




Capital Selection CHP \$15/\$30/\$50  
(ER: 20% Coinsurance)

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: \$3,000 single coverage / \$6,000 family coverage. Pharmacy: \$4,000 single coverage \$8,000 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 <a href="#">network provider</a> 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 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 <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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	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 <a href="#">network providers</a> through remote access technology including the 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 <a href="#">specialist</a> visits. Your benefits/services may be denied. Telehealth – Services are provided by <a href="#">network providers</a> 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	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 <a href="#">prescription drug coverage</a> is available at <a href="https://capitalhealth.com/members/about-your-">https://capitalhealth.com/members/about-your-</a>	Tier 1 – Preferred Generic 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="#">medications</a>	<a href="#">Specialty drugs</a> Tier 5 – Preferred Specialty 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 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	No Charge	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% Coinsurance / visit	20% Coinsurance / visit	<a href="#">Coinsurance</a> is waived if Inpatient admission occurs; however, if moved to Observation status you will pay 20% Coinsurance for the ER visit and 20% Coinsurance for services rendered while in Observation status.
	<a href="#">Emergency medical transportation</a>	\$100 / transport	\$100 / transport	Covered if medically necessary.
	<a href="#">Urgent care</a>	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 <a href="#">network providers</a> 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 \$250 / observation	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge	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:**

<b>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>.)</b>		
<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>

<b>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your <a href="#">plan</a> document.)</b>	
<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, 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

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 [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$250
- Other [copayment](#) \$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*)

**Total Example Cost** \$5,600

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 [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$250
- Other [coinsurance](#) 20%

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	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>

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