Capital BlueCross

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Benefit Highlights

PPO 250 Plan

Central Susquehanna Trust

SUMMARY OF COST SHARING	Amounts Members Are Responsible For:	
	Participating Providers	*Non-Participating Providers*
Deductible (per annual benefit period) *Deductible applies to all services unless a Copayment is applied or otherwise noted*	$250 per member $750 per family	$500 per member $1,000 per family
Copayments		
• Office Visits (Family Practitioner, General Practitioner, Internist, Pediatrician)	$ 20 copayment per visit	30% coinsurance
• Specialist Office Visit	$ 40 copayment per visit	30% coinsurance
• Emergency Room	$ 100 copayment per visit, waived if admitted	
• Urgent Care	$ 50 copayment per visit	30% coinsurance
• Inpatient (Per Admission)	Not Applicable	Not Applicable
• Outpatient Surgery Copayment (facility)	Not Applicable	Not Applicable
Coinsurance	10% coinsurance	30% coinsurance
Out-of-Pocket Maximum (per annual benefit period)	$400 per member $1,200 per family	$3,000 per member $6,000 per family
Coverage Lifetime Maximum	Unlimited	Unlimited

SUMMARY OF BENEFITS	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	*Non-Participating Providers*
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full, No deductible, No copay	30% coinsurance after deductible
• Adult Preventive Care		Covered in full, No deductible, No copay	30% coinsurance after deductible
Immunizations		Covered in full, waive deductible	30% coinsurance, waive deductible
Mammograms			
• Screening Mammogram (age 35 and older)	One per 12 month period	Covered in full, waive deductible	30% coinsurance, waive deductible
Gynecological Services			
• Screening Gynecological Exam	One per 12 month period	Covered in full, No deductible, No copay	30% coinsurance, waive deductible
• Screening Pap Smear	One per 12 month period	Covered in full, waive deductible	30% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		10% coinsurance after deductible	50% coinsurance after deductible
Acute Inpatient Rehabilitation		10% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility		10% coinsurance after deductible	50% coinsurance after deductible
Surgery			
• Surgical Procedure		10% coinsurance after deductible	30% professional and 50% facility coinsurance after deductible
• Anesthesia		10% coinsurance after deductible	30% professional and 50% facility coinsurance after deductible
Maternity Services and Newborn Care		10% coinsurance after deductible	30% coinsurance after deductible
Diagnostic Services			
• Radiology		10% coinsurance after deductible	30% professional and 50% facility coinsurance after deductible
• Laboratory		10% coinsurance after deductible	30% professional and 50% facility coinsurance after deductible
Outpatient Therapy Services			
• Physical Therapy		Copayment per visit	30% coinsurance after deductible
• Occupational Therapy		Copayment per visit	30% coinsurance after deductible
• Speech Therapy		Copayment per visit	30% coinsurance after deductible
• Manipulation Therapy		Copayment per visit	30% coinsurance after deductible
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted	
Medical Transport			
• Emergency Ambulance		Covered in full, waive deductible	
• Non-Emergency Ambulance		Covered in full, waive deductible	

Benefits are underwritten by Capital Advantage Insurance Company®, a subsidiary of Capital BlueCross. Independent licensee of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

SUMMARY OF BENEFITS (CONTINUED)	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	*Non-Participating Providers*
Mental Health Care Services • Inpatient Services		10% coinsurance after deductible	30% professional and 50% facility coinsurance after deductible
• Outpatient Services		Copayment per visit	30% professional and 50% facility coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient		10% coinsurance after deductible	30% professional and 50% facility coinsurance after deductible
• Rehabilitation – Outpatient		Copayment per visit	30% professional and 50% facility coinsurance after deductible
Home Health Care Services	90 visits/benefit period	10% coinsurance after deductible	30% coinsurance after deductible
Hospice Care	$12,500 lifetime max	10% coinsurance after deductible	30% coinsurance after deductible
Durable Medical Equipment (DME)		10% coinsurance after deductible	30% coinsurance after deductible
Prosthetic Appliances and Orthotic Devices		10% coinsurance after deductible	30% coinsurance after deductible
Diabetic Supplies and Education		10% coinsurance after deductible	30% coinsurance after deductible

OTHER STANDARD PLAN FEATURES	
Preauthorization	Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs.
Disease Management	Disease Management Programs are a collaborative process that assess the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression.
Nurse Line	Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE.
Better Health Works℠ Personal Profile	Answer questions about yourself and the way you live and, based on the answers you provide, you will receive customized recommendations for your health situation. Support is available to follow through on these recommendations and to make positive health changes.
mycapbluecross.com	Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWell℠ member newsletter, view explanation of benefits, and much more.

STANDARD BENEFIT EXCLUSIONS. The following list highlights ***some*** standard benefit exclusions. It is **NOT** intended to be a complete list or a complete description of all categories of benefit exclusions.

Cosmetic procedures – Acupuncture – Routine foot care; or support devices of the feet – Eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses – Corneal surgery and other procedures to correct refractive errors – Prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider – Hearing aids or examinations for the prescription or fitting of hearing aids – All dental services rendered after stabilization of a member in an emergency following an accidental injury – Treatment of obesity, except for surgical treatment of morbid obesity – Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcisions - Procedures to reverse sterilization

THIS IS NOT A CONTRACT. This information highlights ***some*** of the benefits available through this program and is **NOT** intended to be a complete list or complete description of available services.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's charges and the allowable amount. Non-Participating Providers may balance bill the member.

For more information or to locate a participating provider, visit **www.capbluecross.com**.

Contact Capital BlueCross Customer Service Department at 1-866-787-9872 for the applicable benefit period.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size > 51.