




Quality Choice \$15/\$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](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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: \$2,000 single coverage / \$4,500 family coverage. Pharmacy: \$4,850 single coverage \$9,200 family coverage.	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 <u>plan</u> , 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 <u>network providers</u> .	Be aware, your network provider 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 <u>specialists</u> require a <u>referral</u> . For a list of <u>specialists</u> that require a <u>referral</u> go to <a href="http://capitalhealth.com/ReferralAndAuth">capitalhealth.com/ReferralAndAuth</a>	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> 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)	
<b>If you visit a health care provider's office or clinic</b>	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 are provided by <u>network providers</u> through remote access technology including the web and mobile devices.
	<a href="#">Specialist</a> visit	Office: \$75 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain <u>specialist</u> visits. Your benefits/services may be denied. Telehealth – Services are provided by <u>network providers</u> 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 <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<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)	\$250 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
<b>If you need drugs to treat your illness or condition</b> 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	\$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	\$50 / 30-day supply	Not Covered	
	Tier 4 – Non-Preferred Brand	\$100 / 30-day supply	Not Covered	

	<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 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: \$250 / visit Hospital: \$500 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	\$75 / provider	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$750 / visit \$500 / observation	\$750 / visit \$500 / 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>	\$250 / transport	\$250 / 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 <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)	\$500 / admission \$500 / observation	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted \$75 / provider for observation	Not Covered	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$75 / 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.
<b>If you are pregnant</b>	Office visits	\$75 / 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.
<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>	\$75 / 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, kwijijigo 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>	\$75
■ 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg 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	\$60
<b>The total Peg would pay is</b>	<b>\$960</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>	\$75
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,700
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</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>	\$75
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ 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>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,400</b>

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