




3102 Platinum \$10/\$40/\$60/\$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](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 <u>deductible</u> ?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>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 <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	Yes. \$60 per child for pediatric dental services (if purchased through the alliance dental plan). There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	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 <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 plan, 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.
What is not included in the <u>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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.capitalhealth.com">www.capitalhealth.com</a> or call 850-383-3311 for a list of network providers.	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 provider before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes. Some specialists require a referral. For a list of specialists that require a referral 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 specialist for covered services but only if you have a referral 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Office: \$15 / 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.
	<a href="#">Specialist</a> visit	Office: \$30 / 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.
	<a href="#">Preventive care/screening/immunization</a>	No Charge for covered services	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	<a href="#">Diagnostic tests</a> other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	\$200 / 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 <a href="#">prescription drug coverage</a> 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	\$10 / 30-day supply	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown. One copay per 30 day supply up to 90 days.
	Tier 3 – Preferred Brand	\$40 / 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.
	Tier 4 – Non-Preferred Brand	\$60 / 30-day supply	Not Covered	Prior authorization and/or quantity limit may apply. Your benefits/services may be denied. Retail or

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)	
				mail order, one copay per 30 day supply up to 90 days.
	<a href="#">Specialty drugs</a> 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	\$30 / provider	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 Copayment + 25% Coinsurance	\$100 Copayment + 25% Coinsurance	<u>Copayment</u> and <u>Coinsurance</u> is waived if Inpatient admission occurs; however, if moved to observation status, you will pay \$100 <u>Copayment</u> +25% <u>Coinsurance</u> for the ER visit and 25% <u>Coinsurance</u> for services rendered while in Observation status.
	<a href="#">Emergency medical transportation</a>	\$200 / transport	\$200 / transport	Covered if medically necessary.
	<a href="#">Urgent care</a>	Urgent care center: \$50 / visit Telehealth: \$50 / visit Amwell: \$15 / visit	Urgent care center: \$50 / visit Telehealth: \$50 / 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)	\$500 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Inpatient services	\$500 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you are pregnant	Office visits	\$30 / 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	\$500 / admission	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>	No Charge	Not Covered	Limited to 20 visits per calendar year.
	<a href="#">Rehabilitation services</a>	\$30 / visit	Not Covered	Rehabilitation service is limited to a combined 35 visits per year. Cost share applies regardless of place of service, including office, telehealth, school, etc.
	<a href="#">Habilitation services</a>	\$30 / 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	\$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       | • Dental care (Adult)   | • Private-duty nursing |
| • Bariatric Surgery | • Hearing aids          | • Routine foot care    |
| • Cosmetic Surgery  | • Infertility treatment | • Weight loss programs |
|                     | • Long-term care        |                        |

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](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](#). For more information about the [Marketplace](#), 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 [www.dol.gov/ebsa/consumer\\_info\\_health.html](http://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, 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">copayment</a>	\$60

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
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,600
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">coinsurance</a>	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
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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