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 $2,000 per family	$1,750 per member $3,500 per family
Coinsurance (Percentage you pay after your deductible is met.	10% coinsurance after deductible	20% coinsurance after deductible
Out-of-pocket maximum (The most you pay per benefit period, after which benefits are paid at 100%).	Overall in-network out-of-pocket maximum includes deductible, copayments, and coinsurance for medical and prescription drugs: $5,000 per member $10,000 per family	Out-of-network medical coinsurance-only maximum: $7,500 per member $15,000 per family Overall out-of-network out-of-pocket 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	$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	No charge, deductible waived	20% coinsurance, deductible waived
Screening mammogram	No charge, deductible waived	20% coinsurance, deductible waived
Facility / Surgical Services		
Inpatient hospital room and board including maternity services and newborn care	10% coinsurance after deductible	20% coinsurance after deductible
Acute inpatient rehabilitation	10% coinsurance after deductible	20% coinsurance after deductible
Skilled nursing facility (100 days per benefit period)	10% coinsurance after deductible	20% coinsurance after deductible
Surgical procedure and anesthesia (professional charges)	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery at ambulatory surgical center (facility charge only)	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery at acute care hospital (facility charge only)	10% coinsurance after deductible	20% coinsurance after deductible
Diagnostic Services		
High tech imaging (such as MRI, CT, PET)	10% coinsurance after deductible	20% coinsurance after deductible
Radiology (other than high tech imaging)	10% coinsurance after deductible	20% coinsurance after deductible
Independent laboratory	10% coinsurance after deductible	20% coinsurance after deductible
Facility-owned laboratory (i.e. Health System owned)	10% coinsurance after deductible	20% coinsurance after deductible
Diagnostic mammogram	10% coinsurance, 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	10% coinsurance 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	10% coinsurance 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)	10% coinsurance after deductible	20% coinsurance after deductible
Durable medical equipment and supplies; prosthetic appliances and orthotic devices	10% coinsurance after deductible	20% 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.

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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