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Capital

BENEFIT HIGHLIGHTS

CapitalBlueCross.com

PPO 500 Plan

Central Susquehanna Trust

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)	$500 per member $1,500 per family	$500 per member $1,500 per family
Coinsurance (Percentage you pay after your deductible is met)	10% coinsurance **after** deductible	Professional 30% coinsurance **after** deductible Facility 50% coinsurance **after** deductible (30% for MH and SUD)
Coinsurance Out-of-Pocket Maximum (includes coinsurance amounts; when this amount is satisfied, no further coinsurance is applied)	$500 per member $1,500 per family	$3,000 per member $6,000 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, for in-network providers only.)	$4,725 per member $9,450 per family	No maximum. Copayments continue to be your out-of-pocket cost. Also, balance billing by *out-of-network providers* continues to be your out-of-pocket cost.
Office Visit / Urgent Care / Emergency Room Copayments		
VirtualCare (non-specialist) visits—delivered via the Capital Blue Cross VirtualCare platform	$20 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	30% coinsurance
Specialist office visits (in-person, telehealth & via the Capital Blue Cross VirtualCare platform)	$40 copayment per visit	30% coinsurance VirtualCare–Not covered
Urgent care services	$50 copayment per visit	30% coinsurance
Emergency room	$100 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and adult preventive care	No charge, waive deductible	30% coinsurance
Screening gynecological exam and pap smear (one per benefit period)	No charge, waive deductible	30% coinsurance, waive deductible
Screening mammogram (one per benefit period)	No charge, waive deductible	30% coinsurance, waive deductible
Facility / Surgical Services		
Inpatient hospital room and board	10% coinsurance	50% coinsurance
Acute inpatient rehabilitation (60 days per benefit period)	10% coinsurance	50% coinsurance
Skilled nursing facility (100 days per benefit period)	10% coinsurance	50% coinsurance
Maternity services and newborn care	10% coinsurance	50% coinsurance
Surgical procedure and anesthesia (professional charges)	10% coinsurance	30% coinsurance
Outpatient surgery at ambulatory surgical center (facility charge only)	10% coinsurance	50% coinsurance
Outpatient surgery at acute care hospital (facility charge only)	10% coinsurance	50% coinsurance
Diagnostic Services		
High tech imaging (such as MRI, CT, PET)	10% coinsurance	30% coinsurance
Radiology (other than high tech imaging)	10% coinsurance	30% coinsurance
Independent laboratory	10% coinsurance	30% coinsurance
Facility-owned laboratory (i.e. Health System owned)	10% coinsurance	30% coinsurance
Therapy Services (Rehabilitative and Habilitative Services)		
Physical therapy	$40 copayment per visit	30% coinsurance
Occupational therapy	$40 copayment per visit	30% coinsurance
Speech therapy	$40 copayment per visit	30% coinsurance
Respiratory therapy	10% coinsurance	30% coinsurance
Manipulation therapy	$40 copayment per visit	30% coinsurance
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH inpatient services	10% coinsurance	Professional 30% coinsurance **after** deductible Facility 30% coinsurance **after** deductible
MH outpatient services	$40 copayment per visit	Professional 30% coinsurance **after** deductible Facility 30% coinsurance **after** deductible
SUD detoxification inpatient	10% coinsurance	Professional 30% coinsurance **after** deductible Facility 30% coinsurance **after** deductible
SUD rehabilitation outpatient	$40 copayment per visit	Professional 30% coinsurance **after** deductible Facility 30% coinsurance **after** deductible
Additional Services		
Home healthcare services (90 visits per benefit period)	10% coinsurance	50% coinsurance
Durable medical equipment and supplies	10% coinsurance	30% coinsurance
Prosthetic appliances	10% coinsurance	30% coinsurance

Orthotic devices	10% coinsurance	30% 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.

In-network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit a 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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Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.