







**BENEFIT HIGHLIGHTS**

[CapitalBlueCross.com](https://www.CapitalBlueCross.com)

**PPO H S A Min. Deductible IRSQ/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.

<b>YOUR MEDICAL PLAN SUMMARY OF COST SHARING</b>		
	<b>Member Responsibilities</b>	
	<b>If provider is in-network</b>	<b>If provider is out-of-network</b>
 <b>Deductible</b> (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.	\$1,600 single coverage \$3,200 family coverage	
 <b>Coinsurance</b> (Percentage you pay after your deductible is met)	0% coinsurance after deductible	20% coinsurance after deductible
<b>Coinsurance Out-of-Pocket Maximum</b> (includes coinsurance amounts; when this amount is satisfied, no further coinsurance is applied)	Not Applicable	\$5,000 per member \$10,000 per family
 <b>Out-of-pocket maximum</b> (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 <i>out-of-network providers</i> continues to be your out-of-pocket costs.
<b>Office Visit / Urgent Care / Emergency Room Copayments</b>		
 <b>VirtualCare (non-specialist) visits</b> —delivered via the Capital Blue Cross VirtualCare platform	\$20 copayment per visit after deductible	Not covered
<b>Office visits and consultations (in-person &amp; telehealth)</b> —performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	\$20 copayment per visit after deductible	20% coinsurance after deductible
<b>Specialist office visits (in-person, telehealth &amp; via the Capital Blue Cross VirtualCare platform)</b>	\$40 copayment per visit after deductible	20% coinsurance after deductible VirtualCare—Not covered
<b>Urgent care services</b>	\$50 copayment per visit after deductible	20% coinsurance after deductible
<b>Emergency room</b>	\$100 copayment per visit after deductible, waived if admitted	
<b>Preventive Care</b>		
<b>Pediatric and adult preventive care</b>	No charge, waive deductible and copayment	20% coinsurance after deductible
<b>Screening gynecological exam and pap smear</b> (one per benefit period)	No charge, waive deductible and copayment	20% coinsurance, after deductible
<b>Screening mammogram</b> (one per benefit period)	No charge, waive deductible and copayment	20% coinsurance, after deductible
<b>Facility / Surgical Services</b>		
<b>Inpatient hospital room and board</b>	No charge after deductible	50% coinsurance after deductible
<b>Acute inpatient rehabilitation</b> (60 days per benefit period)	No charge after deductible	50% coinsurance after deductible
<b>Skilled nursing facility</b> (100 days per benefit period)	No charge after deductible	50% coinsurance after deductible
<b>Maternity services and newborn care</b>	No charge after deductible	50% coinsurance after deductible
<b>Surgical procedure and anesthesia</b> (professional charges)	No charge after deductible	20% coinsurance after deductible
 <b>Outpatient surgery at ambulatory surgical center</b> (facility charge only)	No charge after deductible	50% coinsurance after deductible
<b>Outpatient surgery at acute care hospital</b> (facility charge only)	No charge after deductible	50% coinsurance after deductible
<b>Diagnostic Services</b>		
<b>High tech imaging</b> (such as MRI, CT, PET)	No charge after deductible	20% coinsurance after deductible
<b>Radiology</b> (other than high tech imaging)	No charge after deductible	20% coinsurance after deductible
 <b>Independent laboratory</b>	No charge after deductible	20% coinsurance after deductible
<b>Facility-owned laboratory</b> (i.e. Health System owned)	No charge after deductible	20% coinsurance after deductible
<b>Therapy Services (Rehabilitative and Habilitative Services)</b>		
<b>Physical therapy</b> (20 visits per benefit period)	\$40 copayment after deductible	20% coinsurance after deductible
<b>Occupational therapy</b> (20 visits per benefit period)	\$40 copayment after deductible	20% coinsurance after deductible
<b>Speech therapy</b> (12 visits per benefit period)	\$40 copayment after deductible	20% coinsurance after deductible
<b>Respiratory therapy</b> (20 visits per benefit period)	\$40 copayment after deductible	20% coinsurance after deductible
<b>Manipulation therapy</b> (20 visits per benefit period)	\$40 copayment after deductible	20% coinsurance after deductible
<b>Mental Health (MH) and Substance Use Disorder Services (SUD)</b>		
<b>MH inpatient services</b>	No charge after deductible	Professional 20% coinsurance <b>after</b> deductible Facility 20% coinsurance <b>after</b> deductible
<b>MH outpatient services</b>	\$40 copayment after deductible	Professional 20% coinsurance <b>after</b> deductible Facility 20% coinsurance <b>after</b> deductible

<b>SUD detoxification inpatient</b>	No charge after deductible	Professional 20% coinsurance <b>after</b> deductible Facility 20% coinsurance <b>after</b> deductible
<b>SUD rehabilitation outpatient</b>	\$40 copayment after deductible	Professional 20% coinsurance <b>after</b> deductible Facility 20% coinsurance <b>after</b> deductible
<b>Additional Services</b>		
<b>Home healthcare services (90 visits per benefit period)</b>	No charge after deductible	20% coinsurance after deductible
<b>Durable medical equipment and supplies</b>	No charge after deductible	20% coinsurance after deductible
<b>Prosthetic appliances</b>	No charge after deductible	20% coinsurance after deductible
<b>Orthotic devices</b>	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.

 Voice activated paper.

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