Capital BLUE

www.capbluecross.com

Benefit Highlights

PPO 1500/100 Plan

Albright 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) ***Deductible may be waived for certain services related to chronic condition management***	$1,500 per member $3,000 per family	$1,500 per member $3,000 per family
Copayments		
• **Office Visits** *(performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic)*	$25 copayment per visit	Coinsurance applies
• **Specialist Office Visit**	$25 copayment per visit	Coinsurance applies
• **Emergency Room**	$100 copayment per visit, waived if admitted	
• **Urgent Care**	$50 copayment per visit	20% coinsurance
• **Inpatient** (Per Admission)	Not Applicable	Coinsurance applies
• **Outpatient Surgery Copayment** (facility)	Not Applicable	Coinsurance applies
Coinsurance	Not Applicable	20% coinsurance
Out-of-Pocket Maximum *(includes INN Deductible, Copayments and Coinsurance)*	$6,350 per member $12,700 per family	$2,500 per member $5,500 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	20% coinsurance after deductible
• Adult Preventive Care		Covered in full, waive deductible	20% coinsurance after deductible
Immunizations		Covered in full, waive deductible	20% coinsurance, waive deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	20% coinsurance, waive deductible
• Diagnostic Mammogram		Covered in full after deductible	20% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	20% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		Covered in full after deductible	20% coinsurance after deductible
Acute Inpatient Rehabilitation	60 days/benefit period	Covered in full after deductible	20% coinsurance after deductible
Skilled Nursing Facility	100 days/benefit period	Covered in full after deductible	20% coinsurance after deductible
Surgery			
• Surgical Procedure & Anesthesia		Covered in full after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care		Covered in full after deductible	20% coinsurance after deductible
Diagnostic Services			
• Radiology		Covered in full after deductible	20% coinsurance after deductible
• Lab		Covered in full after deductible	20% coinsurance after deductible
• Medical tests		Covered in full after deductible	20% coinsurance after deductible
Outpatient Surgery		Covered in full after deductible	20% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine	20 visits/benefit period	Copayment applies	20% coinsurance after deductible
• Occupational Therapy	12 visits/benefit period	Copayment applies	20% coinsurance after deductible
• Speech Therapy	12 visits/benefit period	Copayment applies	20% coinsurance after deductible
• Respiratory Therapy		Covered in full after deductible	20% coinsurance after deductible
• Manipulation Therapy	20 visits/benefit period	Copayment applies	20% coinsurance after deductible
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross, an 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	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	*Non-Participating Providers*
Mental Health Care Services • Inpatient Services		Covered in full after deductible	20% coinsurance after deductible
• Outpatient Services		Copayment applies	20% coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient		Covered in full after deductible	20% coinsurance after deductible
• Rehabilitation – Outpatient		Copayment applies	20% coinsurance after deductible
Home Health Care Services	90 visits/benefit period	Covered in full after deductible	20% coinsurance after deductible
Durable Medical Equipment (DME)		Covered in full after deductible	20% coinsurance after deductible
Prosthetic Appliances		Covered in full after deductible	20% coinsurance after deductible
Orthotic Devices		Covered in full after deductible	20% coinsurance after deductible

Other Standard Plan Features	
Preauthorization	Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs.
Disease Management	Disease Management Programs are a collaborative process that assess the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression.
Nurse Line	Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE.
Better Health Works℠ Personal Profile	Answer questions about yourself and the way you live and, based on the answers you provide, you will receive customized recommendations for your health situation. Support is available to follow through on these recommendations and to make positive health changes.
mycapbluecross.com	Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWell℠ member newsletter, view explanation of benefits, and much more.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered.

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.

