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Capital

BENEFIT HIGHLIGHTS

CapitalBlueCross.com

PPO H S A 2000Q/100 Plan

PAT/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) 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.	$2,000 single coverage $4,000 family coverage	
Coinsurance (Percentage you pay after your deductible is met)	0% coinsurance after deductible	20% coinsurance after deductible
Coinsurance Out-of-Pocket Maximum (includes coinsurance amounts; when this amount is satisfied, no further coinsurance is applied)	Not Applicable	$5,000 per member $10,000 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 and prescription drug for in-network providers only.)	$8,050 single coverage $16,100 family coverage	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 costs.
Office Visit / Urgent Care / Emergency Room Copayments		
VirtualCare (non-specialist) visits—delivered via the Capital Blue Cross VirtualCare platform	$20 copayment per visit after deductible	Not covered
Office visits and consultations (in-person & telehealth)—performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	$20 copayment per visit after deductible	20% coinsurance after deductible
Specialist office visits (in-person, telehealth & via the Capital Blue Cross VirtualCare platform)	$40 copayment per visit after deductible	20% coinsurance after deductible VirtualCare–Not covered
Urgent care services	$50 copayment per visit after deductible	20% coinsurance after deductible
Emergency room	$100 copayment per visit after deductible, waived if admitted	
Preventive Care		
Pediatric and adult preventive care	No charge, waive deductible and copayment	20% coinsurance after deductible
Screening gynecological exam and pap smear (one per benefit period)	No charge, waive deductible and copayment	20% coinsurance, after deductible
Screening mammogram (one per benefit period)	No charge, waive deductible and copayment	20% coinsurance, after deductible
Facility / Surgical Services		
Inpatient hospital room and board	No charge after deductible	50% coinsurance after deductible
Acute inpatient rehabilitation (60 days per benefit period)	No charge after deductible	50% coinsurance after deductible
Skilled nursing facility (100 days per benefit period)	No charge after deductible	50% coinsurance after deductible
Maternity services and newborn care	No charge after deductible	50% 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	50% coinsurance after deductible
Outpatient surgery at acute care hospital (facility charge only)	No charge after deductible	50% 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
Therapy Services (Rehabilitative and Habilitative Services)		
Physical therapy (20 visits per benefit period)	$40 copayment after deductible	20% coinsurance after deductible
Occupational therapy (20 visits per benefit period)	$40 copayment after deductible	20% coinsurance after deductible
Speech therapy (12 visits per benefit period)	$40 copayment after deductible	20% coinsurance after deductible
Respiratory therapy (20 visits per benefit period)	$40 copayment after deductible	20% coinsurance after deductible
Manipulation therapy (20 visits per benefit period)	$40 copayment after deductible	20% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH inpatient services	No charge after deductible	Professional 20% coinsurance **after** deductible Facility 20% coinsurance **after** deductible
MH outpatient services	$40 copayment after deductible	Professional 20% coinsurance **after** deductible Facility 20% coinsurance **after** deductible

SUD detoxification inpatient	No charge after deductible	Professional 20% coinsurance **after** deductible Facility 20% coinsurance **after** deductible
SUD rehabilitation outpatient	$40 copayment after deductible	Professional 20% coinsurance **after** deductible Facility 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	No charge after deductible	20% coinsurance after deductible
Prosthetic appliances	No charge after deductible	20% coinsurance after deductible
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 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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