HIGHMARK. | PPO Blue

Moravian University PPO Blue Student Health Insurance Plan
2023- {Gold Tier} *(85.21% Actuarial Value)*

Undergraduate Students: $2,350
Graduate Students: $4,844

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		
Benefit Period[1]	Contract Year	
Deductible (per benefit period) Individual Family	 $250 $500	 $600 $1,200
Plan Payment Level – based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Limit (includes deductible and coinsurance; excludes copayments and prescription drug cost sharing) Once met, the plan pays 100% of covered medical and pediatric dental services for the rest of the benefit period. Individual Family	 $6,850 $13,700	 $15,000 $30,000
Total Maximum Out-of-Pocket[2] (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only. Once met, the plan pays 100% of covered services for the rest of the benefit period.) Individual Family	 $9,100 $18,200	 Not Applicable Not Applicable
Outpatient Medical Care Services		
Retail Clinic Visits (including Virtual Visits)	100% after $25 copayment	60% after deductible
Primary Care Provider Visits (including Virtual Visits)	100% after $25 copayment	60% after deductible
Specialist Visits (including Virtual Visits)	100% after $30 copayment	60% after deductible
Virtual Visit Originating Site Fee	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after $50 copayment (Does not apply to visits for the treatment of Mental Health or Substance Abuse.)	60% after deductible
Telemedicine Services[3]	100% after $10 copayment	Not Covered
Preventive Care Services[4]		
Routine Physical exams (Adult & Pediatric)	100% no deductible	Not Covered
Adult immunizations	100% no deductible	60% after deductible
Colorectal cancer screenings	100% no deductible	60% after deductible
Routine gynecological exam and Pap Smear	100% no deductible	60% after deductible
Mammographic Screening	100% no deductible	60% after deductible
Routine Screening tests and procedures	100% no deductible	60% after deductible
Pediatric immunizations	100% no deductible	60% no deductible
Pediatric Vision[5] Exam (including dilation as professional indicated)	 100% no deductible	 Not Covered
Frames	100% no deductible	Not Covered
Lenses	100% no deductible	Not Covered
Pediatric Dental[5] Routine Exam, X-rays, Cleanings, Consultations, Fluoride Treatments, Palliative Treatment (emergency), Sealants and Space Maintainers	 100% no deductible	 Not Covered
Other Pediatric Dental Services[6]	50% no deductible	Not Covered
Emergency Room and Ambulance Services		
Emergency Room Services	100% after $150 copayment (waived if admitted)	
Ambulance - Emergency	100% no deductible	
Ambulance – Non-Emergency[7]	80% after deductible	60% after deductible
Hospital and Medical/Surgical Services[8]		
Hospital Inpatient[9]	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services)	80% after deductible	60% after deductible
Inpatient Medical Care Services, Surgical Services	80% after deductible	60% after deductible

Therapy, Habilitative and Rehabilitative Services		
Physical Medicine[10]	100% after $30 copayment	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[10]	100% after $30 copayment	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.	
Occupational Therapy[10]	100% after $30 copayment	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.	
Spinal Manipulations	100% after $30 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Cardiac Rehabilitation	80% after deductible	60% after deductible
Home Infusion and Suite Infusion Therapy	80% after deductible	60% after deductible
Other Therapy Services (Chemotherapy, Dialysis, Infusion Therapy, Pulmonary Therapy, Radiation Therapy, Respiratory Therapy)	80% after deductible	60% after deductible
Mental Health/Substance Abuse Services		
Inpatient[9]	80% after deductible	60% after deductible
Outpatient	100% after $25 copayment	60% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Dental Services Related to Accidental Injury	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
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
	Respite Care is limited to 7 days every six (6) consecutive months	
Private Duty Nursing	80% after deductible	60% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Services	80% after deductible	60% after deductible
Therapeutic Injections	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Prescription Drugs		
Deductible Individual Family	None None	
Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary[11] Hard Mandatory Generic[12]	**Retail Drugs (31-day Supply)** $25 generic copayment $45 formulary copayment $60 non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $50 generic copayment $90 formulary copayment $120 non-formulary copayment	

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your school's effective date. Contact your school to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
(6) Includes Medically Necessary orthodontic services which are part of an approved orthodontic plan intended to treat a severe dentofacial abnormality. Prior approval is required.
(7) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
(8) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(9) If you receive services from an out-of-area provider or a provider who does not participate with the local Blue Cross and/or Blue Shield plan, you must contact Highmark Utilization Management prior to a planned inpatient admission, or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
(10) Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis.

(11) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover by their cost-sharing requirements. This formulary covers all FDA-approved generic and brand-name drugs.

(12) Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs.