Capital Health Plan

www.capitalhealth.com/FEHB

Customer service 850-383-3311

Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

2024

A Health Maintenance Organization (High Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 1.

Serving: Tallahassee, Florida area

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

Enrollment codes for this Plan:

EA1 High Option - Self Only
EA3 High Option - Self Plus One
EA2 High Option - Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2024: Page 14
- Summary of Benefits: Page 85

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Capital Health Plan About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Capital Health Plan's (CHP) prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, TTY: 800-325-0778.

Potential Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE (800-633-4227), (TTY 877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of Capital Health Plan, Inc. under contract (CS 2034) between Capital Health Plan, Inc. and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 850-383-3311 or through our website: www.capitalhealth.com. The address for Capital Health Plan's (CHP) Administrative office is:

Capital Health Plan, Inc.
2140 Centerville Place
Tallahassee, FL. 32308

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means Capital Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop HealthCare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 850-383-3311 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE

877-499-7295

Or go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/.

This online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly by your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1.**Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. **Keep and bring a list of all the medications you take.**

- Bring the actual medications or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital or clinic is best for your health needs.**

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor: "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct "Never Events", if you use Capital Health Plan preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment;
  - How you can cover your family members;
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
  - What happens when your enrollment ends;
  - When the next Open Season for enrollment begins.

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee, and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/Healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2024 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2023 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment
- You are a family member no longer eligible for coverage

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's Website at www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium you cannot convert):
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 850-383-3311 or visit our website at www.capitalhealth.com.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Capital Health Plan holds the following accreditation: National Committee for Quality Assurance (www.ncqa.org). To learn more about this plan's accreditation, please visit the following website: www.capitalhealth.com. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General Features of High Option

How we pay providers

We employ physicians and contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments when you follow Plan procedures for accessing care.

Preventive Care Services

Preventive care service are generally covered with no cost sharing and are not subject to copayments, or annual limits when received from a network provider.

Catastrophic protection

We protect you against catastrophic-out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including copayments, to no more than $7,000 for Self Only enrollment, and $14,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, our providers and our facilities. OPM's FEHB website www.opm.gov/healthcare-insurance lists the specific types of information that we must make available to you. Some of the required information is listed below.

- **We operate under a State of Florida Certificate of Authority and are federally qualified under Title XIII, PHSA.**
- **We have been in existence for 39 years.**
- **We are a Non-Profit Corporation.**

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Capital Health Plan at www.capitalhealth.com.

If you want more information about us, call 850-383-3311, or write to Capital Health Plan, 2140 Centerville Place, Tallahassee, Fl. 32308. You may also contact us by fax at 850-383-3339 or visit our website at www.capitalhealth.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website Capital Health Plan at www.capitalhealth.com/Members/About-Your-Care/Your-Health-Record to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is: Calhoun, Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2024

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5. Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- No Program-wide changes for 2024

Changes to this Plan

- Your share of the premium rate will **increase** for Self Only, Self Plus One, and Self and Family. **See page 86**.
- Capital Health Plan will provide coverage of artificial insemination (AI): intrauterine insemination (IUI), intravaginal insemination (IVI), and intracervical insemination (ICI) for three cycles annually. Pre-approval will be required for this benefit. Members utilizing this service will pay a $60 copayment for a specialist visit or $250 copayment per ambulatory surgical center facility visits. **See page 36**.
- Capital Health Plan will cover oral and injectable drugs associated with in vitro fertilization (IVF) procedures for three cycles annually when deemed medically necessary. Injectable drugs given at a provider's office would be covered under the medical benefit and oral or self-administered medications and injectables would be covered under prescription drug benefit. Oral and injectable drugs associated with IVF medications will require prior authorization and include quantity limits. **See pages 36 and 61**.
- Capital Health Plan will cover oral and injectable drugs associated with artificial insemination when deemed medically necessary. Injectable drugs given at a provider's office would be covered under the medical benefit and oral or self-administered medications and injectables would be covered under prescription drug benefit. Oral and injectable drugs associated with artificial insemination medications will require prior authorization and include quantity limits. **See pages 36 and 61**.
- Capital Health Plan will provide coverage for medically necessary gender affirming care services – including facial gender affirming surgeries. Gender affirmation services will require prior authorization and all services must be performed by a Capital Health Plan contracted or designated provider and/or facility. **See page 46**.
- Capital HealthPlan's service area has been expanded to Madison and Taylor counties in North Florida. **See page 13**.
- Capital Health Plan will increase the member's cost share for DME benefits from nothing to 20% of the Plan's allowance. The DME must be prescribed by a plan physician and requires preauthorization. **See page 41**.
- Capital Health Plan will increase the copayment for inpatient hospital visits from $250 copay per day/maximum two (2) days per admission for inpatient hospitalization to $250 copay per day (days one (1) through six (6) only)/maximum $1,500 per admission. **See page 52.**

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 850-383-3311 or write to us at Capital Health Plan, 2140 Centerville Place, Tallahassee, FL 32308. You may also request replacement cards through our website: www.capitalhealth.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and you will not have to file claims.

