Capital BLUE

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Benefit Highlights
PPO 80 Plan
Lehigh University

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:	
	Participating Providers	*Non-Participating Providers*
Deductible (per benefit period) *Deductible applies to all services unless a Copayment is applied or otherwise noted*	$200 per member $600 per family	$500 per member
Copayments		
• Office Visits (Family Practitioner, General Practitioner, Internist, Pediatrician)	$ 20 copayment per visit	Coinsurance applies
• Specialist Office Visit	$ 20 copayment per visit	Coinsurance applies
• Emergency Room	$ 35 copayment per visit	Coinsurance applies
• 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
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	Unlimited
Coverage Lifetime Maximum	Unlimited	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	One per benefit period	Covered in full, waive deductible	30% coinsurance, waive deductible
• Screening 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
• Transplant Services		20% coinsurance	30% coinsurance
Skilled Nursing Facility	100 days/benefit period	20% coinsurance	30% coinsurance
Surgery			
• Surgical Procedure		20% coinsurance	30% coinsurance
• 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 Therapy Services			
• Physical Medicine		20% coinsurance	30% coinsurance
• Occupational Therapy		20% coinsurance	30% coinsurance
• Speech Therapy		20% coinsurance	30% coinsurance
• Respiratory & Infusion Therapy		20% coinsurance	30% coinsurance
• Manipulation Therapy		20% coinsurance	30% coinsurance
Emergency Services		$35 copayment waived if admitted	30% coinsurance
Medical Transport			
• Emergency Ambulance		20% coinsurance	30% coinsurance
• Medically Necessary Ambulance		20% coinsurance	30% coinsurance

Benefits are underwritten by Capital Advantage Assurance Company or by Capital Advantage Insurance Company, subsidiaries of Capital BlueCross and independent licensees of the BlueCross BlueShield Association.

SUMMARY OF BENEFITS (CONTINUED)	**Limits and Maximums**	**Amounts Members Are Responsible For:**	
		Participating Providers	***Non-Participating Providers***
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
Hospice Care		20% coinsurance	30% coinsurance
Private Duty Nursing	240 hours/benefit period	20% coinsurance	30% coinsurance
Durable Medical Equipment (DME)		20% coinsurance	30% coinsurance
Prosthetic Appliances and Orthotic Devices		20% coinsurance	30% coinsurance
Diabetic Supplies and Education		20% coinsurance	30% coinsurance
Infertility Services	$2,500 benefit lifetime max/subscriber & spouse each	50% coinsurance	Not covered
Assisted Fertilization		Not Covered	Not Covered

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, except for surgical treatment of morbid obesity – Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcisions – 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.