Keystone HEALTH PLAN® CENTRAL
A Capital BlueCross Company
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Benefit Highlights
HMO 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 complete description of available services. Refer to your Certificate of Coverage for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:
Deductible (per benefit period)	Not Applicable
Copayments	
• **Office Visits - PCP** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$20 copayment per visit
• **Specialist Office Visit**	$20 copayment per visit
• **After Hours Office Visit** (in addition to the PCP office visit copayment)	$10 copayment per visit
• **Emergency Room**	$25 copayment per visit, waived if admitted
• **Urgent Care** – Outside service area	Covered in full, after $25 copayment (PCP or Emergency Room)
• **Urgent Care** – In service area	Covered in full after $25 copayment (additional $10 copayment for after hours visit)
• **Inpatient** (Per Admission)	Covered in full
• **Outpatient Surgery Copayment** (facility)	Not Applicable
Coinsurance	50% coinsurance, where applicable
Out-of-Pocket Maximum (*includes deductible, copayments and coinsurance for Medical (including ER) for Participating Providers only*)	$4,150 per member $8,300 per family

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*		
Preventive Care Services		
• Pediatric Preventive Care		Covered in full
• Adult Preventive Care		Covered in full
Immunizations		Covered in full
Mammograms		
• Screening Mammogram	One per benefit period	Covered in full (no referral necessary)
• Diagnostic Mammogram		Covered in full
Gynecological Services		
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full (no referral necessary)
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET		
Acute Care Hospital Room & Board		Covered in full
Acute Inpatient Rehabilitation Skilled Nursing Facility	60 days/benefit period combined	Covered in full
Surgery		
• Surgical Procedure & Anesthesia		Covered in full
Maternity Services and Newborn Care		Covered in full
Diagnostic Services		
• Radiology		Covered in full
• Laboratory		Covered in full
• Medical tests		Covered in full
Outpatient Therapy Services		
• Physical Medicine • Occupational Therapy • Respiratory Therapy • Speech Therapy	30 (visits each type/benefit period)	Covered in full
Emergency Services		Emergency room copayment applies, waived if admitted inpatient
Mental Health Care Services		
• Inpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
• Outpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
Substance Abuse Services		
• Rehabilitation – Inpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
• Rehabilitation – Outpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
Home Health Care Services	100 visits/benefit period	Covered in full
Durable Medical Equipment (DME)		Covered in full
Prosthetic Appliances		Covered in full
Orthotic Devices		Covered in full

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