- **Balance Billing**

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we employ or contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards. You must select a primary care physician to direct all of your medical care. Capital Health Plan offers you a choice of primary care physicians at many different locations in the greater Tallahassee area.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website, www.capitalhealth.com.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, or gender.

- **Plan facilities**

This plan provides Care Coordinators for complex conditions and can be reached Capital Health Plan Member Services 850-383-3311 for assistance. Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website, www.capitalhealth.com. Primary care physician offices in our two health centers at Centerville Road and Governors Square Boulevard also offer the convenience of lab, x-ray, and vision care.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your health care.

- **Primary care**

Your primary care provider can be a family practitioner, internist, or pediatrician. Your primary care provider will provide most of your healthcare, or give you a referral to see a specialist.

It is important to understand the difference between a referral and an authorization, and how to obtain each one.

If you want to change primary care provider or if your primary care provider leaves the Plan, call us. We will help you select a new one.

Capital Health Plan's Directory of Physicians and Service Providers lists the primary care providers and their office locations. You can make your selections from this list. This directory is provided to all new members at the time of enrollment, on request by calling CHP's Member Services Department at 850-383-3311, or on our website at www.capitalhealth.com. This directory is subject to change and is updated on a regular basis. On occasion, some physicians may not accept new patients. CHP's Member Services staff gladly will assist you with your selection of a primary care physician.

- **Specialty care**

Your primary care provider will refer you to a specialist for needed care. CHP has eliminated the need for a CHP Authorization number of most but not all local network practitioner office based on specialty covered services. You will need a referral or written orders for specialty care. CHP endorses and encourages referrals for clinical recommendations from the primary care provider. Some specialty care offices may have a policy requiring an authorization number before making an appointment or require new patients to be seen by their primary care provider first. Primary care providers and specialists communicate with each other to coordinate members' care as needed. CHP authorization numbers still are required for certain medical services including, but not limited to:

- All inpatient services
- Outpatient Hospital based services for Wound Care, Hyperbaric oxygen treatment (HBO), and Observation
- All non-participating practitioners or facilities in or out of Capital Health Plan's service area
- All nonemergency services received outside CHP's service area, including out of area contracted practitioners and facilities (ex. Shands)
- All services related to the mouth and/or teeth
- Speech Therapy
- All home health care services except hospice care
- Services that may be investigational or outside the realm of accepted mainstream medical care.
- All procedures or surgery that have Capital Health Plan clinical criteria requires review and an authorization at any location. See a listing of Capital Health Plan Clinical Criteria on the Medical Policies page: http://www.www.capitalhealth.com/Providers/clinical-criteria.

If you have any questions regarding the referrals system, please call CHP Member Services at 850-383-3311 or visit www.capitalhealth.com/providers/Clinical-Criteria.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

- Your primary care provider will create your treatment plan, the physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. Your primary care provider will decide what treatment you need. If they decide to refer you to a specialist, ask if you can see your current specialist.
- If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our service area and you enroll in another FEHB plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 850-383-3311. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care provider arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- You must get prior approval for certain services. Failure to do so will result in services not being covered.

- **Inpatient hospital admission**

  Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

  Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

  Your primary care provider has authority to refer you for most services. For certain services, however, your primary care provider must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

  - Admissions (non-emergent) to all facilities, including:
    - Hospitals
    - Rehabilitation Facilities
    - Skilled Nursing Facilities
  - Bariatric Surgeries (Surgery for Clinically Severe Obesity)
  - Behavioral Health services including:
    - Inpatient admissions, non-emergent
    - Partial hospitalization services
    - Residential treatment (Ex. Eating Disorder and Substance Abuse Facilities)
  - Non-routine outpatient services including Applied Behavioral Analysis (ABA) and Transcranial Magnetic Stimulation
  - Breast Reduction and Reconstruction Surgeries
  - Cardiac Rehabilitation
  - Clinical Trials (only routine patient costs for items and services are covered)
  - Cochlear Implants
  - Computed Tomographic Colonography (Virtual Colonoscopy or CT Colonoscopy)
  - Continuous Glucose Monitoring Systems
  - Continuous Passive Motion Device
  - Cosmetic/Reconstructive Surgery including:
    - Abdominoplasty
    - Blepharoplasty / Ptosis repair
    - Destruction of Vascular Cutaneous Lesions
    - Mastectomy for Gynecomastia
    - Orthognathic Surgery
    - Panniculectomy/Removal of Excess Tissue
    - Ptosis repair
    - Reduction Mammoplasty (Breast Reduction)
    - Removal of Breast Implants
    - Repair of Congenital Chest Wall Deformities
    - Rhinoplasty
    - Scar revision
    - Septoplasty
  - Dental and Oral Surgery Services
  - Enzyme Replacement Therapy

