



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a [summary](#). For more information about your coverage, or to get a copy of the complete terms of coverage, at [www.capitalhealth.com/sbc](http://www.capitalhealth.com/sbc). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-850-383-3311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the deductible amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$60 per child for pediatric dental services (if purchased through the alliance dental plan). There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$10,600 Individual/\$21,200 Family Combined Medical & Rx	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket</a> limit has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.capitalhealth.com">www.capitalhealth.com</a> or call 850-383-3311 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . Prior authorization is required for an <a href="#">out-of-network provider</a> . Your benefits/services may be denied. Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services..
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes. Some <a href="#">specialists</a> require a <a href="#">referral</a> . For a list of <a href="#">specialists</a> that require a <a href="#">referral</a> go to <a href="http://capitalhealth.com/ReferralAndAuth">capitalhealth.com/ReferralAndAuth</a> .	This plan will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office: \$35 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Exception: Amwell telehealth is a \$15 copay. Medical drugs (infusions or injections) administered in the office are subject to a \$100 copay. Prior authorization required for certain specialist visits your benefits/services may be denied.
	<u>Specialist visit</u>	Office: \$100 / visit	Not Covered	
	<u>Preventive care/screening/immunization</u>	No Charge for covered services	Not Covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Not Covered	<u>Diagnostic tests</u> other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	\$500 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="https://capitalhealth.com/members/about-your-medications">https://capitalhealth.com/members/about-your-medications</a>	Tier 1 Preferred Generic Tier 2 Non-Preferred Generic	\$40/ 30-day supply \$40/ 30-day supply	Not Covered	Pharmacy Network: CHP Value Network. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
	Tier 3 Preferred Brand Tier 4 Non-Preferred Brand	\$100/ 30-day supply \$200/ 30-day supply	Not Covered	Prescriptions covered up to a 90-day supply for generic and brand drugs (at 3 copays per 90-day supply) at Retail or Mail Order Pharmacies.
	<u>Specialty drugs</u> Tier 5 Preferred Specialty Tier 6 Non-Preferred Specialty	\$300/ 30-day supply \$500/ 30-day supply	Not Covered	Pharmacy Network: CHP Value Network. Limited to 30-day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limit may apply. Your benefits/services may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: \$350/ visit Hospital: \$750 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	\$100 / provider	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$1,000 / Visit \$750 / Observation	\$1,000 / Visit \$750 / Observation	Copayment is waived if inpatient admission occurs; however, if moved to observation status, an additional copayment may apply based on services rendered.
	<a href="#">Emergency medical transportation</a>	\$250 / transport	\$250 / transport	Covered if medically necessary.
	<a href="#">Urgent care</a>	Urgent care center: \$75 / visit Telehealth: \$75 / visit Amwell: \$15 / visit	Urgent care center: \$75 / visit Telehealth: \$75 / visit Amwell: \$15 / visit	Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 / day for first 4 days	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	\$100 / provider	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$100 / visit	Not Covered	————none————
	Inpatient services	\$1,000 / day for first 4 days	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you are pregnant	Office visits	\$100 / visit	Not Covered	Cost share applies regardless of place of service, including telehealth, office, school, etc. Exception: Amwell telehealth is a \$15 copay
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	\$1,000 / day for first 4 days	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$35 / visit	Not Covered	Limited to 20 visits per calendar year.
	<a href="#">Rehabilitation services</a>	\$100 / visit	Not Covered	Rehabilitation service is limited to a combined 35 visits per year, including chiropractic care. Cost share applies

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				regardless of place of service, including office, telehealth, school, etc.
	<a href="#">Habilitation services</a>	\$100 / visit	Not Covered	Habilitation services is limited to a combined 35 visits per year. Cost share applies regardless of place of service, including office, telehealth, school, etc
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	Limited to 60 days per calendar year.
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	<a href="#">Hospice services</a>	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	\$100 / visit	Not Covered	Limited to 1 visit per calendar year.
	Children's glasses	Covered	Not Covered	Limited to 1 pair of glasses (lenses and frames) per calendar year, provided at Capital Health Plan's Eye Care Centers.
	Children's dental check-up	Covered	Not Covered	Covered through our alliance dental plan, a standalone dental plan, or the insurance marketplace (for an additional premium, billed directly by the dental carrier).

#### Excluded Services & Other Covered Services:

#### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery (unless [medically necessary](#))
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs
- Dental care (Adult)

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care –Limited to 35 visit per calendar year; limit combined with Rehabilitation services
- Non-emergency care when traveling outside the US
- Annual Routine eye care (Adult)
- Site of Care Guidelines for Select Medications. Requests for select medications to be administered in a hospital-affiliated outpatient setting will be redirected to the CHP Infusion Clinic unless criteria for medical necessity are met. Refer to the Site of Care guideline on the Florida Blue medical coverage guidelines page for specific criteria. <https://mcgs.bcbstfl.com/>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.healthcare.gov). For more information about the [Marketplace](http://www.healthcare.gov), visit [www.HealthCare.gov](http://www.healthcare.gov) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Capital Health Plan at 1-850-383-3311. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or [Affordable Care Act](#) | [U.S. Department of Labor \(dol.gov\)](#) and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 850-383-3311, 1-877-247-6512

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 850-383-3311, 1-877-247-6512.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 850-383-3311, 1-877-247-6512.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 850-383-3311, 1-877-247-6512.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

<a href="#">The plan's overall deductible</a>	\$0
<a href="#">Specialist copayment</a>	\$100
<a href="#">Hospital (facility) copayment</a>	\$1,000
<a href="#">Other copayment</a>	\$0

**This EXAMPLE event includes services like:**  
[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$2,600
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,660</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

<a href="#">The plan's overall deductible</a>	\$0
<a href="#">Specialist copayment</a>	\$100
<a href="#">Hospital (facility) copayment</a>	\$1,000
<a href="#">Other copayment</a>	\$100

**This EXAMPLE event includes services like:**  
[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,420</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

<a href="#">The plan's overall deductible</a>	\$0
<a href="#">Specialist copayment</a>	\$100
<a href="#">Hospital (facility) copayment</a>	\$1,000
<a href="#">Other coinsurance</a>	\$0

**This EXAMPLE event includes services like:**  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,700
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.