licensee of the Blue Cross Blue Shield Association.

**COST SHARING FOR PRESCRIPTION DRUGS DOES NOT APPLY TO THE MEDICAL DEDUCTIBLE SHOWN ON PAGE ONE**

**YOUR PRESCRIPTION DRUG SUMMARY OF COST-SHARING**

	Member Responsibilities		
	If provider is in-network	If provider is out-of-network	
<b>Deductible</b> (per benefit period)	\$300 per member \$900 per family	Not applicable	
	Retail pharmacy (up to a 31-day supply)	Home delivery (up to a 90-day supply)	Specialty pharmacy (up to a 30-day supply)
<b>Prescription drug tier</b>			
Generic preferred	\$10 copayment	\$20 copayment	\$75 copayment
Generic nonpreferred	\$10 copayment	\$20 copayment	\$75 copayment
Brand preferred	\$40 copayment	\$80 copayment	\$75 copayment
Brand nonpreferred	\$60 copayment	\$120 copayment	\$75 copayment
<b>Contraceptives* (self-administered)</b>			
Generic	\$0 copayment	\$0 copayment	Not covered
Select brands (no generic equivalent available)	\$0 copayment	\$0 copayment	Not covered
Brand preferred	\$40 copayment	\$80 copayment	Not covered
Brand nonpreferred	\$60 copayment	\$120 copayment	Not covered
<b>Additional pharmacy benefits/details</b>			
<b>Network</b> (for specialty pharmacy information please refer to the guide to Rx benefits at <a href="https://www.capitalbluecross.com">CapitalBlueCross.com</a> )	Broad Plus		
<b>Formulary</b>	Advantage		
<b>\$0 preventive Rx coverage</b>	No charge		
<b>Generic substitution program</b>	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) <u>regardless</u> of whether the prescribing physician requests that the brand drug be dispensed.		
<b>Extended supply network (ESN)</b>	Members have the ability to obtain covered drugs for up to a 90-day supply at in-network 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.

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