- Experimental Items and Services
- Formulas and Enteral Nutrition
- Functional Neuromuscular Stimulation
- Gender Reassignment Surgeries (limited to those surgeries that can be performed by a general surgeon such as mastectomies, hysterectomies, oophorectomies and gonadectomies.)
- Genetic Testing
- Gynecomastia Surgery
- Hearing Devices - Implantable
- Hip Arthroplasty/Hip Replacement
- Home Health Care services
- Hospice Services – Inpatient
- Hospital Admissions (Non-emergent)
- Hyperbaric Oxygen (HBO) Therapy
- Implantable Neurostimulators
- Infertility Services
- Inpatient Non-emergent Admissions to all Facilities
- Insulin Infusion Pumps and Supplies
- Investigational Items and Services
- Knee Arthroplasty/Knee Replacement
- Left Atrial Appendage Closure Device (WATCHMAN™)
- Negative Pressure Wound Therapy Pump
- New Technologies that have not been assessed and incorporated into Capital Health Plan benefits
- Non-Emergent Medical Transportation
- Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders
- Osteogenesis Stimulators
- Outpatient Diagnostic Imaging Services including:
  - Magnetic Resonance Imaging (MRI) of the cervical spine (neck)Magnetic Resonance Imaging (MRI) of the lumbar spine (back)
- Outpatient Pulmonary Rehabilitation
- Outpatient Speech/Language Therapy
  - Physical and/or Occupational Therapy services require prior authorization if services are expected to exceed the member’s benefit limit.
- Out-of-Network / Non-contracted provider referrals
- Prosthetic Devices
- Proton Beam Therapy
- Pulmonary Rehabilitation
- Quantitative Elecrtoencephalography (QEEG)
- Radiation Oncology
- Respiratory Assist Devices (CPAP, APAP, BiPAP)
- Seat Lift Mechanisms

- Selected Medical Benefit drugs and biologicals: See CHP's website https://www.capitalhealth.com/Physicians-Providers/Medication-Center.
- Shoulder Arthroplasty/Shoulder Replacement
- Speech Generating Devices
- Spinal Cord Stimulation
- Spine Surgeries including:
  - Cervical (Neck)
  - Lumbar (Back)
  - Kyphoplasty
  - Vertebroplasty
- Subcutaneous Implantable Cardioverter-Defibrillator (ICD)
- Thoracic Outlet Syndrome Surgery
- Transcranial Magnetic Stimulation
- Transplant Services
- Tumor treatment field therapy
- Wearable and Non-Wearable Cardioverter-Defibrillators (WCD)
- Weight Control Services (including services provided at the Tallahassee Memorial Hospital Bariatric Center)
- Wheelchairs – Powered or customized wheelchairs only
- Wound Treatment Centers

The following are just a few of the services that have clinical criteria and require a review and a prior authorization:

- Genetic Testing
- Back (lumbar) and neck (cervical) surgery also known as spinal surgery, and MRI's
- Transcranial Magnetic Stimulation
- Implantable Hearing Devices
- Certain Durable Medical Equipment (DME), such as: External Insulin Infusion Pumps & Supplies, Continuous Glucose Monitoring, and Power Wheelchairs
- Gender Reassignment Surgeries (limited to those surgeries that can be performed by a general surgeon such as mastectomies, hysterectomies, oophorectomies and gonadectomies.)

Questions about Capital Health Plan’s prior authorization process?

Call Member Services at (850) 383-3311. For TTY/TDD – Telecommunication Device for the Deaf (for speech or hearing impaired) service, call (850) 383-3534 or 711. Outside the area? Call us toll-free at 1-877-247-6512.

Prior Authorization

Capital Health Plan requires prior authorization (prospective review of medical necessity, clinical appropriateness, eligibility, and level of benefits) for selected medications, procedures, services and items. Authorization and denial decisions are made in a timely manner that accommodates the clinical urgency of the situation. Providers are responsible for obtaining prior authorizations when required. Your physician will submit authorization requests electronically, by phone, or in writing by fax or mail. If approved, an authorization number is then generated by Capital Health Plan and is available to you via CHP*Connect*. If the requested service is not authorized, the member and provider are notified in writing with the specific reasons for the denial. Members are responsible for ensuring a prior authorization is in place *prior* to receiving these services. Failure to comply with these prior authorization requirements will result in denial of the claim payment. Prior authorization requirements are subject to change. For up-to-date information on services requiring a prior authorization, Members should contact the Member Services Department (850-383-3311) or visit our website at www.capitalhealth.com/Members/items-and-services-requiring-prior-authorizations.

Referrals and Authorizations

It is important to understand the difference between a referral and an authorization, and how to obtain each one.

Referral is the process of sending a patient to another practitioner (ex. specialist) for consultation or a health care service that the referring source believes is necessary but is not prepared or qualified to provide. Your primary care physician will refer you to a participating specialist or a health care service provider if they cannot personally provide the care you need. Many referrals do not require an authorization number.

Authorization, also known as precertification or prior authorization, is a process of reviewing certain medical, surgical or behavioral health services to ensure medical necessity and appropriateness of care prior to services being rendered. The review also includes a determination of whether the service being requested is a covered benefit under your benefit plan. Authorizations are only required for certain services.

How to request precertification for an admission or get prior authorization for Other services

First, your provider, your hospital, you, or your representative, must call us at 850-383-3311 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number,
- patient's name, birth date, identification number and phone number,
- reason for hospitalization, proposed treatment, or surgery,
- name and phone number of admitting physician,
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the provider and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e. when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision with 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 850-383-3311. You may also call OPM's Health Insurance 3 at 202-606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at 850-383-3311. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Maternity Care is defined as hospital services provided to a member for normal pregnancy, delivery, miscarriage, or pregnancy complications within the CHP service area only, unless the need for these services was not, and reasonably could not have been, anticipated before leaving the service area.

