Moravian University 2022 <65 Retiree Benefits Summary

HEALTH / Rx PLANS

Capital BlueCross/ Magellan Rx

Monthly Plan Premium Costs

	PPO Plan Higher semi-monthly deductions Lower deductibles		QHDHP Lower semi-monthly deductions Higher deductibles	
Coverage Option				
Single	$327.98		$295.18	
Single + Spouse	$944.79		$896.46	
HSA Employer Contribution				
Single	**N/A**		**Yes**	
Two Person or Family	**N/A**		**Yes**	
Plan Features	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual* Deductible				
Single	**$750**	**$1,500**	**$1,500**	
Two Person or Family	**$1,500**	**$3,000**	**$3,000**	
Plan pays	**100% after deductible**	**80% after deductible**	**100% after deductible**	**80% after deductible**
Out-of-Pocket Limit				
Single	None	$3,000	None	$3,000
Two Person or Family	None	$6,000	None	$6,000
Annual out-of-Pocket Maximum				
Single	$8,150	N/A	$6,900	N/A
Two Person or Family	$16,300	N/A	$13,800	N/A
Office/Clinic/Urgent Care Visits				
Retail Clinic	$15 Copay	80% after deductible	$15 Copay after deductible	80% after deductible
Telemedicine	$10 Copay	Not covered	$10 Copay after deductible	Not covered
Primary Care	$25 Copay	80% after deductible	$25 Copay after deductible	80% after deductible
Specialist	$35 Copay	80% after deductible	$35 Copay after deductible	80% after deductible
Urgent Care	$45 Copay	80% after deductible	$45 Copay after deductible	80% after deductible
Emergency Room**	$200 Copay	$200 Copay	$200 Copay	$200 Copay
Other Services/ Expenses				
Routine Adult/ Pediatric	**100% covered**	80% after deductible	**100% covered**	80% after deductible
Maternity	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Diagnostic Services (imaging, lab/pathology, allergy, MRI, etc.)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Prescriptions | Vendor: Magellan Rx				
	IN-NETWORK		**IN-NETWORK**	
Annual Deductible	$100 per individual		Integrated with medical deductible	
Retail (31-day supply)	$10, $15, $35, $65 Copay after the deductible		$10, $15, $35, $65 Copay after the deductible	
Maintenance (90-day supply Mail Order rq'd)	$25, $37, $87.50, $162.50 Copay after the deductible		$25, $37, $87.50, $162.50 Copay after the deductible	

This a shortened summary of coverage. For more information about coverage, reference summary of benefits and coverage (SBC).
**Annual year is January 1 through December 31. **Emergency Room copay waived if admitted.*
Annual out-of-Pocket Maximum - Includes deductible, copays and coinsurance for medical (including ER), and prescription drug for participating providers only. Out-of-Pocket Limit - Once met, plan pays 100% coinsurance for the rest of the benefit period.

Service/ age requirement may differ. Retirees hired after 01/01/2004 are ineligible for health insurance benefit.

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VISION PLANS

National Vision Administrators

Quarterly Plan Premium Costs

	BASIC	ENHANCED
Coverage Option		
Single	$19.95	$27.15
2 Individuals	$35.88	$48.87
3+ Individuals	$51.84	$70.59

	BASIC Lower semi-monthly deductions Less retail allowance		ENHANCED Higher semi-monthly deductions More retail allowance	
Plan Features	**PARTICIPATING**	**NON-PART.**	**PARTICIPATING**	**NON-PART.**
Examination	100% covered	Reimbursed up to $32	100% covered	Reimbursed up to $32
Contact Lense Eval/ Fitting	100% covered	Daily wear $20 Extended wear $30	100% covered	Daily wear $20 Extended wear $30
Lenses	100% covered	Depends on lense type	100% covered	Depends on lense type
Frames*	Up to $60 retail	Up to $30 retail	Up to $100 retail	Up to $50 retail
Contact Lenses**	Up to $85 retail	Up to $85 retail	Up to $100 retail	Up to $85 retail
LASIK consultation	1st initial free	N/A	1st initial free	N/A
Laser Eye Surgery	15% off standard prices 5% off promo pricing	N/A	15% off standard prices 5% off promo pricing	N/A

**Frame allowance valid once every 2 calendar years. **In lieu of lenses & frame.*
Pre-approvals may be required. Discounts not offered at all eye locations. Additional lens options extra.
For more plan coverage details and additional exclusions, visit e-nva.com.

DENTAL PLAN

United Concordia

Quarterly Plan Premium Costs

	ADVANTAGE+
Coverage Option	
Single	$88.92
2 Individuals	$177.96
3+ Individuals	$231.99

Plan Features	**IN-NETWORK**	**NON-NETWORK**
Annual Deductible	None	None
Diagnostic/ Preventive Services (excluded from program max)	**100% covered**	80% covered
Basic services	80% covered	60% covered
Major services	50% covered	50% covered
Annual program maximum (per person)	$1,000	$1,000
Lifetime orthodontic max (per person)	$800	$800

For covered services, see certificate of coverage and visit unitedconcordia.com.

questions?
Visit moravian.edu/benefits.