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)	No member coinsurance	20% coinsurance after deductible
Out-of-pocket maximum	Overall in-network out-of-pocket maximum includes deductible, copayments, and coinsurance for medical and prescription drugs: $8,500 single coverage $17,000 family coverage	Out-of-network: $5,000 single coverage $10,000 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 applicable
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 applicable
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, deductible waived and copayment	20% coinsurance after deductible
Screening gynecological exam and pap smear	No charge, deductible waived and copayment	20% coinsurance after deductible
Screening mammogram	No charge, deductible waived and copayment	20% coinsurance after deductible
Facility / Surgical Services		
Inpatient hospital room and board including maternity services and newborn care	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
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 & SUD detoxification inpatient services	No charge after deductible	20% coinsurance after deductible
MH & SUD rehabilitation outpatient services	$40 copayment after deductible	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; prosthetic appliances and orthotic devices	No charge after deductible	20% coinsurance after deductible