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Capital

BENEFIT HIGHLIGHTS

CapitalBlueCross.com

QHDHP PPO 2500

Ollie's Bargain Outlet, 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.	$2,500 single coverage $5,000 family coverage	
Coinsurance (Percentage you pay after your deductible is met.)	20% coinsurance after deductible	40% coinsurance after deductible
Coinsurance Out-of-Pocket Maximum (includes medical coinsurance amounts; when this is satisfied, no further medical coinsurance is applied.)	$3,000 per member $6,000 per family	$5,000 single coverage $10,000 family coverage
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.)	$7,500 single coverage $15,000 family coverage	Not Applicable
Office Visit / Urgent Care / Emergency Room Copayments		
VirtualCare (non-specialist) visits—delivered via the Capital Blue Cross VirtualCare platform	$20 copay after deductible	Not covered
Office visits and consultations (in-person & telehealth)—performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	$20 copay after deductible	40% coinsurance after deductible
Specialist office visits (in-person, telehealth & via the Capital Blue Cross VirtualCare platform)	$40 copay after deductible	40% coinsurance after deductible VirtualCare–Not covered
Urgent care services	$40 copay after deductible	40% coinsurance after deductible
Emergency room	$150 copayment per visit after deductible, copayment waived if admitted	
Preventive Care		
Pediatric and adult preventive care	No charge, waive deductible	40% coinsurance after deductible
Screening gynecological exam and pap smear (one per benefit period)	No charge, waive deductible	40% coinsurance after deductible
Screening mammogram (one per benefit period)	No charge, waive deductible	40% coinsurance after deductible
Facility / Surgical Services		
Inpatient hospital room and board	$250 copay per admission plus deductible then 20% coinsurance	$500 copay per admission plus deductible then 40% coinsurance
Acute inpatient rehabilitation	$250 copay per admission plus deductible then 20% coinsurance	$500 copay per admission plus deductible then 40% coinsurance
Skilled nursing facility	$250 copay per admission plus deductible then 20% coinsurance	$500 copay per admission plus deductible then 40% coinsurance
Maternity services and newborn care	$250 copay per admission plus deductible then 20% coinsurance	$500 copay per admission plus deductible then 40% coinsurance
Surgical procedure and anesthesia (professional charges)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery at ambulatory surgical center (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery at acute care hospital (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Services		
High tech imaging (such as MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible
Radiology (other than high tech imaging)	20% coinsurance after deductible	40% coinsurance after deductible
Independent laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Facility-owned laboratory (i.e. Health System owned)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic mammogram	20% coinsurance after deductible	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (rehabilitative and habilitative, 20 visits per benefit period)	$40 copay per visit after deductible	40% coinsurance after deductible
Occupational Therapy (rehabilitative and habilitative, 12 visits per benefit period)	$40 copay per visit after deductible	40% coinsurance after deductible
Speech Therapy (rehabilitative and habilitative, 12 visits each per benefit period)	$40 copay per visit after deductible	40% coinsurance after deductible
Respiratory/Pulmonary Therapy (unlimited visits per benefit period)	$40 copay per visit after deductible	40% coinsurance after deductible
Manipulation Therapy (20 visits per benefit period)	$40 copay per visit after deductible	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		

MH inpatient services	$250 copay per admission plus deductible then 20% coinsurance	$500 copay per admission plus deductible then 40% coinsurance
MH outpatient services	$40 copayment per visit after deductible	40% coinsurance after deductible
SUD detoxification inpatient	$250 copay per admission plus deductible then 20% coinsurance	$500 copay per admission plus deductible then 40% coinsurance
SUD rehabilitation outpatient	$40 copayment per visit after deductible	40% coinsurance after deductible
Additional Services		
Home healthcare services (120 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Durable medical equipment and supplies	20% coinsurance after deductible	40% coinsurance after deductible
Prosthetic appliances	20% coinsurance after deductible	40% coinsurance after deductible
Orthotic devices	20% coinsurance after deductible	40% coinsurance after deductible
Transplant Services	20% coinsurance after deductible	40% 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)	$2,500 single coverage $5,000 family coverage		
	Retail pharmacy (up to a 31-day supply)	Home delivery (up to a 90-day supply)	Specialty pharmacy (up to a 30-day supply)
Prescription drug tier			
Generic preferred	$5 copayment after deductible	$10 copayment after deductible	$5 copayment after deductible
Generic nonpreferred	$5 copayment after deductible	$10 copayment after deductible	$5 copayment after deductible
Brand preferred	$40 copayment after deductible	$80 copayment after deductible	$40 copayment after deductible
Brand nonpreferred	$60 copayment after deductible	$120 copayment after deductible	$60 copayment 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	$40 copayment after deductible	$80 copayment after deductible	Not covered
Brand nonpreferred	$60 copayment after deductible	$120 copayment 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.		
Mandatory home delivery	For maintenance medications, only one original fill plus one refill are covered at retail.		

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.

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