

## BENEFIT HIGHLIGHTS

[CapitalBlueCross.com](http://CapitalBlueCross.com)

### PPO 250 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
<b>Deductible</b> (per benefit period)	\$250 per member \$750 per family	\$500 per member \$1,000 per family
<b>Coinsurance</b> (Percentage you pay after your deductible is met)	10% coinsurance after deductible	Professional 30% coinsurance after deductible Facility 50% coinsurance after deductible
<b>Out-of-pocket maximum</b>	Medical coinsurance-only maximum (when satisfied, no additional medical coinsurance is applied): \$400 per member \$1,200 per family  Overall in-network out-of-pocket maximum includes deductible, copayments, and coinsurance for medical: \$5,300 per member \$10,600 per family	Out-of-network medical coinsurance-only maximum: \$3,000 per member \$6,000 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 costs.
Office Visit / Urgent Care / Emergency Room Copayments		
<b>VirtualCare (non-specialist) visits</b> —delivered via the Capital Blue Cross VirtualCare platform	\$20 copayment per visit	Not applicable
<b>Office visits and consultations (in-person &amp; telehealth)</b> —performed by a family practitioner, general practitioner, internist, pediatrician network retail clinic or in-person	\$20 copayment per visit	30% coinsurance after deductible
Specialist office visits (in-person, telehealth & via the Capital Blue Cross VirtualCare platform)	\$40 copayment per visit	30% coinsurance after deductible VirtualCare—Not applicable
<b>Urgent care services</b>	\$50 copayment per visit	30% coinsurance after deductible
<b>Emergency room</b>	\$100 copayment per visit, waived if admitted	
Preventive Care		
<b>Pediatric and adult preventive care</b>	No charge, deductible waived	30% coinsurance after deductible
<b>Screening gynecological exam and pap smear</b>	No charge, deductible waived	30% coinsurance, deductible waived
<b>Screening mammogram</b>	No charge, deductible waived	30% coinsurance, deductible waived
Facility / Surgical Services		
<b>Inpatient hospital room and board including maternity services and newborn care</b>	10% coinsurance after deductible	50% coinsurance after deductible
<b>Acute inpatient rehabilitation</b> (60 days per benefit period)	10% coinsurance after deductible	50% coinsurance after deductible
<b>Skilled nursing facility</b> (100 days per benefit period)	10% coinsurance after deductible	50% coinsurance after deductible
<b>Surgical procedure and anesthesia</b> (professional charges)	10% coinsurance after deductible	30% coinsurance after deductible
<b>Outpatient surgery at ambulatory surgical center</b> (facility charge only)	10% coinsurance after deductible	50% coinsurance after deductible
<b>Outpatient surgery at acute care hospital</b> (facility charge only)	10% coinsurance after deductible	50% coinsurance after deductible
Diagnostic Services		
<b>High tech imaging</b> (such as MRI, CT, PET)	10% coinsurance after deductible	30% coinsurance after deductible
<b>Radiology</b> (other than high tech imaging)	10% coinsurance after deductible	30% coinsurance after deductible
<b>Independent laboratory</b>	10% coinsurance after deductible	30% coinsurance after deductible
<b>Facility-owned laboratory</b> (i.e. Health System owned)	10% coinsurance after deductible	30% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
<b>Physical therapy</b>	\$40 copayment per visit	30% coinsurance after deductible
<b>Occupational therapy</b>	\$40 copayment per visit	30% coinsurance after deductible
<b>Speech therapy</b>	\$40 copayment per visit	30% coinsurance after deductible
<b>Respiratory therapy</b>	10% coinsurance after deductible	30% coinsurance after deductible
<b>Manipulation therapy</b>	\$40 copayment per visit	30% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
<b>MH &amp; SUD detoxification inpatient services</b>	10% coinsurance after deductible	30% coinsurance after deductible
<b>MH &amp; SUD rehabilitation outpatient services</b>	\$40 copayment per visit	30% coinsurance after deductible
Additional Services		
<b>Home healthcare services</b> (90 visits per benefit period)	10% coinsurance after deductible	50% coinsurance after deductible
<b>Durable medical equipment and supplies; prosthetic appliances and orthotic devices</b>	10% coinsurance after deductible	30% coinsurance after deductible

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