## 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** |
| **Deductible** (per benefit period) | $1,500 per member<br>$4,500 per family | $3,000 per member<br>$8,000 per family |
| **Coinsurance** (Percentage you pay after your deductible is met) | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Out-of-pocket maximum** | Overall in-network out-of-pocket maximum includes deductible, copayments, and coinsurance for medical and prescription drugs:<br>$5,000 per member<br>$10,000 per family | Out-of-network medical coinsurance-only maximum:<br>$10,000 per member<br>$20,000 per family<br><br>Overall out-of-network out-of-pocket not applicable |
| **Office Visit / Urgent Care / Emergency Room Copayments** | | |
| **VirtualCare (non-specialist) visits**—delivered via the Capital Blue Cross VirtualCare platform | $10 copayment per visit | Not applicable |
| **VirtualCare (specialist) visits**—delivered via the Capital Blue Cross VirtualCare platform | $10 copayment per visit | Not applicable |
| **Office visits and consultations (in-person & telehealth)**—performed by a family practitioner, general practitioner, internist, pediatrician network retail clinic or in-person | $25 copayment per visit | 40% coinsurance after deductible |
| **Specialist office visits** (in-person, telehealth & via the Capital Blue Cross VirtualCare platform) | $40 copayment per visit | 40% coinsurance after deductible |
| **Urgent care services** | $50 copayment per visit | 40% coinsurance after deductible |
| **Emergency room** | $200 copayment per visit, waived if admitted | |
| **Preventive Care** | | |
| **Pediatric and adult preventive care** | No charge, deductible waived | 40% coinsurance after deductible |
| **Screening gynecological exam and pap smear** | No charge, deductible waived | 40% coinsurance, deductible waived |
| **Screening mammogram** | No charge, deductible waived | 40% coinsurance after deductible |
| **Facility / Surgical Services** | | |
| **Inpatient hospital room and board including maternity services and newborn care** | 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 |
| **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 |
| **Diagnostic mammogram** | No charge, deductible waived | 40% coinsurance after deductible |
| **Therapy Services (Rehabilitative and Habilitative Services)** | | |
| **Physical therapy** | $40 copayment per visit | 40% coinsurance after deductible |
| **Occupational therapy** (30 visits per benefit period) | $40 copayment per visit | 40% coinsurance after deductible |
| **Speech therapy** (30 visits per benefit period) | $40 copayment per visit | 40% coinsurance after deductible |
| **Respiratory therapy** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Manipulation therapy** (20 visits per benefit period) | $40 copayment per visit | 40% coinsurance after deductible |
| **Mental Health (MH) and Substance Use Disorder Services (SUD)** | | |
| **MH & SUD detoxification inpatient services** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **MH & SUD rehabilitation outpatient services** | $40 copayment per visit | 40% coinsurance after deductible |
| **Additional Services** | | |
| **Home healthcare services** (90 visits per benefit period) | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Durable medical equipment and supplies; prosthetic appliances and orthotic devices** | 20% coinsurance after deductible | 40% coinsurance after deductible |

| 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** | |
| **Deductible** (per benefit period) | $300 per member<br>$900 per family | Not applicable | |
| | Retail pharmacy<br>(up to a 31-day supply) | Home delivery<br>(up to a 90-day supply) | Specialty pharmacy<br>(up to a 30-day supply) |
| **Prescription drug tier** | | | |
| 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 |
| **Contraceptives* (self-administered)** | | | |
| 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 |
| **Additional pharmacy benefits/details** | | | |
| **Network** (for specialty pharmacy information please refer to the guide to Rx benefits at CapitalBlueCross.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 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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