

BENEFIT HIGHLIGHTS

CapitalBlueCross.com

QHDHP PPO PLAN

Lehigh University

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) Deductible is combined to include medical and prescription drug benefits for in-network providers. If you enroll in a family plan, the overall family deductible must be met before the plan begins to pay.	\$2,000 single coverage \$4,000 family coverage	\$2,500 single coverage \$5,000 family coverage
Coinsurance (Percentage you pay after your deductible is met).	20% coinsurance after deductible	40% coinsurance after deductible
Out-of-pocket maximum	Overall in-network out-of-pocket maximum includes deductible, copayments, and coinsurance for medical and prescription drugs: \$5,000 per member \$10,000 per family	Overall out-of-network out-of-pocket not applicable
Office Visit / Urgent Care / Emergency Room Copayments		
VirtualCare (specialist) visits —delivered via the Capital Blue Cross VirtualCare platform	\$10 copayment per visit after deductible	Not applicable
VirtualCare (specialist) visits —delivered via the Capital Blue Cross VirtualCare platform	\$30 copayment per visit after deductible	Not applicable
Office visits and consultations (in-person & telehealth) —performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	20% coinsurance after deductible	40% coinsurance after deductible
Specialist office visits (in-person, telehealth & via the Capital Blue Cross VirtualCare platform)	20% coinsurance after deductible	40% coinsurance after deductible
Urgent care services	20% coinsurance after deductible	40% coinsurance after deductible
Emergency room	20% coinsurance after deductible	
Preventive Care		
Pediatric and adult preventive care	No charge, deductible waived	Not covered
Screening gynecological exam and pap smear	No charge, deductible waived	40% coinsurance after deductible
Screening mammogram	No charge, deductible waived	40% coinsurance after deductible
Facility / Surgical Services		
Inpatient hospital room and board including maternity services and newborn care	20% coinsurance after deductible	40% coinsurance after deductible
Acute inpatient rehabilitation (60 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Skilled nursing facility (100 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Surgical procedure and anesthesia (professional charges)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery at ambulatory surgical center (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery at acute care hospital (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Services		
High tech imaging (such as MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible
Radiology (other than high tech imaging)	20% coinsurance after deductible	40% coinsurance after deductible
Independent laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Facility-owned laboratory (i.e. Health System owned)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic mammogram	20% coinsurance after deductible	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical therapy (30 visits per condition per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Occupational therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Speech therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Respiratory therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Manipulation therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH & SUD detoxification inpatient services	20% coinsurance after deductible	40% coinsurance after deductible
MH & SUD rehabilitation outpatient services	20% coinsurance after deductible	40% coinsurance after deductible
Additional Services		
Home healthcare services (90 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Durable medical equipment and supplies; prosthetic appliances and orthotic devices	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.

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.

In-network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider's charges and the allowed amount. Out-of-network providers may balance bill the member. Some out-of-network 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.

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



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage: about health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and about vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$2,000 individual / \$4,000 family participating providers ; \$2,500 individual / \$5,000 family non-participating providers . Deductible applies to all services, including prescription drug , before any copayment or coinsurance are applied.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Network preventive services .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For participating providers \$5,000 individual / \$10,000 family; for non-participating providers \$0 individual combined out-of-pocket limit for medical and prescription drug .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Pre-authorization penalties, premiums , balance billing charges, vision care costs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. For a list of participating providers , see www.capbluecross.com or call 1-800-962-2242. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No charge	Mandated screening and immunizations 40% coinsurance ; Routine Physical exams; Not covered	Deductible does not apply to services at participating providers . You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for lab and 20% coinsurance for tests. 20% coinsurance for outpatient radiology.	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or call 1-866-383-7420.	Generic drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	25% coinsurance (retail and mail order)	25% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	35% coinsurance (retail and mail order)	35% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	25% coinsurance for preferred brand drugs and 35% coinsurance For non-preferred brand drugs	Not covered	Some drugs may require purchase through Accredo Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Services at non-participating ambulatory surgical facilities 40% coinsurance .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Depending on the type of services, a copayment , coinsurance , or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	90 visits*See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	20% coinsurance	40% coinsurance	30 visits per condition per benefit year
	Habilitation services	20% coinsurance	40% coinsurance	30 visit per condition
	Skilled nursing care	20% coinsurance	40% coinsurance	100 day limit
	Durable medical equipment	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If your child needs dental or eye care More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431.	Children's eye exam	No charge	Full cost less \$32	Limited to one exam per year
	Children's glasses	No charge for standard lenses and select frames; Amount over \$60 for provider frames	Full cost less \$55 for standard lenses and any frame	Limited to one pair of glasses per year
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- | | | |
|--|------------------|--|
| • Acupuncture | • Dental care | • Routine foot care (unless medically necessary) |
| • Bariatric Surgery (unless medically necessary) | • Hearing aids | • Weight loss programs |
| • Cosmetic Surgery | • Long-term care | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|-------------------------|--|------------------------|
| • Chiropractic Care | • Non-emergency care when traveling outside the U.S. | • Private-duty nursing |
| • Infertility treatment | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: for health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; for prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and for vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言咨询传译员，请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)

(للتحدث مجاناً إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interprète dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

දුරකථන මගින් වැදගත් කරන, 800.962.2242 (TTY: 711) ට කතා කරන්න.

Aby porozmawiac z tłumaczem w języku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711)

Pou pale avèk yon entèprèt nan lang ou gratis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែបន្ទាប់មកជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅលេខ 800.962.2242 (TTY: 711)

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).

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To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$2000
■ Specialist [<i>cost sharing</i>]	20%
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,160

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2000
■ Specialist [<i>cost sharing</i>]	20%
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2000
Copayments	\$0
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,820

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2000
■ Specialist [<i>cost sharing</i>]	20%
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200