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 BLUE Rx

Albright College

HIGHLIGHTS	AMOUNTS YOU ARE RESPONSIBLE FOR:		
	Retail Pharmacy (up to a 30-day supply)	Mail Service Pharmacy (up to a 90-day supply)	Specialty Pharmacy (up to a 30-day supply)
DEDUCTIBLE			
Per benefit period*	$100 per member $200 per family		
OUT-OF-POCKET MAXIMUM			
When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the benefit period ends.	None		
PRESCRIPTION DRUG TIER	**BENEFIT**		
Generic Prescription Drugs	$30 / $60 / $90 copayment	$30 copayment	$30 copayment
Preferred Brand Prescription Drugs	$60 / $120 / $180 copayment	$60 copayment	$60 copayment
Non-Preferred Brand Prescription Drugs	$90 / $180 / $270 copayment 30 day / 60 day / 90 day supply	$90 copayment	$90 copayment
Network	CVS Caremark National Pharmacy Network		
Voluntary Maintenance Choice	The dispensing of maintenance covered drugs for up to a 90 day supply is available through Mail Service or at CVS Pharmacies.		
PRESCRIPTION DRUG TIER (Contraceptives)	**BENEFIT**		
Generic Prescription Drugs	$0 copayment	$0 copayment	Not covered
Select Brand Prescription Drugs**	$0 copayment	$0 copayment	Not covered
Preferred Brand Prescription Drugs	$60 copayment	$60 copayment	Not covered
Non-Preferred Brand Prescription Drugs	$90 copayment	$90 copay	Not covered
PRESCRIPTION CATEGORY	**BENEFIT**		
Contraceptives	Covered	Covered	Not covered
Fertility Drugs ($2,500 maximum benefit limit per member)	Covered	Covered	Covered
Sexual Dysfunction Drugs	Covered	Covered	Not covered
Weight Loss Drugs	Covered	Covered	Not covered
Non-Specialty Injectables (self-administered)	Covered	Covered	Not covered
Specialty Drugs (self-administered)	Covered	Not covered	Covered
Nicotine Cessation Products (prescription)	Covered	Covered	Not covered
Vitamins (prescription, non-prenatal)	Covered	Covered	Not covered
Prenatal Vitamins (prescription)	Covered	Covered	Not covered
Anti-Flu Therapies	Covered	Not covered	Not covered
Diabetic Supplies	Covered	Covered	Not covered
Topical Retinoid (Acne) Products	Covered	Covered	Not covered
Over-the-Counter Equivalents	Not covered	Not covered	Not covered
UTILIZATION PROGRAM	**BENEFIT**		
Generic Substitution Program	**Restrictive Generic Substitution** – In addition to the coinsurance/ copayment, the member pays the difference between the brand and generic drug price (when there is a generic alternative) unless the prescribing physician requests the brand be dispensed.		
Quantity Level Limits (per prescription, per day supply or per copayment)	**Applicable to selected drugs. Please refer to the Capital BlueCross formulary or go to** www.capbluecross.com.		
Prior Authorization	**Applicable to selected drugs. Please refer to the Capital BlueCross formulary or go to** www.capbluecross.com.		
Enhanced Prior Authorization	**Applicable to selected drugs. Please refer to the Capital BlueCross formulary or go to** www.capbluecross.com.		

This is not a Contract. Programs are subject to change. This information highlights benefits, limitations and exclusions of the prescription drug coverage and is not intended to be a complete list or complete description of available services. The terms and conditions of coverage shall be governed solely by the contract issued to the group. Contact your employer, marketing representative, or broker for additional benefit details.

*Refer to your Certificate of Coverage or contact your employer for the applicable benefit period.

**Select Brands include contraceptives for which there is no generic equivalent.

The pharmacy network includes many chain and independent retail pharmacies nationwide. Visit www.capbluecross.com to find a participating pharmacy.

Participating pharmacies agree to accept our allowance as payment in full, often less than their normal charge. If you use a non-participating pharmacy, you are responsible for paying the difference between what the non-participating pharmacy charges and the allowable amount in addition to any deductible, coinsurance or copayment. You will also need to complete and submit a claim form for reimbursement. 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.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments described in your company's other health benefits coverage.

The prescription drug reimbursement plan is not offered in conjunction with the POS medical plan.

On behalf of Capital BlueCross, CVS/Caremark assists in the administration of our prescription drug program. CVS/Caremark is an independent pharmacy benefit manager.

On behalf of Capital BlueCross, CVS/Caremark assists in the administration of our prescription drug program. CVS/Caremark is an independent pharmacy benefit manager. Accredo Health Group, Inc. is the exclusive vendor for specialty prescription drugs. On behalf of Capital BlueCross, Accredo Health Group, Inc. assists in the delivery of specialty medications directly to our Members. Accredo Health Group, Inc. is an independent company.

Benefits are underwritten by Capital Advantage Assurance Company or by Capital Advantage Insurance Company. Both companies are subsidiaries of Capital BlueCross and are independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.