




Capital Selection \$15/\$30/\$50

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 <a href="#">deductible</a> ?                                | \$0   | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes.  | This <a href="#">plan</a> covers some items and services even if you haven't yet met the deductible amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Medical: \$2,000 single coverage / \$4,500 family coverage.<br>Pharmacy: \$4,600 single coverage \$8,700 family coverage.   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn't cover.   | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.capitalhealth.com">www.capitalhealth.com</a> or call 850-383-3311 for a list of <a href="#">network providers</a> .  | Be aware, your network provider might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your provider before you get services.  |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes. Some <a href="#">specialists</a> require a <a href="#">referral</a> . For a list of <a href="#">specialists</a> that require a <a href="#">referral</a> go to <a href="http://capitalhealth.com/ReferralAndAuth">capitalhealth.com/ReferralAndAuth</a> | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .  |

 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<br>(You will pay the least) | Out-of-Network Provider<br>(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 web and mobile devices.   |
|   | <a href="#">Specialist</a> visit                             | Office: \$40 / 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 web and mobile devices. |
|   | <a href="#">Preventive care/screening/</a> immunization      | 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  | 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<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://capitalhealth.com/">https://capitalhealth.com/</a> | Tier 1 – Preferred Generic<br>Tier 2 – Non-Preferred Generic | \$15 / 30-day supply                         | Not Covered  | 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. Retail or mail order, one copay per 30 day supply up to 90 days.   |
|   | Tier 3 – Preferred Brand                                     | \$30 / 30-day supply                         | Not Covered  |  |
|   | Tier 4 – Non-Preferred Brand                                 | \$50 / 30-day supply                         | Not Covered  |  |

|  |   |  |  |   |
|--|---|--|--|---|
| <a href="#">members/about-your-medications</a>                                   | <a href="#">Specialty drugs</a><br>Tier 5 – Preferred Specialty<br>Tier 6 – Non-Preferred Specialty | \$50 / 30-day supply   | Not Covered  | Limited to 30-day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.          |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)  | Ambulatory Surgical Center: \$100 / visit<br>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  | \$40 / provider  | Not Covered  |   |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>   | \$300 / visit<br>\$250 / observation   | \$300 / visit<br>\$250 / observation   | <u>Copayment</u> is waived if inpatient admission occurs; however, if moved to observation status, an additional <u>copayment</u> may apply based on services rendered. |
|  | <a href="#">Emergency medical transportation</a>  | \$100 / transport  | \$100 / transport  | Covered if medically necessary.   |
|  | <a href="#">Urgent care</a>   | Urgent care center: \$25 / visit<br>Telehealth: \$25 / visit<br>Amwell: \$15 / visit | Urgent care center: \$25 / visit<br>Telehealth: \$25 / visit<br>Amwell: \$15 / visit | Telehealth – Services are provided by <u>network providers</u> through remote access technology including the web and mobile devices.                                   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)  | \$250 / admission<br>\$250 / observation   | Not Covered  | Prior authorization required. Your benefits /services may be denied.  |
|  | Physician/surgeon fees  | No Charge if admitted<br>\$40 /provider for observation                              | Not Covered  | —————none—————  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services   | \$40 / 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.  |
| <b>If you are pregnant</b>   | Office visits   | \$40 / 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  | \$250 / admission  | Not Covered  | Prior authorization required. Your benefits   |

|   |   |              |             |  |
|---|---|--------------|-------------|--|
|   | services                                  |              |             | /services may be denied.   |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No Charge    | Not Covered | Prior authorization required. Your benefits/services may be denied.  |
|   | <a href="#">Rehabilitation services</a>   | \$40 / 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. |
|   | <a href="#">Habilitation services</a>     | Not Covered  | Not Covered | —————none—————   |
|   | <a href="#">Skilled nursing care</a>      | No Charge    | Not Covered | Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.   |
|   | <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.   |
| <b>If your child needs dental or eye care</b>                         | 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |   |   |  |
|---|---|---|--|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> <li>Dental care (Adult)</li> <li>Dental care (Child)</li> </ul>                      | <ul style="list-style-type: none"> <li>Glasses</li> <li>Habilitation services</li> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the US</li> <li>Private-duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |  |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |   |
|--|---|
| <ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>  | <ul style="list-style-type: none"> <li>Annual routine eye care (Adult)</li> </ul> |

**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, 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.

*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>                          | \$40  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$250 |
| ■ 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$500        |
| <a href="#">Coinsurance</a>       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$560</b> |

### 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>                          | \$40  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$250 |
| ■ Other <a href="#">copayment</a>                               | \$50  |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe 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              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,020</b> |

### 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>                          | \$40  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$250 |
| ■ Other <a href="#">copayment</a>                               | \$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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

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          |
| <b>The total Mia would pay is</b> | <b>\$900</b> |

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