



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: |
|--|--|--|
| <u>What is the overall deductible?</u> | \$0 | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| <u>Are there services covered before you meet your deductible?</u> | Yes. | This <u>plan</u> covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| <u>Are there other deductibles for specific services?</u> | No. | You don't have to meet <u>deductibles</u> for specific services. |
| <u>What is the out-of-pocket limit for this plan?</u> | \$3,000 single coverage \$6,000 family coverage. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| <u>What is not included in the out-of-pocket limit?</u> | <u>Premiums</u> and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| <u>Will you pay less if you use a network provider?</u> | Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers. | This <u>plan</u> uses a <u>provider network</u> . Prior authorization is required for an <u>out-of-network provider</u> . Your benefits/services may be denied. Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <u>Do you need a referral to see a specialist?</u> | Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |



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: \$15 / visit (CHP office) \$25 / visit (affiliate offices) | Not Covered | Cost share applies regardless of place of service, including office, telehealth, school, etc. Exception: Amwell telehealth is a \$15 copay. |
| | <u>Specialist</u> visit | Office: \$50 / visit | Not Covered | Cost share applies regardless of place of service, including office, telehealth, school, etc. Exception: Amwell telehealth is a \$15 copay. Prior authorization required for certain specialist visits. Your benefits/services may be denied. |
| | <u>Preventive care/screening/immunization</u> | No Charge for covered services | Not Covered | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No Charge | Not Covered | Diagnostic tests other than x-ray or blood work may incur a cost share. |
| | Imaging (CT/PET scans, MRIs) | \$100 / 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 https://capitalhealth.com/members/about-your-medications | Tier 1 – Preferred Generic | Not Covered | Not Covered | Prescription drugs are not covered with this benefit plan. |
| | Tier 2 – Non-Preferred Generic | Not Covered | Not Covered | |
| | Tier 3 – Preferred Brand Tier 4 – Non-Preferred Brand | Not Covered | Not Covered | |
| | <u>Specialty drugs</u> Tier 5 – Preferred Specialty Tier 6 – Non-Preferred Specialty | Not Covered | Not Covered | |
| | | | | |

| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|--|
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgical Center: \$200 / visit Hospital: \$200 / visit | Not Covered | Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services. |
| | Physician/surgeon fees | \$50 / provider | Not Covered | |
| If you need immediate medical attention | Emergency room care | \$100 / visit \$200 / observation | \$100 / visit \$200 / observation | ————none———— |
| | Emergency medical transportation | \$100 / transport | \$100 / transport | Covered if medically necessary. |
| | Urgent care | Urgent care center: \$25 / visit Telehealth: \$25 / visit Amwell: \$15 / visit | Urgent care center: \$25 / visit Telehealth: \$25 / visit Amwell: \$15 / visit | Telehealth – Services are provided by <u>network providers</u> through remote access technology including the web and mobile devices. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$250 / admission \$200 / observation | Not Covered | Prior authorization required. Your benefits /services may be denied. |
| | Physician/surgeon fees | No Charge if admitted \$50 /provider for observation | Not Covered | ————none———— |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$50 / visit | Not Covered | Limited to 20 visits per calendar year. Cost share applies regardless of place of service, including office, telehealth, school, etc. |
| | Inpatient services | \$250 / admission | Not Covered | Mental/Behavioral health limited to 31 days per calendar year. Substance abuse services limited to coverage for inpatient detoxification only, limited to the time necessary for the removal of toxic substances from the blood. |
| If you are pregnant | Office visits | \$50 / visit | Not Covered | Cost share applies regardless of place of service, including office, telehealth, school, etc. Exception: Amwell telehealth is a \$15 copay. |
| | Childbirth/delivery professional services | No Charge | Not Covered | ————none———— |
| | Childbirth/delivery facility services | \$250 / admission | Not Covered | Prior authorization required. Your benefits /services may be denied. |

| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | What You Will Pay Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| If you need help recovering or have other special health needs | Home health care | No Charge | Not Covered | Prior authorization required. Your benefits/services may be denied. |
| | Rehabilitation services | \$25 / visit | Not Covered | Limited to the consecutive 62-day period immediately following the first service date. Cost share applies regardless of place of service, including office, telehealth, school, etc. |
| | Habilitation services | Not Covered | Not Covered | _____none_____ |
| | Skilled nursing care | No Charge | Not Covered | Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission. |
| | Durable medical equipment | No Charge | Not Covered | Prior authorization required for certain devices. Your benefits/services may be denied. |
| | Hospice services | 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 | \$15 / visit | Not Covered | _____none_____ |
| | Children's glasses | Not Covered | Not Covered | _____none_____ |
| | Children's dental check-up | Not Covered | Not Covered | _____none_____ |

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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- 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
- Routine eye care (Adult)
- Routine foot care (when associated with the treatment of diabetes)

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](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. 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 a'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)

| | |
|---|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$50 |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other copayment | \$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*)

| | |
|--|-----------------|
| Total Example Cost | \$12,700 |
| In this example, Peg would pay: | |
| Cost Sharing | |
| Deductibles | \$0 |
| Copayments | \$600 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$670 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$50 |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other copayment | \$0 |

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 | \$0 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$3,500 |
| The total Joe would pay is | \$3,700 |

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$50 |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other copayment | \$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*)

| | |
|--|----------------|
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| Cost Sharing | |
| Deductibles | \$0 |
| Copayments | \$800 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$810 |

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

For more information about limitations and exceptions, see the [plan](#) or policy document at www.capitalhealth.com/sbc **Page 6 of 6**