Keystone HEALTH PLAN® CENTRAL
A Capital BlueCross Company
Independent Licensees of the BlueCross BlueShield Association

www.capbluecross.com

Benefit Highlights
HMO Plan
Lehigh University

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:
Deductible (per benefit period) ***Deductible applies to all services unless a Copayment is applied or otherwise noted***	Not applicable
Copayments	
• Office Visits - PCP (Family Practitioner, General Practitioner, Internist, Pediatrician)	$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 Copayments for all services)* When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the benefit period ends.	$6,350 per member $12,700 per family
Coverage Lifetime Maximum	None

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
• Newborn Circumcisions		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	One per benefit period	Covered in full (no referral necessary)
• Screening 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		Covered in full
• Anesthesia		Covered in full
• Removal of boney impacted teeth		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 and occupational, respiratory, speech, cardiac, orthoptic and urinary incontinence therapy	30 visits/condition per calendar year	Covered in full
Emergency Services		Covered in full Emergency room copayment applies, waived if admitted inpatient
Urgent Medical Care		
• In Service Area		Covered in full after payment (additional copayment for AH visit)
• Outside Service Area		Covered in full after PCP or Emergency Room copayment
Medical Transport		
• Emergency Ambulance		Covered in full
• Medically Necessary Ambulance		Coverd in full (between facility providers)

SUMMARY OF BENEFITS (CONTINUED)	Limits and Maximums	Amounts Members Are Responsible For:
Mental Health Care Services • Inpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
• Outpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
Substance Abuse Services • Rehabilitation – Inpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
• Rehabilitation – Outpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
Home Health Care Services	100 visits/benefit period	Covered in full
Hospice Care		Covered in full
Durable Medical Equipment (DME)		Covered in full
Prosthetic Appliances and Orthotic Devices		Covered in full
Diabetic Supplies and Education		Covered in full when obtained at Participating (DME) Provider 50% coinsurance when obtained at a Participating Pharmacy
Infertility Services	$2,500 benefit lifetime max/subscriber & spouse each	50% coinsurance (artificial insemination)
Assisted Fertilization		Not Covered (invitro fertilization)

OTHER STANDARD PLAN FEATURES	
Preauthorization	Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs.
Disease Management	Disease Management Programs are a collaborative process that assesses the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression.
Nurse Line	Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE.
Better Health Works[SM] Personal Profile	Answer questions about yourself and the way you live and, based on the answers you provide, you will receive customized recommendations for your health situation. Support is available to follow through on these recommendations and to make positive health changes.
mycapbluecross.com	Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWell[sm] member newsletter, view explanations of benefits, and much more.

STANDARD BENEFIT EXCLUSIONS. The following list highlights ***some*** standard benefit exclusions. It is **NOT** intended to be a complete list or a complete description of all categories of benefit exclusions.

Cosmetic procedures – Acupuncture – Routine foot care; or support devices of the feet – Eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses – Corneal surgery and other procedures to correct refractive errors – Prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider – Hearing aids or examinations for the prescription or fitting of hearing aids – All dental services rendered after stabilization of a member in an emergency following an accidental injury – Treatment of obesity and/or morbid obesity, except to correct morbid obesity - Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcision - Invitro fertilization and/or embryo transplants - - Private duty nursing services - Procedures to reverse sterilization -

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.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered.

For more information or to locate a participating provider, visit www.capbluecross.com.

Refer to your Certificate of Coverage for the applicable benefit period.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size > 51.