Capital BLUE

www.capbluecross.com

Document Assistant
Ask Alexa "Open my Cap BlueCross" and follow instructions

BENEFIT HIGHLIGHTS

PPO Plus 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 benefit 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)	Not Applicable	$500 per member
Coinsurance (percentage you pay after your deductible is met)	15% coinsurance	40% coinsurance
Out-of-Pocket Maximum (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.)	$4,000 per member $8,000 per family	Unlimited
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist) Visits – delivered via the Capital BlueCross Virtual Care platform (excluding behavioral health visits)	$10 copayment per visit	Not covered
Office Visits and Consultations (In-person & Telehealth) - performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	$30 copayment per visit	40% coinsurance after deductible
Specialist Office Visits (In-person & Telehealth	$50 copayment per visit	40% coinsurance after deductible Virtual Care – Not covered
Urgent Care Services	$50 copayment per visit	40% coinsurance after deductible
Emergency Room	$150 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and Adult Preventive Care	No charge	Not covered
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge	40% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge	40% coinsurance, waive deductible
Diagnostic Mammogram	15% coinsurance	40% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	15% coinsurance	40% coinsurance after deductible
Acute Inpatient Rehabilitation	15% coinsurance	40% coinsurance after deductible
Skilled Nursing Facility (120 days per benefit period)	15% coinsurance	40% coinsurance after deductible
Maternity Services and Newborn Care (professional charges)	15% coinsurance	40% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	15% coinsurance	40% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	15% coinsurance	40% coinsurance after deductible
Outpatient Surgery at Acute Care Hospital (facility charge only)	15% coinsurance	40% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	15% coinsurance	40% coinsurance after deductible
Radiology (other than high tech imaging)	15% coinsurance	40% coinsurance after deductible
Independent Laboratory	15% coinsurance	40% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	15% coinsurance	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (30 visits per benefit period per condition)	15% coinsurance	40% coinsurance after deductible
Occupational Therapy (30 visits per benefit period)	15% coinsurance	40% coinsurance after deductible
Speech Therapy (30 visits per benefit period)	15% coinsurance	40% coinsurance after deductible
Respiratory Therapy	15% coinsurance	40% coinsurance after deductible
Manipulation Therapy	15% coinsurance	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
MH Outpatient Services		
SUD Detoxification Inpatient		
SUD Rehabilitation Outpatient		
Additional Services		
Home Health Care Services (90 visits per benefit period)	15% coinsurance	40% coinsurance after deductible
Durable Medical Equipment and Supplies	15% coinsurance	40% coinsurance after deductible
Prosthetic Appliances	15% coinsurance	40% coinsurance after deductible
Orthotic Devices	15% coinsurance	40% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. An independent licensee of the BlueCross BlueShield 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 a out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider' 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.

Voice activated paper.
Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.