Moravian University - Student Health Insurance Plan PPO Smart Rx 80/60

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Effective Date	08/01/2026	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $250 $500	 $600 $1,200
Plan Pays - based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Limit Individual Family	 None None	 $15,000 $30,000
Total Maximum Out-of-Pocket Individual Family	 $9,100 $18,200	 Not Applicable Not Applicable
Outpatient Medical Care Visits and Telemedicine Services		
Retail Clinic Visits & Virtual Visits	100% after $25 copayment	60% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits (2) (3)	100% after $25 copayment	60% after deductible
Specialist Office Visits & Virtual Visits (2)	100% after $30 copay	60% after deductible
Virtual Visit Provider Originating Site Fee	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after $50 copay	60% after deductible
	copay does not apply when urgent care services are prescribed for the treatment of mental health or substance abuse	
On-Demand Telemedicine Services (4)	100% after $15 copay	Not Covered
Preventive Care Services (5)		
Routine Physical exams (Adult & Pediatric)	100% (deductible does not apply)	Not Covered
Adult immunizations	100% (deductible does not apply)	60% after deductible
Breast Cancer Screenings (includes mammograms and BRCA-Related Genetic Counseling and Genetic Testing)	100% (deductible does not apply)	60% after deductible
Colorectal cancer screenings	100% (deductible does not apply)	60% after deductible
Diabetes Prevention Program	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	60% after deductible
Routine Gynecological Examinations and Papanicolaou Smear	100% (deductible does not apply)	60% after deductible
Routine Screening tests and procedures	100% (deductible does not apply)	60% after deductible
Tobacco Use Counseling and Interventions	100% (deductible does not apply)	60% after deductible
Women's Wellbeing	100% (deductible does not apply)	60% after deductible
Vision Care Services Pediatric Vision Care (10)	100% (deductible does not apply)	Not Covered
Pediatric Dental Services (6) Consultations, Routine Exams, X-rays, Cleanings, Fluoride Treatments, Palliative Treatment (emergency), Occlusal Guard, Sealants and Space Maintainers	100% (deductible does not apply)	Not Covered
Other Pediatric Dental Services	50% (deductible does not apply)	Not Covered
Emergency Room and Ambulance Services		
Emergency Room Services	100% after a $150 copay	
Ambulance - Emergency	80% (deductible does not apply)	
Ambulance - Non-emergency (7)	80% after deductible	60% after deductible
Hospital and Medical/Surgical Services		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Maternity Services (9)	80% after deductible	60% after deductible
Inpatient Medical Care Services	80% after deductible	60% after deductible
Surgical Services	80% after deductible	60% after deductible

Habilitative and Rehabilitative Services		
Cardiac Rehabilitation	100% after $30 copay	60% after deductible
	Cardiac Rehabilitation does not include services provided for habilitative purposes.	
Occupational Therapy	100% after $30 copay	60% after deductible
	limit: 30 visits/benefit period each for Habilitative and Rehabilitative. Limits do not apply to services prescribed for the treatment of Mental Health or Substance Abuse.	
Physical Medicine	100% after $30 copay	60% after deductible
	limit: 30 visits/benefit period each for Habilitative and Rehabilitative. Limits do not apply to services prescribed for the treatment of Mental Health or Substance Abuse.	
Speech Therapy	100% after $30 copay	60% after deductible
	limit: 30 visits/benefit period each for Habilitative and Rehabilitative. -limit does not apply when rehabilitative or habilitative speech therapy services are prescribed for the treatment of childhood stuttering-Limits do not apply to services prescribed for the treatment of Mental Health or Substance Abuse.	
Mental Health Care Services and Substance Abuse Services		
Inpatient Care	80% after deductible	60% after deductible
Outpatient Care	100% after $30 copay	60% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited) and Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Artificial Insemination	80% after deductible	Not Covered
Autism Spectrum Disorders Applied Behavioral Analysis (8)	100% after $30 copay	60% after deductible
Diabetes Treatment		
Equipment and Supplies	80% after deductible	60% after deductible
Diabetes Education Program	80% after deductible	60% after deductible
Diagnostic Services		
Advanced Imaging (CT, CTA, MRI, MRA, PET scan, PTE/CT scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	80% after deductible	60% after deductible
Enteral Foods	80% (deductible does not apply)	60% (deductible does not apply)
Home Health Care and Hospice Care Services	80% after deductible	60% after deductible
	Respite Care is limited to 7 days every six (6) consecutive months	
Home Infusion and Suite Infusion Therapy	80% after deductible	60% after deductible
Private Duty Nursing Services	80% after deductible	60% after deductible
	limit: 90 Hours per Benefit Period	
Skilled Nursing Facility Services	80% after deductible	60% after deductible **limit:** 100 days/benefit period
Spinal Manipulations	100% after $30 copay	60% after deductible
	limit: 20 visits/benefit period	
Therapeutic Injections	80% after deductible	60% after deductible
Therapy Services (Chemotherapy, Dialysis Treatment, Infusion Therapy, Radiation Therapy, Respiratory Therapy)	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Coverage Outside of the United States	Coverage for medical services provided outside of the United States is the same as coverage for medical services provided inside the United States. In most cases you will need to pay up front and submit a claim for reimbursement. To learn more, visit www.bcbsglobalcore.com. Prescription drugs are not covered when dispensed outside the United States	
Travel Assistance Services	Your plan includes a package of Travel Assistance Services to help you when you are traveling outside of your home country or more than 100 miles from your home. This package includes emergency medical evacuation, medical repatriation, return of mortal remains and many other benefits. The maximum benefit per trip is $500,000. See your Travel Assistance Program Brochure for more details.	