## BENEFIT HIGHLIGHTS

CapitalBlueCross.com

## QHDHP 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) Deductible is combined to include medical and prescription drug benefits for in-network providers. If you enroll in a family plan, the overall family deductible must be met before the plan begins to pay. | $1,650 single coverage<br>$3,300 family coverage | |
| **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%). | Overall in-network out-of-pocket maximum includes deductible, copayments, and coinsurance for medical and prescription drugs:<br>$6,900 single coverage<br>$13,800 family coverage | Out-of-network medical coinsurance-only maximum:<br>$3,000 single coverage<br>$6,000 family coverage<br><br>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 after deductible | Not applicable |
| **VirtualCare (specialist) visits**—delivered via the Capital Blue Cross VirtualCare platform | $35 copayment per visit after deductible | Not applicable |
| **Office visits and consultations (in-person & telehealth)**—performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic | $25 copayment per visit after deductible | 20% coinsurance after deductible |
| **Office Visits** performed by a retail clinic | $15 copayment per visit after deductible | 20% coinsurance after deductible |
| **Specialist office visits** (in-person & telehealth) | $35 copayment per visit after deductible | 20% coinsurance after deductible |
| **Urgent care services** | $45 copayment per visit after deductible | 20% coinsurance after deductible |
| **Emergency room** | $200 copayment per visit after deductible, 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** | 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 after deductible | 20% coinsurance after deductible |
| **Therapy Services (Rehabilitative and Habilitative Services)** | | |
| **Physical therapy** | $25 copayment after deductible | 20% coinsurance after deductible |
| **Occupational therapy** | $35 copayment per visit after deductible | 20% coinsurance after deductible |
| **Speech therapy** | $35 copayment per visit after deductible | 20% coinsurance after deductible |
| **Respiratory therapy** | No charge after deductible | 20% coinsurance after deductible |
| **Manipulation therapy** | $35 copayment per visit after deductible | 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 after deductible | 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.

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