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Capital Health Plan is a health maintenance organization (HMO). We require you to see specific provider, hospitals, and other providers that contract with us. When you receive services from plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments described in this brochure. When you receive emergency services from non-plan providers, you may have to submit claim forms.

Benefits are available for care from non-plan providers in a medical emergency only if a delay in reaching a plan provider would result in death, disability, or significant jeopardy to your condition. Capital Health Plan members can access out-of-area urgent and emergency care at any affiliated Blue Cross and Blue Shield provider in the country through the BlueCard network and claims automatically will be routed to CHP.

Out-of-Area Services

Capital Health Plan has a variety of relationships with other Blue Cross and Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Programs." These Inter-Plan Arrangements operate based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever a Member obtain Covered Services outside of the Service Area, the claims for these services may be processed through one of these Inter-Plan Programs.

When a Member receives care for Covered Services outside of the Service Area, the Member will receive the care from one or two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") do not contract with the Host Blue. Capital Health Plan explains below how Capital Health Plan pays both kinds of providers.

Capital Health Plan covers only limited healthcare services received outside of the Service Area. As used in this section "Out-of-Area Covered Healthcare Services" include emergency care, urgent care, or care authorized by Capital Health Plan obtained outside of the Service Area. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. unless authorized by the Member's Primary Care Physician.

A. BlueCard® Program

Under the BlueCard® Program, when a Member obtains Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Capital Health Plan will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers. The BlueCard® Program enables a Member to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to the Member, so there are no claim forms for the Member to complete. The Member will be responsible for the Member Copayment amount, as stated in his or her Summary of Benefits and Coverage.

Emergency Care Services: If a Member experiences a Medical Emergency while traveling outside Capital Health Plan's Service Area, the Member should go to the nearest Emergency (or Urgent Care) facility.

When a Member receives Out-of-Area Covered Healthcare Services outside of the Service Area, and the claim is processed through the BlueCard® Program, the amount the Member pays for Out-of-Area Covered health Care Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Capital Health Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group. These arrangements may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price Capital Health Plan uses for the Member's claim because they will not be applied retroactively to claims already paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, Capital Health Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

B. Non-Participating Healthcare Providers Outside Our Service Area

1. Member Liability Calculation

When Out-of-Area Covered Healthcare Services are provided outside of Capital Health Plan by nonparticipating providers, the amount the Member pays for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment Capital Health Plan will make for the Out-of-Area Covered Healthcare Services as set forth in the Member's Employer Sponsored Plan. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, Capital Health Plan may use other payment bases, such as billed covered charges, the payment Capital Health Plan would make if the healthcare services had been obtained within the Service Area, or a special negotiated payment to determine the amount Capital Health Plan will pay for services provided by nonparticipating providers. In situations where services are provided by nonparticipating providers, the Member may be liable for the difference between the amount that the nonparticipating healthcare provider bills and the payment Capital Health Plan will make for the Out-of-Area Covered Services.

C. BlueCross BlueShield Global® Core

If a Member is outside the United States, they may be able to take advantage of the BlueCross BlueShield Global® Core Program when accessing covered healthcare services. The BlueCross BlueShield Global® Core Program is unlike the BlueCard Program available in the United States in certain ways. For instance, although the BlueCross BlueShield Global® Core Program assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when a Member receives care from providers outside the United States, they may typically have to pay the providers and submit the claims as provided below to obtain reimbursement for these services. If a member needs to access emergency services (including locating a doctor or hospital) outside the United States, they should (a) go to https://bcbsglobalcore.com or download the BlueCross BlueShield Global® Core mobile app to access a list of providers and facilities, or (b) call BlueCross BlueShield Global® Core Program Service Center at 1-800-810-BLUE (2583) or collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or Hospitalization, if necessary. Please note: Medical services obtained internationally that are not urgent or emergent in nature are not covered services.

- Inpatient Services

In most cases, if a Member contacts the BlueCross BlueShield Global® Core Program BlueCard Worldwide Service Center for assistance, Hospitals will not require the Member to pay for covered inpatient services, except for his or her cost share amount. In such cases, the Hospital will submit the Member's claims to the BlueCross BlueShield Global® Core Program BlueCard Worldwide Service Center to begin claims processing. However, if the member paid in full at the time of service, he or she must submit a claim to receive reimbursement for covered healthcare services.

- Outpatient Services

Providers, urgent care centers and other outpatient providers located outside the United States will typically require a Member to pay in full at the time of service. In such cases, the Member must submit a claim to obtain reimbursement for covered healthcare services.

