



FEHB: High Option \$15/\$30/\$50 Rx

Coverage for: Self Only, Self Plus One or Self and 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.** Please read the FEHB Plan brochure (RI 73-197) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.capitalhealth.com/fehb and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-850-383-3311 to request a copy of either document.

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 plan covers.
Are there services covered before you meet your deductible ?	Yes.	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 ?	Medical: \$2,000 self / \$4,500 self plus one / \$4,500 self and family coverage. Pharmacy: \$4,600 self / \$8,700 self plus one / \$8,700 self and family coverage.	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 , prescription drug brand additional charges, 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 .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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 ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .





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	\$15 / visit	Not Covered	-----none-----
	Specialist visit	\$40 / visit	Not Covered	Prior authorization required for certain specialist visits. Your benefits/services may be denied.
	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)	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 prescription drug coverage is available at www.capitalhealth.com/MedCenter	Tier 1 drugs	\$15/30-day supply \$30/60-day supply \$45/90-day supply (retail & mail order)	Not Covered	If a generic drug is available, and a more expensive brand name drug is dispensed at the request of the member or the prescriber, the member must pay the copayment amount for the brand name drug plus pay the pharmacist 100% of the additional cost for the more expensive brand name prescription drug. This additional cost does not count towards your out-of-pocket limit. Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Tier 2 drugs	\$30/30-day supply \$60/60-day supply \$90/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Tier 3 drugs	\$50/30-day supply \$100/60-day supply \$150/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.

	Specialty drugs	\$50 /30-day supply	Not Covered	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: \$100 / visit Hospital: \$250 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	\$15 / PCP visit \$40 / Specialist visit	Not Covered	
If you need immediate medical attention	Emergency room care	\$300 / visit	\$300 / visit	<u>Copayment</u> is waived if inpatient admission occurs.
	Emergency medical transportation	\$100 / transport	\$100 / transport	Covered if medically necessary.
	Urgent care	Urgent care: \$25 / visit Telehealth :\$15 / visit	Urgent care: \$25 / visit Telehealth :\$15 / visit	Telehealth services are available through our contracted vendor in all states where telehealth services are permitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 / admission \$250 / observation	Not Covered	Prior authorization required. Your benefits/services may be denied.
	Physician/surgeon fees	No Charge	Not Covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 / visit	Not Covered	-----none-----
	Inpatient services	\$250 / admission	Not Covered	Prior authorization required. Your benefits/services may be denied.
If you are pregnant	Office visits	\$15 / PCP initial visit \$40 / Specialist initial visit	Not Covered	-----none-----
	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.
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	\$40 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date.
	Habilitation services	\$40 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date.

	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 / PCP visit \$40 / Specialist 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 plan's FEHB brochure for more information and a list of any other [excluded services](#).)

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|--|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) • Dental care (Child) • Glasses | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the US | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Bariatric Surgery | <ul style="list-style-type: none"> • Chiropractic care | <ul style="list-style-type: none"> • Routine eye care (Adult) |
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Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] or visit www.opm.gov/insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. 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 www.dol.gov/ebsa/consumer_info_health.html.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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, ☐ ☐ ☐ ☐ ☐ ☐ 850-383-3311, 1-877-247-6512.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo 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	\$40
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,060

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	\$40
■ Hospital (facility) copayment	\$250
■ Other copayment	\$15

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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$1,155

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$40
■ 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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

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