Capital BLUE

www.capbluecross.com

Benefit Highlights
PPO Low
Lafayette College

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	Amounts *Members* Are Responsible For:	
	Participating Providers	***Non-Participating Providers***
Deductible (per benefit period)	$300 per member $900 per family	$1,200 per member $3,600 per family
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$10 copayment per visit	25% coinsurance
• **Specialist Office Visit**	$20 copayment per visit	25% coinsurance
• **Emergency Room**	$100 copayment per visit, waived if admitted	
• **Urgent Care**	$50 copayment per visit	25% coinsurance
• **Inpatient** (Per Admission)	Not Applicable	25% coinsurance
• **Outpatient Surgery Copayment** (facility)	Not Applicable	25% coinsurance
Coinsurance	10% coinsurance	25% coinsurance
Out-of-Pocket Maximum *(includes Deductible, Copayments and Coinsurance for Medical (including ER),* for Participating Providers only).	$1,200 per member $3,600 per family	$2,250 per member $6,750 per family

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	***Non-Participating Providers***
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full, waive deductible	25% coinsurance after deductible
• Adult Preventive Care		Covered in full, waive deductible	25% coinsurance after deductible
Immunizations		Covered in full, waive deductible	25% coinsurance waive deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	25% coinsurance waive deductible
• Diagnostic Mammogram		Covered in full, waive deductible	25% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	25% coinsurance waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		10% coinsurance after deductible	25% coinsurance after deductible
Acute 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
Surgery			
• Surgical Procedure & Anesthesia		10% coinsurance after deductible	25% coinsurance after deductible
Maternity Services and Newborn Care		10% coinsurance after deductible	25% coinsurance after deductible
Diagnostic Services			
• Radiology		10% coinsurance after deductible	25% coinsurance after deductible
• Laboratory		10% coinsurance after deductible	25% coinsurance after deductible
• Medical tests		10% coinsurance after deductible	25% coinsurance after deductible
Outpatient Surgery		10% coinsurance after deductible	25% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine		$20 copayment per visit	25% coinsurance after deductible
• Occupational Therapy	30 visits/benefit period	$20 copayment per visit	25% coinsurance after deductible
• Speech Therapy	30 visits/benefit period	$20 copayment per visit	25% coinsurance after deductible
• Respiratory Therapy		10% coinsurance after deductible	25% coinsurance after deductible
• Manipulation Therapy	20 visits/benefit period	$20 copayment per visit	25% coinsurance after deductible
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
Mental Health Care Services • Inpatient Services		10% coinsurance after deductible	25% coinsurance after deductible
• Outpatient Services		$20 copayment per visit	25% coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient		10% coinsurance after deductible	25% coinsurance after deductible
• Rehabilitation – Outpatient		$20 copayment per visit	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.*

SUMMARY OF BENEFITS	Amounts Members Are Responsible For:		
PRESCRIPTION DRUG DEDUCTIBLE Per benefit period*	$150 per member $450 per family		
PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM When the out-of-pocket maximum is reached, the Plan pays 100% until the end of the benefit period.	$5,400 per member $9,600 per family		
	Retail Pharmacy (up to a 31-day supply)	**Mail Service Pharmacy (up to a 90-day supply)**	**Specialty Pharmacy (up to a 30-day supply)**
PRESCRIPTION DRUG TIER	**BENEFIT**		
Generic Preferred Prescription Drugs	$10 copayment	$20 copayment	$10 copayment
Generic Non-Preferred Prescription Drugs	$10 copayment	$20 copayment	$10 copayment
Brand Preferred Prescription Drugs	$30 copayment	$60 copayment	$30 copayment
Brand Non-Preferred Prescription Drugs	$45 copayment	$90 copayment	$45 copayment
Network	CVS Caremark National Pharmacy Network		
PRESCRIPTION DRUG TIER (Contraceptives)	**BENEFIT**		
Generic Prescription Drugs	$0 copayment	$0 copayment	Not covered
Select Brand Prescription Drugs**	$0 copayment	$0 copayment	Not covered
Brand Preferred Prescription Drugs	$30 copayment	$60 copayment	Not covered
Brand Non-Preferred Prescription Drugs	$45 copayment	$90 copayment	Not covered
FORMULARY SYSTEM	Open		
UTILIZATION PROGRAM	**BENEFIT**		
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.		
Specialty Pharmacy	**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 www.capbluecross.com.**		
Quantity Level Limits (per prescription, day supply or copayment)	**Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com.**		
Prior Authorization and Enhanced Prior Authorization	**Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com.**		

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，有關於您的健康计划方面的問題，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)。