- Submitting a BlueCross BlueShield Global® Core Program Claim

When a Member pays for covered emergency healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, the Member should register and complete the claim form online at https://bcbsglobalcore.com to initiate claims processing. Following the instructions on the website will help ensure timely processing of the claim. If a Member needs assistance with his or her claim submission, the Member should call the BlueCross BlueShield Global® Core Program Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

- **Circumstances beyond our control**

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive call 850-383-3311.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-Sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., copayment) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care provider, you pay a copayment of $15 per office visit, and when you go in the hospital, you pay $250 per day (days 1-6 maximum $1500) per admission.
Deductible	We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan you pay 20% of our allowance for durable medical equipment.
Differences between our Plan allowance and the bill	You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	After your copayments total $3,500 for Self Only, $7,000 for Self Plus One, or $7,000 per person for Self and Family for medical maximum-out-of-pocket (MOOP) and $4,600 for Self Only $8,700 for Self Plus One, or $8,700 per Self and Family enrollment for pharmacy MOOP in any calendar year, you do not have to pay any more for covered services. ***The medical maximum annual limitation on cost sharing listed under Self Only of $3,500 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.*** Example Scenario: Your plan has a $3,500 Self Only medical maximum out-of-pocket limit and a $7,000 Self Plus One or Self and Family medical maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $3,500 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $7,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $7,000 for the calendar year before their qualified medical expenses will begin to be covered in full. ***The pharmacy maximum annual limitation on cost sharing listed under Self Only of $4,600 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.*** Example Scenario: Your plan has a $4,600 Self Only pharmacy maximum out-of-pocket limit and a $8,700 Self Plus One or Self and Family pharmacy maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified pharmacy expenses of $4,600 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $8,700, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified pharmacy expenses up to a maximum of $8,700 for the calendar year before their qualified pharmacy expenses will begin to be covered in full. However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Medical Services not covered by Capital Health Plan. (Medical services not approved or authorized by Capital Health Plan.)

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services. They can also happen when you receive non-emergency services at participating facilities, but you receive some care from nonparticipating providers.

A surprise bill is an unexpected bill you receive for
• emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
• non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
• air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to https://capitalhealth.com/transparency-in-coverage or contact the health plan at 850-383-3311.

- **The Federal Flexible Spending Account Program - FSAFEDS**

HealthCare FSA (HCFSA) Reimburses you for eligible out of pocket healthcare expenses (such as copayments, deductibles, provider prescribed over the counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High Option Benefits

See page 14 for how our benefits changed this year. Page 82 is a benefits summary. Make sure that you review the benefits that are available under this plan.

Section 5. High Benefits Option Overview

This Plan offers a High Option. Our benefit package is described in Section 5. Make sure that you carefully review the benefits.

The High Option Section 5 is divided into subsections. Please read the *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about the High Option Plan benefits, contact us at 850-383-3311 or on our website at www.capitalhealth.com.

Our benefit package offers the following unique features:

- High Option

Capital Health Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These plan providers coordinate your health care services. Capital Health Plan is solely responsible for the selection of these providers in your area. To receive our most recent provider directory, call 850-383-3311 or visit our website at www.capitalhealth.com.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments described in this brochure. When you receive emergency services from non-plan providers, you may have to submit claim forms.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits.

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Office medical consultations	$15 per primary care visit $60 per specialist visit
• Telehealth services	$15 per primary care visit $60 per specialist visit
• Second Surgical Opinion	$60 per specialist visit
Professional services of physicians • In an urgent care center	$50 per visit
• During a hospital stay • In a skilled nursing facility • At home • Advance care planning	Nothing
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap test • Pathology • X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG	Nothing
• MRI/PET/CT Scans	$250 per visit

Benefit Description	You pay
Preventive care, adult	**High Option**
Routine annual physical every year **The following preventive services are covered at the time interval recommended at each of the links below**. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/Tdap, and Human papillomavirus (HPV). For a complete list of immunizations go to the centers for Disease Control (CDC website at https://www.cdc.gov/vaccines/schedules. • Screenings such as cancer, osteoporosis depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U. S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at https//www.healthcare.gov/preventive-care-women/. • To build your personalized list of preventive services go tohttps://health.gov/myhealthfinder • Routine mammogram – covered • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. • Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities as recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations. • Routine exams limited to: - One routine eye exam every 12 months - One routine hearing exam every 12 months. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing
Routine mammogram - covered	Nothing
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.*	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
• *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**High Option**
Well-child care visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org. • Immunizations such as Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html. • You can also find a complete list of preventive care services recommended under the U. S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression	$15 for initial visit for primary care $60 for initial visit to specialist $250 copay day/maximum 2 days per admission
Breastfeeding support, supplies and counseling for each birth. Note: Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for 1 breast pump per pregnancy as breastfeeding equipment. Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery, see page 17 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery (you do not need to precertify the normal length of stay). We will extend your inpatient stay if medically necessary.	Nothing

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother' s confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. Note: Maternity Care is defined as care provided to a member for normal pregnancy, delivery, miscarriage, or pregnancy complications within the CHP service area only, unless the need for these services was not, and reasonably could not have been, anticipated before leaving the service area	Nothing
Family planning	**High Option**
Contraceptive counseling on an annual basis A range of voluntary family planning services, limited to: • Intrauterine devices (IUDs) • Voluntary sterilization (See Surgical procedures Section 5 (b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Diaphragms • Tubal ligation Note: We cover oral contraceptives under the prescription drug benefit.	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*
Infertility services	**High Option**
Infertility is defined as inability to: • conceive after 1 year of unprotected sex when female (or individual with female reproductive organs) is under 35 years of age, or 6 months for female (or individual with female reproductive organs) age 35 and older; • conceive after a period of artificial insemination (AI for a period of time, for example 12 months).	$15 per primary care visit $60 per specialist visit $250 copayment per ambulatory surgical center facility visit.

