Capital BLUE

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Benefit Highlights
PPO 80 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)	$200 per member $600 per family	$500 per member
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$20 copayment per visit	Coinsurance applies
• **Specialist Office Visit**	$20 copayment per visit	Coinsurance applies
• **Emergency Room**	$35 copayment per visit, waived if admitted	
• **Urgent Care**	$20 copayment per visit	Coinsurance applies
• **Inpatient** (Per Admission)	Coinsurance applies	Coinsurance applies
• **Outpatient Surgery Copayment** (facility)	Coinsurance applies	Coinsurance applies
Coinsurance	20% coinsurance	30% coinsurance
Coinsurance Out-of-Pocket Maximum *(includes Coinsurance amounts; when this amount is satisfied, no further coinsurance is applied*).	$800 per member $2,400 per family	Unlimited
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	Unlimited

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	30% coinsurance, waive deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	30% coinsurance, waive deductible
• Diagnostic Mammogram		20% coinsurance after deductible	30% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	30% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		20% coinsurance	30% coinsurance
Acute Inpatient Rehabilitation		20% coinsurance	30% coinsurance
Skilled Nursing Facility	100 days/benefit period	20% coinsurance	30% coinsurance
Surgery			
• Surgical Procedure & Anesthesia		20% coinsurance	30% coinsurance
Maternity Services and Newborn Care		20% coinsurance	30% coinsurance
Diagnostic Services			
• Radiology		20% coinsurance	30% coinsurance
• Laboratory		20% coinsurance	30% coinsurance
• Medical tests		20% coinsurance	30% coinsurance
Outpatient Surgery		20% coinsurance	30% coinsurance
Outpatient Therapy Services			
• Physical Medicine		20% coinsurance	30% coinsurance
• Occupational Therapy		20% coinsurance	30% coinsurance
• Speech Therapy		20% coinsurance	30% coinsurance
• Respiratory Therapy		20% coinsurance	30% coinsurance
• Manipulation Therapy		20% coinsurance	30% coinsurance
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
Mental Health Care Services • Inpatient Services		20% coinsurance	30% coinsurance
• Outpatient Services		Copayment applies	30% coinsurance
Substance Abuse Services • Rehabilitation – Inpatient		20% coinsurance	30% coinsurance
• Rehabilitation – Outpatient		Copayment applies	30% coinsurance
Home Health Care Services	90 visits/benefit period	20% coinsurance	30% coinsurance
Durable Medical Equipment (DME)		20% coinsurance	30% coinsurance
Prosthetic Appliances		20% coinsurance	30% coinsurance
Orthotic Devices		20% coinsurance	30% coinsurance

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