Capital Health PLAN **3101- Platinum $10/$30/$50/$100** **Coverage for:** Employee 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?	**$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?	**Yes. $60** per child for pediatric dental services (if purchased through the alliance dental plan).There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical: $2,800 single coverage / $5,600 family coverage. Pharmacy: $2,800 single coverage / $5,600 family coverage. Pediatric dental: $375 per child / $750 2+ children.	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?	Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth.	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	Office: $10 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth – Services provided by network providers through remote access technology including the web and mobile devices.
	Specialist visit	Office: $25 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain specialist visits. Your benefits/services may be denied. Telehealth – Services provided by network providers through remote access technology including the web and mobile devices.
	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**	Tier 1 – Preferred Generic Tier 2 – Non-Preferred Generic	$10 / 30 day supply	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown. Retail or mail order, one copay per 30 day supply up to 90 days.
	Tier 3 – Preferred Brand	$30 / 30 day supply	Not Covered	Prior authorization and/or quantity limit may apply. Your benefits/services may be denied. Retail or

coverage is available at https://capitalhealth.com/members/about-your-medications				mail order, one copay per 30 day supply up to 90 days.
	Tier 4 – Non-Preferred Brand	$50 / 30 day supply	Not Covered	Prior authorization and/or quantity limit may apply. Your benefits/services may be denied. Retail or mail order, one copay per 30 day supply up to 90 days.
	Specialty drugs Tier 5 – Preferred Specialty Tier 6 – Non-Preferred Specialty	$100 / 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: $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	$25 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$100 Copayment + 25% Coinsurance	$100 Copayment + 25% Coinsurance	Copayment and Coinsurance is waived if Inpatient admission occurs; however, if moved to observation status, you will pay $100 Copayment +25% Coinsurance for the ER visit and 25% Coinsurance for services rendered while in Observation status.
	Emergency medical transportation	No Charge	No Charge	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 network providers through remote access technology including the web and mobile devices.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted	Not Covered	————none————

If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Inpatient services	$250 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you are pregnant	Office visits	$25 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, etc.
	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	Limited to 20 visits per calendar year.
	Rehabilitation services	$25 / visit	Not Covered	Rehabilitation service is 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	$25 / 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.
	Skilled nursing care	No Charge	Not Covered	Limited to 60 days per calendar year.
	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	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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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
- Non-emergency care when traveling outside the US
- Annual Routine eye care (Adult)

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 www.dol.gov/ebsa/consumer_info_health.html 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， □ □ □ □ □ □ □ 850-383-3311, 1-877-247-6512.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,210**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,980
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,035**

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 ***coinsurance***	25%

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	$660
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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