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
• Or demonstration of a disease or condition of the reproductive tract such that unprotected sex or AI would be ineffective. Diagnosis and treatment of infertility is based on medical history or diagnostic testing. • Artificial Insemination (AI)- Limited to 3 cycles per year with prior authorization. - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Iatrogenic Fertilization Benefits • Iatrogenic Fertilization Benefits will be limited to standard fertility preservation procedures. Storage will not exceed a period of one (1) year and benefits are limited to one cycle of fertility preservation per covered person during the entire period a member is enrolled with Capital Health Plan. • Fertility preservation for medical reasons that cause irreversible infertility related to but not limited to those facing chemotherapy, radiation treatment, surgery, or other treatments including medical / surgical gender transition treatments that could affect reproductive organs or processes. • Fertility drugs (See Section 5f Prescription Drug Benefits)	$15 per primary care visit $60 per specialist visit $250 copayment per ambulatory surgical center facility visit.
Not covered: Infertility treatment and services except as specified above, including but not limited to: • Reversal of voluntary surgical sterilization procedures. • All Services associated with the donation or purchase of sperm or donor eggs. • “Elective” fertility preservation, such as egg freezing sought due to natural aging. • Long-term storage. • Infertility services after voluntary sterilization • In vitro fertilization (IVF) - Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	$15 per primary care visit $60 per specialist visit
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*

Benefit Description	You pay
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 45. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy-Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) - Children with autism spectrum disorder • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorized the treatment. Your provider will request preauthorization. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under "You need prior Plan approval"* for certain services page 17.	$15 per primary care visit $60 per specialist visit
Physical, Occupational and Habilitative therapies	**High Option**
Limited per member per condition to the number of medically necessary rehabilitation services received by the member within the consecutive 62-day period immediately following the first date that the member begins such services for each of the following: • Qualified Physical Therapists • Occupational Therapists • Habilitative Services - Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder Note: We only cover therapy when a physician: • orders the care, • identifies the specific professional skills the patient requires and the medical necessity for skilled services; • and indicates the length of time the services are needed.	$60 per specialist visit Included in inpatient hospital facility admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*

Benefit Description	You pay
Speech therapy	**High Option**
Limited per member per condition to the number of medically necessary rehabilitation, habilitative, and speech services which are received by the member within the consecutive 62-day period immediately following the first date that the member begins such services. Note: We only cover therapy when a physician • orders the care, • identifies the specific professional skills the patient requires • and the medical necessity for skilled services; and indicates the length of time the services are needed.	$60 per specialist visit Included in inpatient hospital facility admission
Not covered: • *Speech therapy beyond 62-day period per condition*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D. Note: For routine hearing screening performed during a child's preventive care visit, see *Section 5(a) Preventive care, children.*	$15 per primary care visit $60 per specialist visit
Not covered: • *Hearing aids, testing and examinations for them* • *Hearing services and testing that are not shown as covered* • *Services related to the fitting or provision of hearing aids, included tinnitus maskers.*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts). Note: Initial pair of eyeglasses or contact lenses following cataract surgery or accidental injury which would necessitate corrective lenses (initial pair of eyeglasses are limited to the cost of the basic plastic lens and up to $65.00 for the frames obtained only at Capital Health Plan's Eye Care Centers.) • Annual eye refractions, including eye exam to determine the need for vision correction for children through age 17. Note: See *Preventive care, children* for eye exams for children.	$15 per primary care visit $60 per specialist visit
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eyeglasses, except initial pair following cataract surgery or an accidental injury which requires corrective lenses.* • *An examination and fitting for contact lenses.*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	**High Option**
• *Contact lenses and examinations required for fitting of contact lenses.* • *Replacements for any lenses provided during the same calendar year.*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$15 per primary care visit $60 per specialist visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Implanted hearing-related devices, such as cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy • Braces and covered prosthetic devices (except cardiac pacemaker) are limited to the first such item prescribed for each specific medical condition • Cardiac pacemakers Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	Nothing
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *External hearing aids* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
• *All other prosthetic devices, including braces used during athletic activities, are excluded.* Note: Benefits may be provided for necessary replacement of a prosthetic or orthotic device which is owned by the member when due to irreparable damage, wear, a change in the member's condition, or when necessitated due to growth of a dependent child.	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Crutches • Canes • Manual wheelchairs • Basic hospital beds • Walkers • Blood glucose monitors • Insulin pumps • Oxygen for home use including equipment • prescription and non-prescription enteral formulas for home use when prescribed by a contracted physician when medically necessary to treat inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. This also includes coverage to treat inherited diseases of amino acid and organic acids including food products modified to be low protein. The annual dollar limit is $2,500. Enteral formulas may be administered intermittently or continuously through nasogastric, gastrostomy, or jejunostomy tubes directly into the gastrointestinal tract with or without the assistance of an infusion pump, or they may be administered orally Note: Durable Medical Equipment must be prescribed by your plan physician and authorized by CHP. CHP reserves the right to rent or purchase the most cost-effective DME that meets the member's needs. Note: Call us at 850-383-3311 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% coinsurance
Not covered: • *Cost to repair or replace Durable Medical Equipment except when authorized by CHP* • *Durable Medical Equipment that has not been authorized by CHP*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• *Durable Medical Equipment that is for patient convenience and/or comfort* • *Water therapy devices such as jacuzzis, hot tubs, swimming pools, or whirlpools* • *Exercise and massage equipment* • *Electric scooters* • *Hearing aids* • *Dental braces, air conditioners, humidifiers, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, emergency alert equipment.* • *This exclusion includes but is not limited to:* - *Modifications to motor vehicles* - *Modifications to homes, such as wheelchair lifts or ramps* - *Escalators or elevators, stair glides, handrails, heat appliances and dehumidifiers.*	*All charges*
Home health services	**High Option**
• Home healthcare ordered by a Plan provider and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Note: The Plan provider periodically will review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	**High Option**
• Manipulation of the spine and extremities *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application*	$60 per specialist office visit
Not covered: • *Services that maintain rather than improve a physical function* • *Services that we determine will not result in significant improvement of the member's condition within a 62-day period.*	*All Charges*

