Capital Health PLAN **Silver 2400** **Coverage for: Individual and/or Family | Plan Type: HMO**

**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. 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?** | Combined Medical and Pharmacy: $7,000 individual / $14,000 family. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive Care and certain services such as Primary Care, Specialist, and Telehealth are covered before you meet your deductible. Please refer to the services below for details. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Combined Medical and Pharmacy: $10,000 individual / $20,000 family. | The out-of-pocket limit 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 out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers. | Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. Prior authorization required for certain services performed in a specialist office. |

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: $40 / visit | Not Covered | Cost share applies regardless of place of service, including telehealth, office, school, etc. Medical drugs (infusions or injections) administered in the office are subject to a Deductible + 50% Coinsurance. Prior authorization required for certain specialist visits. Your benefits/services may be denied. |
| | Specialist visit | Office: $ 80 / visit | Not Covered | |
| | Preventive care/screening/ immunization | No Charge for covered services | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Deductible + 50% Coinsurance | Not Covered | Diagnostic tests other than x-ray or blood work may incur a cost share. |
| | Imaging (CT/PET scans, MRIs) | Deductible + 50% Coinsurance | 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 **prescription drug coverage** is available at https://capitalhealth.com/members/about-your-medications | Generic drugs<br>Tier 1 Preferred Generic<br>Tier 2 Non-Preferred Generic | $20 / 30-day supply | Not Covered | Pharmacy Network: CHP Value Network. The formulary is a closed formulary. This means that all available covered medications are shown. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied. 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. |
| | Tier 3 Preferred Brand drugs | $40 / 30-day supply | Not Covered | |
| | Tier 4 Non-Preferred Brand drugs | Deductible + $80 Copayment / 30-day supply | Not Covered | |
| | Specialty drugs<br>Tier 5 Preferred Specialty<br>Tier 6 Non-Preferred Specialty | Deductible + $350 Copayment / 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 limits may apply. Your |

| 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) | |
| | | | | benefits/services may be denied |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible + 50% Coinsurance | Not Covered | Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services, including chemotherapy and radiation therapy. Exception: Medical drugs (infusions or injections) administered outpatient are subject to a Deductible + 40% Coinsurance. |
| | Physician/surgeon fees | Deductible + 50% Coinsurance | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | Deductible + 50% Coinsurance | Deductible + 50% Coinsurance | ————none———— |
| | Emergency medical transportation | Deductible + 50% Coinsurance | Deductible + 50% Coinsurance | Covered if medically necessary. |
| | Urgent care | $60 / visit | $60 / visit | Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices. Telehealth: $60 / visit<br>Amwell: $0 / visit |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Deductible + 50% Coinsurance | Not Covered | Prior authorization required. Your benefits /services may be denied. |
| | Physician/surgeon fees | Deductible + 50% Coinsurance | Not Covered | ————none———— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office: $40 / visit<br>Non-Office: Deductible + 50% Coinsurance | Not Covered | Cost share applies regardless of place of service, including telehealth, office, school, etc. |
| | Inpatient services | Deductible + 50% Coinsurance | Not Covered | Prior authorization required. Your benefits /services may be denied. |
| **If you are pregnant** | Office visits | $80 / visit | Not Covered | Cost share applies regardless of place of service, including telehealth, office, school, etc. |
| | Childbirth/delivery professional services | Deductible + 50% Coinsurance | Not Covered | ————none———— |

| 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) | |
| | Childbirth/delivery facility services | Deductible + 50% Coinsurance | Not Covered | Prior authorization required. Your benefits /services may be denied. |
| **If you need help recovering or have other special health needs** | Home health care | Deductible + 50% Coinsurance | Not Covered | Limited to 20 visits per calendar year. |
| | Rehabilitation services | $40 / visit | Not Covered | Rehabilitation services are limited to a combined 35 visits per year, including chiropractic care. Cost share applies regardless of place of service, including office, telehealth, school, etc. |
| | Habilitation services | $40 / visit | Not Covered | Habilitation services are limited to a combined 35 visits per year. Cost share applies regardless of place of service, including office, telehealth, school, etc. |
| | Skilled nursing care | Deductible + 50% Coinsurance | Not Covered | Limited to 60 days per calendar year. |
| | Durable medical equipment | Deductible + 50% Coinsurance | Not Covered | Prior authorization required for certain devices. Your benefits/services may be denied. |
| | Hospice services | Deductible + 50% Coinsurance | 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 | No Charge | 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 | Not Covered | Not Covered | Not Covered |

## 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.)**

- Abortions
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

| 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<br>• Non-emergency care when traveling outside the US | • 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.bcbsfl.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 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. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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. 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 https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act 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?** **Not Applicable**

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, kwiijigo holne' 850-383-3311, 1-877-247-6512.

## About these Coverage Examples:

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



**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)

- **The plan's overall deductible** **$7,000**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

**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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $7,000 |
| Copayments | $1 |
| Coinsurance | $2,800 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,870** |

## Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$7,000**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

**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)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $900 |
| Copayments | $900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,820** |

## Mia's Simple Fracture

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

- **The plan's overall deductible** **$7,000**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,100 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,500** |

The plan would be responsible for the other costs of these EXAMPLE covered services.