BENEFIT HIGHLIGHTS

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Capital

QHDHP PPO 5000 PLAN

High Deductible Plan

Furmano Foods, Inc.

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.	$5,000 single coverage $10,000 family coverage	$10,000 single coverage $20,000 family coverage
Coinsurance (Percentage you pay after your deductible is met).	No member coinsurance	50% coinsurance after deductible
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 in-network providers only.)	$7,050 single coverage $14,100 family coverage	$10,000 single coverage $20,000 family coverage
Office Visit / Urgent Care / Emergency Room Copayments		
VirtualCare (non-specialist) visits—delivered via the Capital Blue Cross VirtualCare platform	No charge 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	No charge after deductible	50% coinsurance after deductible
Specialist office visits (in-person, telehealth & via the Capital Blue Cross VirtualCare platform)	No charge after deductible	50% coinsurance after deductible VirtualCare– Not applicable
Emergency Room	$250 copay after deductible	$250 copay after deductible
Urgent care services	No charge after deductible	
Preventive Care		
Pediatric and adult preventive care	No charge, deductible waived	50% coinsurance after deductible
Screening gynecological exam and pap smear (one per benefit period)	No charge, deductible waived	50% coinsurance, deductible waived
Screening mammogram (one per benefit period)	No charge, deductible waived	50% coinsurance, deductible waived
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 (120 days per benefit period)	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
Diagnostic mammogram	No charge after deductible	50% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical therapy and Occupational therapy (60 visits combined per benefit period)	No charge after deductible	50% coinsurance after deductible
Speech therapy (60 visits per benefit period)	No charge after deductible	50% coinsurance after deductible
Respiratory therapy (20 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 & SUD detoxification inpatient services	No charge after deductible	50% coinsurance after deductible
MH & SUD rehabilitation outpatient services	No charge after deductible	50% coinsurance after deductible
Additional Services		
Home healthcare services (60 visits per benefit period)	No charge after deductible	50% coinsurance after deductible
Durable medical equipment and supplies; prosthetic appliances and orthotic devices	No charge after deductible	50% coinsurance after deductible

YOUR PRESCRIPTION DRUG SUMMARY OF COST-SHARING			
	Member Responsibilities		
	If provider is in-network		**If provider is out-of-network**
Deductible (includes medical and prescription drug benefits for in-network providers)	$5,000 single coverage $10,000 family coverage		$10,000 single coverage $20,000 family coverage
	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	No charge after deductible	No charge after deductible	No charge after deductible
Generic nonpreferred	No charge after deductible	No charge after deductible	No charge after deductible
Brand preferred	No charge after deductible	No charge after deductible	No charge after deductible
Brand nonpreferred	No charge after deductible	No charge after deductible	No charge 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	No charge after deductible	No charge after deductible	Not covered
Brand nonpreferred	No charge after deductible	No charge after deductible	Not covered
Additional pharmacy benefits/details			
Network (for specialty pharmacy information please refer to the guide to Rx benefits at **CapitalBlueCross.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 (ESN)	Members have the ability to obtain covered drugs for up to a 90-day supply at in-network 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 an in-network pharmacy with a valid prescription in accordance with Preventive Health Guidelines.

In-network providers and pharmacies agree to accept our allowance as payment in full—often less than their normal charge. If you visit an out-of-network provider or pharmacy, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider's or out-of-network pharmacy's charges and the allowed amount. Out-of-network providers may balance bill the member. Some out-of-network facility providers are not covered. Deductibles, any differences paid between brand drug and generic drug prices, and any balances paid to out-of-network 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.

Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.