Benefit Description	You pay
Alternative treatments	**High Option**
No Benefit	*All Charges*
Educational classes and programs	**High Option**
Coverage is provided: • Tobacco cessation programs, including individual/group/ telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence. Note: OTC drugs require a prescription. • Members may choose one or more of the options below if desired: - Healthwise Knowledgebase accessed from www.capitalhealth.com/: enter tobacco into the search bar - Tobacco Free Florida: (877)822-6669 (Maintained by the Florida Department of Health) - Big Bend AHEC (Area Health Education Centers): (850-224-1177) - Quit Smoking Now: a 6 week in person class series offered by Big Bend AHEC - Tools to Quit: A 2 hour program that provides individuals with essential tools to stop all types of tobacco use	Nothing
Diabetes Empowerment Education Program™ (DEEP™) is a Medicare-approved, evidence-based diabetes self-management education (DSME) program for people 18 and older with prediabetes or diabetes and their loved ones. Big Bend AHEC can be reached at 850-224-1177 for registration in the program or for more information. Minor children must be accompanied by parent/guardian.	Nothing
Multicomponent, family centered programs focused on childhood obesity that are part of intensive behavioral interventions (behavior change counseling for healthy diet and physical activity). **Childhood Obesity Initiative for CHP members:** CHP offers the Champions program which is a school based program. The goal of the program is to educate students and family members on the importance of healthy eating and exercise. The program replaces either the PE program or the afterschool program, which is dependent upon the school location. The program includes a daily interactive curriculum with designated exercises. Coaches are present and serve to lead and advise students to improve their performance.	Nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a provider or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PROVIDER MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of severe obesity (bariatric surgery) – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; Note: To meet requirements of bariatric surgery eligible members must be age 18 or over. Preauthorization is required. - Presence of morbid obesity, defined as a body mass index (BMI) greater than or equal to 40 or greater than or equal to 35 in conjunction with severe co-morbidities such as cardiopulmonary complications or severe diabetes; and - An adequately documented history of consistent participation in a weight management program for 12 consecutive months that is similar to that described in the document, *Surgical Treatment of Morbid Obesity Responsibilities*, including regular PCP visits to document compliance; and	$15 per primary care visit $60 per specialist visit Included in inpatient hospital facility admission

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
- An adequately documented history of adaptation of sound nutritional principles as evidenced by a 10% weight reduction at the end of the 12-month program; and - An adequately documented absence of active substance abuse or major uncontrolled psychiatric disorder; or - Life threatening morbid obesity with evidence of imminently life threatening co-morbid conditions that cannot be treated safely and effectively through other means. • Insertion of internal prosthetic devices. See 5(a), *Orthopedic and prosthetic devices*, for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$15 per primary care visit $60 per specialist visit Included in inpatient hospital facility admission
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$15 per primary care visit $60 per specialist visit Included in inpatient hospital facility admission.

