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/ Self Only $0/ Self Plus One $0/ Self and Family	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: $3,500 Self Only coverage / $7,000 Self Plus One / $7,000 Self and Family. Pharmacy: $4,600 Self Only coverage / $8,700 Self Plus One / $8,700 Self and Family.	The out-of-pocket limit, or catastrophic maximum, 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	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, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office: $15 / visit Telehealth: $15 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
	Specialist visit	Office: $60 / visit Telehealth: $60 / 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 are 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)	$250 / 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 Tier 2 durgs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	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.
	Tier 3 drugs	$40/30-day supply $80/60-day supply $120/90-day supply (retail & mail order)	Not Covered	
	Tier 4 drugs	$100/30-day supply $200/60-day supply $300/90-day supply (retail & mail order)	Not Covered	

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, plus you may be balance billed)	
	Tier 5 drugs Tier 6 drugs	$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: $250 / 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 $60 / Specialist visit	Not Covered	
If you need immediate medical attention	Emergency room care	$500 / visit	$500 / visit	Copayment is waived if inpatient admission occurs.
	Emergency medical	$175 / transport	$175 / transport	Covered if medically necessary.
	Urgent care	Urgent care center: $50 / visit Telehealth: $50 / visit Amwell: $15 / visit	Urgent care center: $50 / visit Telehealth: $50 / visit Amwell: $15 /	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 per day	Not Covered	Maximum charge of 6 days per admission. 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	$60 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Inpatient services	$250 per day	Not Covered	Maximum charge of 6 days per admission. Your benefits/services may be denied.
If you are pregnant	Office visits	$15 / PCP initial visit $60 / Specialist initial visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, etc.
	Childbirth/delivery professional services	No Charge	Not Covered	————none————

For more information about limitations and exceptions, see the FEHB Plan brochure (RI 73-197) at www.capitalhealth.com/fehb

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, plus you may be balance billed)	
	Childbirth/delivery facility services	$250 per day	Not Covered	Maximum charge of 6 days per admission. 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	$60 / 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.
	Habilitation services	$60 / 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	20% Coinsurance	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 $60 / 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 FEHB Plan brochure for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- 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 FEHB Plan brochure.)

- Bariatric Surgery
- Chiropractic care
- Annualt Routine eye care (Adult)

For more information about limitations and exceptions, see the FEHB Plan brochure (RI 73-197) at www.capitalhealth.com/

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/healthcare-insurance/healthcare/ [opm.gov]. 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 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 FEHB Plan brochure. If you need assistance, you can contact: [insert applicable contact information from instructions].

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 plan's overall deductible	$0
Specialist *copayment*	$60
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	$700
Coinsurance	$
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$760**

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*	$60
Hospital (facility) *copayment*	$250
Other *copayment*	$100

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	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$0
Specialist *copayment*	$60
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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