BENEFIT HIGHLIGHTS

PPO

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Moravian University – Student Health Plan

Important notice for fully insured individual and employer group plans in Pennsylvania: Advertised health insurance policies or programs may not cover all your healthcare expenses. Read your contract or benefit booklet (certificate of coverage) carefully to determine which healthcare services are covered. Questions? Please call 800.962.2242 or the number on the back of your ID card (TTY: 711).

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is in-network	**If provider is out-of-network**
Deductible (per benefit period)	$250 per member	$600 per member
Coinsurance (Percentage you pay after your deductible is met.)	20% coinsurance after deductible	40% coinsurance after deductible
Coinsurance Out-of-Pocket Maximum (includes medical coinsurance amounts; when this is satisfied, no further medical coinsurance is applied)	$6,850 per member $13,700 per family	$15,000 per member $30,000 per family
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.)	$9,100 per member $18,200 per family	Not applicable
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	$10 copayment per visit	Not applicable
Office visits and consultations (in-person & telehealth)—performed by a family practitioner, general practitioner, internist, pediatrician network retail clinic or in-person	$25 copayment per visit	40% coinsurance after deductible
Specialist office visits (in-person & telehealth)	$30 copayment per visit	40% coinsurance after deductible
Urgent care services	$50 copayment per visit	40% coinsurance after deductible
Emergency room	$150 copayment per visit, waived if admitted	
Preventive Care		
Pediatric preventive care	No charge, deductible waived	Not covered
Adult preventive care	No charge, deductible waived	40% coinsurance after deductible
Screening gynecological exam and pap smear (one per benefit period)	No charge, deductible waived	40% coinsurance, deductible waived
Screening mammogram (one per benefit period)	No charge, deductible waived	40% coinsurance after deductible
Facility / Surgical Services		
Inpatient hospital room and board including maternity services	20% coinsurance after deductible	40% coinsurance after deductible
Inpatient hospital room and board including newborn care	20% coinsurance, deductible waived	40% coinsurance, deductible waived
Acute inpatient rehabilitation (60 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Skilled nursing facility	20% coinsurance after deductible	40% coinsurance after deductible
Surgical procedure and anesthesia (professional charges)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery at ambulatory surgical center (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery at acute care hospital (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Services		
High tech imaging (such as MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible
Radiology (other than high tech imaging)	20% coinsurance after deductible	40% coinsurance after deductible
Independent laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Facility-owned laboratory (i.e. Health System owned)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic mammogram	20% coinsurance after deductible	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical therapy (30 visits per benefit period)	$30 copayment per visit	40% coinsurance after deductible
Occupational therapy (30 visits per benefit period)	$30 copayment per visit	40% coinsurance after deductible
Speech therapy (30 visits per benefit period)	$30 copayment per visit	40% coinsurance after deductible
Respiratory therapy	20% coinsurance after deductible	40% coinsurance after deductible
Manipulation therapy (20 visits per benefit period)	$30 copayment per visit	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH & SUD detoxification inpatient services	20% coinsurance after deductible	40% coinsurance after deductible
MH & SUD rehabilitation outpatient services	$25 copayment per visit	20% coinsurance after deductible
Additional Services		
Home healthcare services	20% coinsurance after deductible	40% coinsurance after deductible
Durable medical equipment and supplies; prosthetic appliances and orthotic devices	20% coinsurance after deductible	40% coinsurance after deductible

COST SHARING FOR PRESCRIPTION DRUGS DOES NOT APPLY TO THE MEDICAL DEDUCTIBLE SHOWN ON PAGE ONE

YOUR PRESCRIPTION DRUG SUMMARY OF COST-SHARING

	Member Responsibilities		
	If provider is in-network		**If provider is out-of-network**
Deductible (per benefit period)	No member deductible		Not covered
	Retail pharmacy (up to a 31-day supply)	Home delivery (up to a 90-day supply)	Specialty pharmacy (up to a 30-day supply)
Prescription drug tier			
Generic preferred	$25 copayment	$50 copayment	$25 copayment
Generic nonpreferred	$25 copayment	$50 copayment	$25 copayment
Brand preferred	$45 copayment	$90 copayment	$45 copayment
Brand nonpreferred	$60 copayment	$120 copayment	$60 copayment
Contraceptives* (self-administered)			
Generic	$0 copayment	$0 copayment	Not covered
Select brands (no generic equivalent available)	$0 copayment	$0 copayment	Not covered
Brand preferred	$45 copayment	$90 copayment	Not covered
Brand nonpreferred	$60 copayment	$120 copayment	Not covered
Additional pharmacy benefits/details			
Network (for specialty pharmacy information please refer to the guide to Rx benefits at CapitalBlueCross.com)	Broad Plus		
Formulary	Advantage		
$0 preventive Rx coverage	No charge		
Generic substitution program	Restrictive generic substitution—In addition to the coinsurance/ copayment, the member pays the difference between the brand and generic drug price (when there is a generic alternative) unless the physician requests the brand be dispensed.		
Extended supply network (ESN)	Members have the ability to obtain covered drugs for up to a 90-day supply at in-network retail pharmacies.		

YOUR PEDIATRIC VISION SUMMARY OF COST-SHARING

(Benefit frequencies are once every 12 months based on date of service)	Member Responsibilities	
	If provider is in-network	**If provider is out-of-network**
Vision Exam	No charge	$32 allowance
Eyeglass Lenses	Single, Bi-focal, Tri-focal, and Polycarbonate – Covered in full	Single - $24; Bi-focal - $36; Tri-focal - $46; Polycarbonate – Not covered
Contact Lenses** (Payment will be made for either lenses or contact lenses within a benefit period. Payment will not be made for both.)	Balance of retail charge less 25% after $75 allowance	$50 allowance
Standard Frames from a collection**	No charge	Balance of retail charge after $30 allowance
All other frames	Balance of retail charge less 30% after $100 allowance	Balance of retail charge after $30 allowance

YOUR PEDIATRIC DENTAL SUMMARY OF COST-SHARING

	Member Responsibilities if provider is in-network
Deductible	$50 per person
Preventive Services	No charge
Basic Services	20% coinsurance after deductible
Major Services	50% coinsurance after deductible
Orthodontia (Medically Necessary)	50% coinsurance after deductible

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.
*Certain preventive contraceptives are required to be covered at no cost to you when filled at an in-network pharmacy with a valid prescription in accordance with Preventive Health Guidelines.
**Frames and contact lens allowances at Walmart® Vision Centers may vary from any allowances indicated above. Refer to your Benefits Booklet for complete details.

In-network providers and pharmacies agree to accept our allowance as payment in full—often less than their normal charge. If you visit an out-of-network provider or pharmacy, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider's or out-of-network pharmacy's charges and the allowed amount. Out-of-network providers may balance bill the member. Some out-of-network facility providers are not covered. Deductibles, any differences paid between brand drug and generic drug prices, and any balances paid to out-of-network pharmacies are not applied to the out-of-pocket maximum. 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.

Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

Premium Rates – 2024/2025 Plan Year	
Annual Rate per Student August 1, 2024 – July 31, 2025	$2,350
Spring/Summer January 1, 2025 – July 31, 2025	$1,365