Capital BLUE

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Benefit Highlights
COMPREHENSIVE Plan

Lehigh University

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)	$600 per member $1,800 per family	
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	Coinsurance applies	Coinsurance applies
• **Specialist Office Visit**	Coinsurance applies	Coinsurance applies
• **Emergency Room**	Coinsurance applies	Coinsurance applies
• **Urgent Care**	Coinsurance applies	Coinsurance applies
• **Inpatient** (Per Admission)	Coinsurance applies	Coinsurance applies
• **Outpatient Surgery Copayment** (facility)	Coinsurance applies	Coinsurance applies
Coinsurance	Coinsurance applies	Coinsurance applies
Coinsurance Out-of-Pocket Maximum *(includes Coinsurance amounts; when this amount is satisfied, no further coinsurance is applied*).	$1,000 per member $3,000 per family	
Out-of-Pocket Maximum *(includes Deductible and Coinsurance for Medical* for Participating Providers only).	$4,000 per member $8,000 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	Not covered
• Adult Preventive Care		Covered in full, waive deductible	Not covered
Immunizations		Covered in full, waive deductible	20% coinsurance after deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	20% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	20% coinsurance after deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		20% coinsurance after deductible	20% coinsurance after deductible
Acute Inpatient Rehabilitation		20% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility	120 days/benefit period	20% coinsurance after deductible	20% coinsurance after deductible
Surgery			
• Surgical Procedure & Anesthesia		20% coinsurance after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care		20% coinsurance after deductible	20% coinsurance after deductible
Diagnostic Services			
• Radiology		20% coinsurance after deductible	20% coinsurance after deductible
• Laboratory		20% coinsurance after deductible	20% coinsurance after deductible
• Medical tests		20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery		20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine		20% coinsurance after deductible	20% coinsurance after deductible
• Occupational Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Speech Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Respiratory Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Manipulation Therapy		20% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		20% coinsurance after deductible	
Mental Health Care Services • Inpatient Services		20% coinsurance after deductible	20% coinsurance after deductible
• Outpatient Services		20% coinsurance after deductible	20% coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient		20% coinsurance after deductible	20% coinsurance after deductible
• Rehabilitation – Outpatient		20% coinsurance after deductible	20% coinsurance after deductible
Home Health Care Services	120 visits/benefit period	20% coinsurance after deductible	20% coinsurance after deductible
Durable Medical Equipment (DME)		20% coinsurance after deductible	20% coinsurance after deductible
Prosthetic Appliances		20% coinsurance after deductible	20% coinsurance after deductible
Orthotic Devices		20% coinsurance after deductible	20% coinsurance after deductible

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