

**BENEFIT HIGHLIGHTS**



**PPO**

[CapitalBlueCross.com](http://CapitalBlueCross.com)

**Cedar Crest College – Student Health Plan**

Important notice for fully insured individual and employer group plans in Pennsylvania: Advertised health insurance policies or programs may not cover all your healthcare expenses. Read your contract or benefit booklet (certificate of coverage) carefully to determine which healthcare services are covered. Questions? Please call 800.962.2242 or the number on the back of your ID card (TTY: 711).

<b>YOUR MEDICAL PLAN SUMMARY OF COST SHARING</b>		
	<b>Member Responsibilities</b>	
	<b>If provider is in-network</b>	<b>If provider is out-of-network</b>
<b>Deductible</b> (per benefit period)	\$250 per member	\$600 per member
<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%. This includes deductible, copayments and coinsurance for medical including ER and prescription drug, for in-network providers only.)	\$7,500 per member \$13,700 per family	\$15,000 per member
<b>Office Visit / Urgent Care / Emergency Room Copayments</b>		
<b>VirtualCare (non-specialist) visits</b> —delivered via the Capital Blue Cross VirtualCare platform	No charge, deductible waived	Not applicable
<b>VirtualCare (specialist) visits</b> —delivered via the Capital Blue Cross VirtualCare platform	No charge, deductible waived	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	20% coinsurance after deductible
<b>Specialist office visits (in-person &amp; telehealth)</b>	\$25 copayment per visit	20% coinsurance after deductible
<b>Urgent care services</b>	\$50 copayment per visit	
<b>Emergency room</b>	\$150 copayment per visit, waived if admitted	
<b>Preventive Care</b>		
<b>Pediatric and adult preventive care</b>	No charge, deductible waived	Not covered
<b>Screening gynecological exam and pap smear</b> (one per benefit period)	No charge, deductible waived	Not covered
<b>Screening mammogram</b> (one per benefit period)	No charge, deductible waived	Not covered
<b>Facility / Surgical Services</b>		
<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>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Skilled nursing facility</b>	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	40% coinsurance after deductible
<b>Outpatient surgery at acute care hospital</b> (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Diagnostic Services</b>		
<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>	20% coinsurance after deductible	Not covered
<b>Therapy Services (Rehabilitative and Habilitative Services)</b>		
<b>Physical therapy</b> (12 visits per benefit period)	\$25 copayment per visit	40% coinsurance after deductible
<b>Occupational therapy</b> (12 visits per benefit period)	\$25 copayment per visit	40% coinsurance after deductible
<b>Speech therapy</b> (12 visits per benefit period)	\$25 copayment per visit	40% coinsurance after deductible
<b>Respiratory therapy</b> (12 visits per benefit period)	\$25 copayment per visit	40% coinsurance after deductible
<b>Manipulation therapy</b> (20 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Mental Health (MH) and Substance Use Disorder Services (SUD)</b>		
<b>MH &amp; SUD detoxification inpatient services</b>	20% coinsurance after deductible	40% coinsurance after deductible
<b>MH &amp; SUD rehabilitation outpatient services</b>	\$25 copayment per visit	20% coinsurance after deductible
<b>Additional Services</b>		
<b>Home healthcare services</b>	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)	No member deductible		Not covered
	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	\$25 copayment	\$62.50 copayment	\$25 copayment
Generic nonpreferred	\$25 copayment	\$62.50 copayment	\$25 copayment
Brand preferred	\$60 copayment	\$150 copayment	\$60 copayment
Brand nonpreferred	\$75 copayment	\$187.50 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	\$60 copayment	\$150 copayment	Not covered
Brand nonpreferred	\$75 copayment	\$187.50 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>	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) <u>unless</u> the physician requests the brand 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.		

**YOUR PEDIATRIC VISION SUMMARY OF COST-SHARING**

(Benefit frequencies are once every 12 months based on date of service)	Member Responsibilities	
	If provider is in-network	If provider is out-of-network
<b>Vision Exam</b>	No charge	\$32 allowance
<b>Eyeglass Lenses</b>	Single, Bi-focal, Tri-focal, and Polycarbonate – Covered in full	Single - \$24; Bi-focal - \$36; Tri-focal - \$46; Polycarbonate – Not covered
<b>Contact Lenses**</b> (Payment will be made for either lenses or contact lenses within a benefit period. Payment will not be made for both.)	Balance of retail charge less 25% after \$75 allowance	\$50 allowance
<b>Standard Frames from a collection**</b>	No charge	Balance of retail charge after \$30 allowance
<b>All other frames</b>	Balance of retail charge less 30% after \$100 allowance	Balance of retail charge after \$30 allowance

**YOUR PEDIATRIC DENTAL SUMMARY OF COST-SHARING**

	Member Responsibilities if provider is in-network
<b>Deductible</b>	\$50 per person
<b>Preventive Services</b>	No charge
<b>Basic Services</b>	20% coinsurance after deductible
<b>Major Services</b>	50% coinsurance after deductible
<b>Orthodontia (Medically Necessary)</b>	50% coinsurance after deductible

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.

Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

<b>Premium Rates – 2024/2025 Plan Year</b>	
Annual Rate per Student August 1, 2024 – July 31, 2025	\$2,400
Spring/Summer January 1, 2025 – July 31, 2025	\$1,400