

## Albright College Benefit Plan Options

### **AmeriHealth Administrators ICHP PPO - Base Plan**

#### **In Network Benefits**

Office visit is \$25/\$40 Specialist co-pay

Prescription drug benefit for pharmacy is \$25 generic/\$50 brand/\$75 non formulary

\$100 Deductible per person, \$200 maximum for 2 Party or Family

Mail Order (provides up to a 90 day supply), same as the above pharmacy charges

\$1,000 Deductible is applicable for basic services, lab work, diagnostic tests, etc.

Doctor visits, prescription fees and State-mandated benefits are separate from the deductible

After the deductible is satisfied, each Subscriber pays 20% of the first \$5,000; eligible expenses are then covered 100%.

Maximum out of pocket expense \$2,000 per individual, \$4,000 for two party and \$4,500 per family

#### **Out of Network Benefits**

\$1,000 deductible, 80/20 coinsurance

### **AmeriHealth Administrators ICHP PPO – Buy Up Plan**

#### **In Network Benefits**

Office visit is \$25 co-pay

Prescription drug benefit for pharmacy is \$25 generic/\$50 brand/\$75 non formulary

\$100 Deductible per person, \$200 maximum for 2 Party or Family

Mail Order (provides up to a 90 day supply), same as the above pharmacy charges

\$500 Deductible is applicable for basic services, lab work, diagnostic tests, etc.

Doctor visits, prescription fees and State-mandated benefits are separate from the deductible

After the deductible is satisfied, each Subscriber pays 20% of the first \$5,000; eligible expenses are then covered 100%.

Maximum out of pocket expense \$1,500 per individual, \$3,000 for two party and \$3,500 per family

#### **Out of Network Benefits**

\$500 deductible, 80/20 coinsurance

### **Albright College Medical Waiver Reimbursement Plan**

All employees who elect NOT to participate in the basic medical coverage may elect this option. This allows the employee to submit for payment those eligible medical expenses NOT covered by their other insurance carriers, based upon Albright College's current medical plan descriptions. This plan covers only the employee and does not include reimbursement for dental and vision expenses. The reimbursement amount shall not exceed \$1,500.00 between June 1, 2011 and May 31, 2012.

### **Dearborn National Dental Insurance Plan**

\$1000.00 per person combined dental expense limit per calendar year.

Low Option – 100% coverage for basic diagnostic, preventative, and 90% of minor restorative services

High Option – 100% coverage for basic diagnostic, preventative, 90% of minor restorative services and 50% major restorative services

### **Avesis Vision Care**

In-Network eye exam free, and full or discounted coverage on eyewear and contact lenses, Out-of-Network reimbursements.

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**NOTE:** This is a summary and not a benefit policy statement. Please consult individual benefit packets for plan details.