Capital BLUE

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BENEFIT HIGHLIGHTS

QHDHP PPO 2750/0/0

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 Certificate of Coverage (also known as "benefit booklet"). Refer to your benefit booklet for complete details.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is participating	If provider is nonparticipating
Deductible (per benefit period) Deductible is combined to include medical and prescription drug benefits for participating providers. If you enroll in a family plan, the overall family deductible must be met before the plan begins to pay.	$2,750 per member $5,500 per family	$5,000 per member $10,000 per family
Coinsurance (percentage you pay after your deductible is met)	No member coinsurance	50% coinsurance
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 participating providers only.)	$6,650 per member $13,300 per family	$10,000 per member $20,000 per family
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Visits (performed through our Virtual Care tool or an approved virtual visit with a participating provider)	No charge after deductible	Not covered
Office Visits (performed by a family practitioner, general practitioner, internist, pediatrician or participating retail clinic)	No charge after deductible	50% coinsurance after deductible
Specialist Office Visits	No charge after deductible	50% coinsurance after deductible
Urgent Care Services	No charge after deductible	
Emergency Room	No charge after deductible	
Preventive Care		
Pediatric and Adult Preventive Care	No charge, waive deductible	50% coinsurance after deductible
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge, waive deductible	50% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge, waive deductible	50% coinsurance, waive deductible
Diagnostic Mammogram	No charge after deductible	50% 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 (120 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	50% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	No charge after deductible	Not covered
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	50% coinsurance after deductible
Radiology (other than high tech imaging)	No charge after deductible	50% coinsurance after deductible
Independent Laboratory	No charge after deductible	50% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	No charge after deductible	50% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy and Occupational Therapy (rehabilitative and habilitative, 60 visits combined per benefit period)	No charge after deductible	50% coinsurance after deductible
Speech Therapy (rehabilitative and habilitative, 60 visits each per benefit period)	No charge after deductible	50% coinsurance after deductible
Respiratory/Pulmonary Therapy (20 rehabilitative visits per benefit period)	No charge after deductible	50% coinsurance after deductible
Manipulation Therapy (20 visits per benefit period)	No charge after deductible	50% coinsurance after deductible
Acupuncture (15 visits per benefit period)	No charge after deductible	50% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	No charge after deductible	50% coinsurance after deductible
MH Outpatient Services	No charge after deductible	50% coinsurance after deductible
SUD Detoxification Inpatient	No charge after deductible	50% coinsurance after deductible
SUD Rehabilitation Outpatient	No charge after deductible	50% coinsurance after deductible
Additional Services		
Home Health Care Services (60 visits per benefit period)	No charge after deductible	50% coinsurance after deductible
Durable Medical Equipment and Supplies	No charge after deductible	50% coinsurance after deductible
Prosthetic Appliances	No charge after deductible	50% coinsurance after deductible
Orthotic Devices	No charge after deductible	50% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. An independent licensee of the BlueCross BlueShield Association.

YOUR PRESCRIPTION DRUG SUMMARY OF COST-SHARING			
	Member Responsibilities		
	If provider is participating		**If provider is nonparticipating**
Deductible (includes medical and prescription drug benefits for participating providers)	$2,750 per member $5,500 per family		$5,000 per member $10,000 per family
	Retail Pharmacy (up to a 30 day supply)	Home Delivery (up to a 90 day supply)	Specialty Pharmacy (up to a 30 day supply)
Prescription Drug Tier			
Generic Preferred	$7 copayment after deductible	$14 copayment after deductible	$95 copayment after deductible
Generic Nonpreferred	$25 copayment after deductible	$50 copayment after deductible	20% coinsurance up to $350 per fill after deductible
Brand Preferred	$55 copayment after deductible	$110 copayment after deductible	$95 copayment after deductible
Brand Nonpreferred	$80 copayment after deductible	$160 copayment after deductible	20% coinsurance up to $350 per fill after deductible
Contraceptives* (self-administered)			
Generic	$0 copayment	$0 copayment	Not covered
Select Brands (no generic equivalent available)	$0 copayment	$0 copayment	Not covered
Brand Preferred	$55 copayment after deductible	$110 copayment after deductible	Not covered
Brand Nonpreferred	$80 copayment after deductible	$160 copayment after deductible	Not covered
Additional Pharmacy Benefits/Details			
Network (for Specialty Pharmacy information please refer to the Guide to Rx Benefits at www.capbluecross.com)	Broad Plus		
Formulary	Advantage		
$0 Preventive Rx Coverage	No charge		
Generic Substitution Program	Restrictive Generic Substitution – In addition to the coinsurance/ copayment, the member pays the difference between the brand and generic drug price (when there is a generic alternative) unless the physician requests the brand be dispensed.		
Extended Supply Network	Members have the ability to obtain covered drugs for up to a 90 day supply at participating retail pharmacies.		

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.
*Certain preventive contraceptives are required to be covered at no cost to you when filled at a participating pharmacy with a valid prescription in accordance with Preventive Health Guidelines.

Participating providers and pharmacies agree to accept our allowance as payment in full—often less than their normal charge. If you visit a nonparticipating provider or pharmacy, you are responsible for paying the deductible, coinsurance and the difference between the nonparticipating provider's or nonparticipating pharmacy's charges and the allowed amount. Nonparticipating Providers may balance bill the member. Some nonparticipating facility providers are not covered. Deductibles, any differences paid between brand drug and generic drug prices, and any balances paid to nonparticipating pharmacies are not applied to the out-of-pocket maximum. 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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Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.