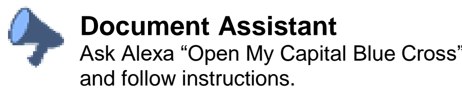

Capital

BENEFIT HIGHLIGHTS

CapitalBlueCross.com

PPO 350

Muhlenberg College

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)	$350 per member $700 per family	$1,000 per member $2,000 per family
Coinsurance (Percentage you pay after your in-network deductible is met. Out-of-network coinsurance is applied after deductible for professional claims, and applies after deductible for facility claims.)	10% coinsurance **after** deductible	Professional 20% coinsurance **after** deductible Facility 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.)	$8,150 per member $16,300 per family	$3,000 per member $6,000 per family
Office Visit / Urgent Care / Emergency Room Copayments		
VirtualCare (non-specialist) visits—delivered via the Capital Blue Cross VirtualCare platform	$0 copayment per visit	Not covered
VirtualCare (specialist) visits—delivered via the Capital Blue Cross VirtualCare platform	$25 copayment per visit	Not covered
Office visits and consultations (in-person & telehealth)—performed by a family practitioner, general practitioner, internist, pediatrician network retail clinic or in-person	$20 copayment per visit	20% coinsurance
Specialist office visits (in-person & telehealth)	$35 copayment per visit	20% coinsurance
Urgent care services	$45 copayment per visit	20% coinsurance
Emergency room	$200 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and adult preventive care	No charge	20% coinsurance
Screening gynecological exam and pap smear (one per benefit period)	No charge	20% coinsurance, waive deductible
Screening mammogram (one per benefit period)	No charge	20% coinsurance, waive deductible
Facility / Surgical Services		
Inpatient hospital room and board	10% coinsurance	20% coinsurance
Acute inpatient rehabilitation	10% coinsurance	20% coinsurance
Skilled nursing facility (100 days per benefit period)	10% coinsurance	20% coinsurance
Maternity services and newborn care	10% coinsurance	20% coinsurance
Surgical procedure and anesthesia (professional charges)	10% coinsurance	20% coinsurance
Outpatient surgery at ambulatory surgical center (facility charge only)	10% coinsurance	20% coinsurance
Outpatient surgery at acute care hospital (facility charge only)	10% coinsurance	20% coinsurance
Diagnostic Services		
High tech imaging (such as MRI, CT, PET)	10% coinsurance	20% coinsurance
Radiology (other than high tech imaging)	10% coinsurance	20% coinsurance
Independent laboratory	10% coinsurance	20% coinsurance
Facility-owned laboratory (i.e. Health System owned)	10% coinsurance	20% coinsurance
Diagnostic mammogram	10% coinsurance	20% coinsurance
Therapy Services (Rehabilitative and Habilitative Services)		
Physical therapy	$25 copayment per visit	20% coinsurance
Occupational therapy	$25 copayment per visit	20% coinsurance
Speech therapy	$25 copayment per visit	20% coinsurance
Respiratory therapy	No charge after deductible	20% coinsurance
Manipulation therapy	$25 copayment per visit	20% coinsurance
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH inpatient services	10% coinsurance	20% coinsurance
MH outpatient services	$25 copayment per visit	20% coinsurance
SUD detoxification inpatient	10% coinsurance	20% coinsurance
SUD rehabilitation outpatient	$25 copayment per visit	20% coinsurance
Additional Services		
Home healthcare services (90 visits per benefit period)	10% coinsurance	20% coinsurance
Durable medical equipment and supplies	10% coinsurance	20% coinsurance
Prosthetic appliances	10% coinsurance	20% coinsurance
Orthotic devices	10% coinsurance	20% coinsurance

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.
*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.

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.

Voice activated paper.

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