Capital BLUE

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BENEFIT HIGHLIGHTS

PPO 1500/100 Plan

Albright 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 $3,000 per family	$1,500 per member $3,000 per family
Coinsurance (percentage you pay after your deductible is met)	No member coinsurance	20% 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.)	$6,350 per member $12,700 per family	$2,500 per member $5,500 per family
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist) Visits – delivered via the Capital BlueCross Virtual Care platform	$15 copayment per visit	Not covered
Office Visits and Consultations (In-person & Telehealth) - performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	$25 copayment per visit	20% coinsurance after deductible
Specialist Office Visits (In-person, Telehealth & via the Capital BlueCross Virtual Care platform)	$25 copayment per visit	20% coinsurance after deductible Virtual Care-not covered
Urgent Care Services	$50 copayment per visit	20% coinsurance after deductible
Emergency Room	$100 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and Adult Preventive Care	No charge	20% coinsurance after deductible
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge	20% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge	20% coinsurance, waive deductible
Diagnostic Mammogram	No charge after deductible	20% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	No charge after deductible	20% coinsurance after deductible
Acute Inpatient Rehabilitation (60 days per benefit period)	No charge after deductible	20% coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	No charge after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care	No charge after deductible	20% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	No charge after deductible	20% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	No charge after deductible	Not covered
Outpatient Surgery at Acute Care Hospital (facility charge only)	No charge after deductible	20% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	No charge after deductible	20% coinsurance after deductible
Radiology (other than high tech imaging)	No charge after deductible	20% coinsurance after deductible
Independent Laboratory	No charge after deductible	20% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	No charge after deductible	20% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (20 visits per benefit period)	$25 copayment per visit	20% coinsurance after deductible
Occupational Therapy (12 visits per benefit period)	$25 copayment per visit	20% coinsurance after deductible
Speech Therapy (12 visits per benefit period)	$25 copayment per visit	20% coinsurance after deductible
Respiratory Therapy	No charge after deductible	20% coinsurance after deductible
Manipulation Therapy (20 visits per benefit period)	$25 copayment per visit	20% coinsurance after deductible
Acupuncture	Not covered	Not covered
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	No charge after deductible	20% coinsurance after deductible
MH Outpatient Services	$25 copayment per visit	20% coinsurance after deductible
SUD Detoxification Inpatient	No charge after deductible	20% coinsurance after deductible
SUD Rehabilitation Outpatient	$25 copayment per visit	20% coinsurance after deductible
Additional Services		
Home Health Care Services (60 visits per benefit period)	No charge after deductible	20% coinsurance after deductible
Durable Medical Equipment and Supplies	No charge after deductible	20% coinsurance after deductible
Prosthetic Appliances	No charge after deductible	20% coinsurance after deductible
Orthotic Devices	No charge after deductible	20% coinsurance after deductible

COST SHARING FOR PRESCRIPTION DRUGS DOES NOT APPLY TO THE MEDICAL DEDUCTIBLE SHOWN ON PAGE 1			
YOUR PRESCRIPTION DRUG SUMMARY OF COST-SHARING			
	Member Responsibilities		
	If provider is in-network	**If provider is out-of-network**	
Deductible (per benefit period)	$100 per member $200 per family		
	Retail Pharmacy (up to a 30 day supply)	Home Delivery (up to a 90 day supply)	Specialty Pharmacy (up to a 30 day supply)
Prescription Drug Tier			
Generic Preferred	$30 copayment	$30 copayment	$30 copayment
Generic Nonpreferred	$30 copayment	$30 copayment	$30 copayment
Brand Preferred	$60 copayment	$60 copayment	$60 copayment
Brand Nonpreferred	$90 copayment	$90 copayment	$90 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	$60 copayment	$60 copayment	Not covered
Brand Nonpreferred	$90 copayment	$90 copayment	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	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 physician requests the brand 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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Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.