## BENEFIT HIGHLIGHTS

CapitalBlueCross.com

## PPO Plan

## Moravian University

**This information is not a contract**, but highlights some of the benefits available to you 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 Benefits Booklet (also known as "Certificate of Coverage"). Refer to your Benefits Booklet for complete details.

| YOUR MEDICAL PLAN SUMMARY OF COST SHARING | | |
|---|---|---|
| | Member Responsibilities | |
| | If provider is in-network | If provider is out-of-network |
| **Deductible** (per benefit period) | $1,000 per member<br>$2,000 per family | $1,750 per member<br>$3,500 per family |
| **Coinsurance** (Percentage you pay after your deductible is met. | No member coinsurance | 20% coinsurance after deductible |
| **Out-of-pocket maximum** (The most you pay per benefit period, after which benefits are paid at 100%. This includes deductible, copayments and coinsurance for medical including ER and prescription drug, for in-network providers only.) | $5,000 per member<br>$10,000 per family | $7,500 per member<br>$15,000 per family |
| **Office Visit / Urgent Care / Emergency Room Copayments** | | |
| **VirtualCare (non-specialist) visits**—delivered via the Capital Blue Cross VirtualCare platform | $10 copayment per visit | Not applicable |
| **VirtualCare (specialist) visits**—delivered via the Capital Blue Cross VirtualCare platform | $35 copayment per visit | Not applicable |
| **Office visits and consultations (in-person & telehealth)**—performed by a family practitioner, general practitioner, internist, pediatrician or in-person | $25 copayment per visit | 20% coinsurance after deductible |
| **Office Visits** performed by a retail clinic | $15 copayment per visit | 20% coinsurance after deductible |
| **Specialist office visits** (in-person & telehealth) | $35 copayment per visit | 20% coinsurance after deductible |
| **Urgent care services** | $45 copayment per visit | 20% coinsurance after deductible |
| **Emergency room** | $200 copayment per visit, waived if admitted | |
| **Preventive Care** | | |
| **Pediatric and adult preventive care** | No charge, deductible waived | 20% coinsurance after deductible |
| **Screening gynecological exam and pap smear** (one per benefit period) | No charge, deductible waived | 20% coinsurance, deductible waived |
| **Screening mammogram** (one per benefit period) | No charge, deductible waived | 20% coinsurance, deductible waived |
| **Facility / Surgical Services** | | |
| **Inpatient hospital room and board including maternity services and newborn care** | No charge after deductible | 20% coinsurance after deductible |
| **Acute inpatient rehabilitation** | No charge after deductible | 20% coinsurance after deductible |
| **Skilled nursing facility** (100 days per benefit period) | No charge after deductible | 20% coinsurance after deductible |
| **Surgical procedure and anesthesia** (professional charges) | No charge after deductible | 20% coinsurance after deductible |
| **Outpatient surgery at ambulatory surgical center** (facility charge only) | No charge after deductible | 20% coinsurance after deductible |
| **Outpatient surgery at acute care hospital** (facility charge only) | No charge after deductible | 20% coinsurance after deductible |
| **Diagnostic Services** | | |
| **High tech imaging** (such as MRI, CT, PET) | No charge after deductible | 20% coinsurance after deductible |
| **Radiology** (other than high tech imaging) | No charge after deductible | 20% coinsurance after deductible |
| **Independent laboratory** | No charge after deductible | 20% coinsurance after deductible |
| **Facility-owned laboratory** (i.e. Health System owned) | No charge after deductible | 20% coinsurance after deductible |
| **Diagnostic mammogram** | No charge, deductible waived | 20% coinsurance, deductible waived |
| **Therapy Services (Rehabilitative and Habilitative Services)** | | |
| **Physical therapy** | $25 copayment per visit | 20% coinsurance after deductible |
| **Occupational therapy** | $35 copayment per visit | 20% coinsurance after deductible |
| **Speech therapy** | $35 copayment per visit | 20% coinsurance after deductible |
| **Respiratory therapy** | No charge after deductible | 20% coinsurance after deductible |
| **Manipulation therapy** | $35 copayment per visit | 20% coinsurance after deductible |
| **Mental Health (MH) and Substance Use Disorder Services (SUD)** | | |
| **MH & SUD detoxification inpatient services** | No charge after deductible | 20% coinsurance after deductible |
| **MH & SUD rehabilitation outpatient services** | $35 copayment per visit | 20% coinsurance after deductible |
| **Additional Services** | | |
| **Home healthcare services** (90 visits per benefit period) | No charge after deductible | 20% coinsurance after deductible |
| **Durable medical equipment and supplies; prosthetic appliances and orthotic devices** | No charge after deductible | 20% coinsurance after deductible |

*Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital Blue Cross. An independent licensee of the Blue Cross Blue Shield Association.*

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments required under any other health benefits coverage you may have.

In-network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider's charges and the allowed amount. Out-of-network providers may balance bill the member. Some out-of-network facility providers are not covered. In certain situations, a facility fee may be associated with an outpatient visit to a professional provider. Members should consult with the provider of the services to determine whether a facility fee may apply to that provider. An additional cost-sharing amount may apply to the facility fee.

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