Muhlenberg College

Health Insurance as of January 1, 2023
Capital Blue Cross PPO

Coverage	In Network	Out of Network
Office Visits	$20 Primary Physician, $35 Specialist	80%* of PRC, after deductible
Preventative Care	100%	80% (deductible may apply)
Outpatient Surgery	90%* of PRC, after deductible	80%* of PRC after deductible
Emergency Room (waived if admitted)	$200 copay (waived if admitted)	$200 copay (waived if admitted)
Retail Clinic Visit	$10	80%* of PRC, after deductible
Urgent Care Visit	$45	80%* of PRC, after deductible
Virtual Visits (non-specialist visit, via the Capital Blue Virtual Care Platform.)	No charge	N/A
Virtual Visits (specialist visit, via the CapBlue Virtual Care Platform)	$35 copay	N/A
Outpatient Diagnostic Tests (x-rays, etc.)	90%* of PRC, after deductible	80%* of PRC, after deductible
Inpatient Hospital Services	90%* of PRC, after deductible	80%* of PRC, after deductible
Mental Health/Substance Abuse:		
Inpatient	90%* of PRC, after deductible	80%* of PRC, after deductible
Inpatient Detoxification/Rehabilitation	90%* of PRC, after deductible	80%* of PRC, after deductible
Outpatient	$25 copay	80%* of PRC, after deductible
Co-Insurance	90% / 10%	80% / 20%
Annual Deductible	$350 individual / $700/family	$1,250 individual / $2,500 family
Maximum Out of Pocket *(once met, plan pays 100%)*	$8,150 individual / $16,300 family	$8,150 individual / $16,300 family
Prescription Drugs *Mandatory generic plan* **	Up to 30-day supply at Pharmacy: $10 generic, $35 preferred brand, $50 non-preferred brand Specialty Rx: 20% coinsurance up to $150/fill maximum	
Mandatory Mail Order *Required after 2 refills of a 30-day Rx*	Maintenance Rx must be filled by mail, with a 90-day supply provided at the following rates: $25 Generic, $85 Preferred Brand, $125 non-preferred brand	

RATES (NO Vision) - Non-Tobacco/Smoke/Vape Users	RATES (NO Vision) - Tobacco/Smoke/Vape Users
Employee only: $134 per month / $61.85 biweekly	**Employee only:** $259 per month / $119.54 biweekly
Employee+Child: $233 per month / $107.54 biweekly	**Employee+Child:** $358 per month / $165.23 biweekly
Employee+Spouse: $308 per month / $142.15 biweekly	**Employee+Spouse:** $433 per month / $199.85 biweekly
Employee+Children: $380 per month / $175.38 biweekly	**Employee+Children:** $505 per month / $233.08 biweekly
Employee+Spouse+Child(ren): $419 per month / $193.38 biweekly	**Employee+Spouse+Child(ren):** $544 per month / $251.08 biweekly

SPOUSAL SURCHARGE:
Additional $125 per month surcharge applies if covering spouse who has other coverage available (through an employer or Medicare).

Vision Rates (Highmark/Davis Vision): Employee only: $3.60 per month/ $1.66 biweekly; Employee plus dependent(s): $10.40 per month, $4.80 biweekly

LEGEND

+= Up to **$350** of Individual in-network deductible expense is reimbursable for employees earning **$32,000** or less annually.
*= After satisfying the deductible; subject to maximum out-of-pocket limit.
N/A = Not Applicable
PRC = Provider's Reasonable Charge

** **Mandatory Generic:** If there is a generic equivalent and you obtain the brand name drug instead, even if this is at your doctor's request, you pay the difference between the cost of the generic and the brand name PLUS the brand co-pay. If there is no generic available, you pay just the brand name co-pay for the brand name drug.

Please Note: *This summary is not intended to replace or supersede the insurer's certificate of coverage. Be sure to examine the handbook provided by* ***the insurer for complete details, restrictions and exclusions.***