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
Gender Affirming Surgery • Gender affirmation services require prior authorization and all services must be performed by a CHP Contracted or Designated Provider / Facility. • Gender affirmation surgery, gender reassignment surgery, or gender confirming surgery, must meet the following: A. Member is 18 years or older. B. Member has the capacity to make a fully informed decision and to consent for treatment. C. Documentation show persistent and well documented gender dysphoria. D. No medical contraindications to surgery. E. Any mental health concerns are well controlled. F. Documentation of 12 continuous months of hormone therapy; exception to this is: a. Unless the member has a medical contraindication or is otherwise unable to take hormones. b. Member is undergoing a mastectomy and creation of a male chest for female to male members. G. Referral letters from two independent licensed mental health professionals unless referred through a multidisciplinary team. • Facial gender affirming surgery: A. The area from your frontal scalp at hairline to the chin. a. Blepharoplasty b. Brow Lift c. Face / forehead tightening d. Facial bone remodeling e. Genioplasty (chin width reduction) f. Cheek, chin, and nose implants g. Mandibular angle augmentation (jaw) h. Orbital recontouring i. Rhinoplasty (nose reshaping) j. Suction assisted lipoplasty, lipofilling, and/or liposuction • B. Purpose of the surgery is to achieve a facial gender congruence in order to be publicly identified as a gender congruent and not solely to improve appearance. • Revisions to any surgical treatment of gender dysphoria is only covered in cases where the revision is required to address complications of the initial surgery (i.e. wound dehiscence, fistula, chronic pain directly related to the surgery, etc.).	$15 per primary care visit $60 per specialist visit Included in inpatient hospital facility admission.
Not covered: • Reversal of gender affirming surgery • Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance, except those listed above.	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Surgical treatment of TMJ	$15 per primary care visit $60 per specialist visit Included in inpatient hospital facility admission
Not covered: • *Related dental care for TMJ* • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. These solid organ transplants are subject to medical necessity and experimental/ investigational review by the Plan. See Other services under You need prior Plan approval for certain services on page 17. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. • Cornea • Heart • Heart-lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	$15 per primary care visit $60 per specialist visit Included in inpatient hospital facility admission.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$15 per primary care visit $60 per specialist visit Included in inpatient hospital facility admission
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute lymphocytic or - Advanced Hodgkins lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Hematopoietic Stem cell Transplant - Marrow failure and related disorders (i.e. Fanconi's Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Asplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency disease (e.g. Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis	$15 per primary care visit $60 per specialist visit Included in inpatient hospital facility admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Breast Cancer - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germcell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CCL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconis, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advance Hodgkin's lymphoma with reoccurrence (relapse) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma **These blood or marrow stem cell transplants** are covered only in a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols.	$15 per primary care visit $60 per specialist visit Included in inpatient hospital facility admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays ad scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. Note: Capital Health Plan covers reasonable costs of searching for donors among family members and donors identified through the National Bone Marrow Donor Program.	$15 per primary care visit $60 per specialist visit Included in inpatient hospital facility admission
Not covered: • *Donor screening tests and donor search expenses associated with the identification of a potential donor from a local, state, or national listing, except those performed for the actual donor.* • *Any organ which is sold rather than donated to the member* • *Any service in connection with the implant of an artificial organ, including the implant of the artificial organ.* • *Any service related to the transplantation of any non-human organ or tissue* • *Services related to the acquisition of an organ or tissue for a recipient who is not a covered member of CHP* • *Transplants not listed as covered* • *Travel and/or lodging and related expenses*	*All charges*

Benefit Description	You pay
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
• Office visit	$60 per specialist visit

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan provider must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your Costs for Covered* Services for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PROVIDER MUST GET PRECERTIFICATION OF HOSPITAL STAYS**. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care • Meals and special diets • Special duty nursing when medically necessary • Private rooms when medically necessary Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$250 copay per day (Days 1-6 only)/maximum $1500 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Blood or blood plasma, if not donated or replaced • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All charges*

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$250 per ambulatory surgical center facility visit $250 copay per day (days 1-6 only) maximum $1500 per admission
Not covered: Blood and blood derivatives not replaced by the member	All charges
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care/skilled nursing facility (SNF): The Plan provides a comprehensive range of benefits for up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission. All necessary services are covered, including: • Bed, board and general nursing care • Drug biological supplies, and equipment ordinarily provided or arranged by the facility when prescribed by a Plan doctor. Note: When full-time care is necessary and confinement in a facility is medically appropriate as determined by a Capital Health Plan doctor and approved by Capital Health Plan.	Nothing
Not covered: • *Custodial care*	*All charges*
Hospice care	**High Option**
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling and are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stage of illness, with a life expectancy of approximately six months or less	Nothing
Not covered: Independent nursing, homemaker services	*All charges*

Benefit Description	You pay
End of life care	**High Option**
Advance Directive (Five Wishes). An advanced directive ensures that both medical professionals and your loved ones understand the end-of-life decisions you want in the event you're unable to explain them due to a medical emergency. An advanced directive is simply a statement, made while you are competent, about the medical treatment you want if you can't make those decisions later. Decisions made early and communicated plainly may have tremendous value for you and your family. • Five Wishes, for anyone 18 or older, is an advance directive document that addresses all of an individual's needs (medical, personal, emotional and spiritual), please call CHP's Health Information Line: 850-383-3400 for more information. • Planning Early About Care at the End (PEACE) Program at Big Bend Hospice provides information needed for you to get started. Results from the PEACE assessment will help you articulate your preference, values and goals to your family and loved ones. To reach a PEACE facilitator, please contact Big Bend Hospice at 850-878-5310 .	Nothing
Ambulance	**High Option**
• Local professional ambulance service when medically appropriate	$175 per transport

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

If you are in an emergency situation, please call your primary care provider. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified in a timely manner.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe that care can be provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if a delay in reaching a Plan provider would result in death, disability, or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$50 per visit
• Telehealth through Amwell (call 1-844-733-3627) for urgent care services.	$15 per visit
• Emergency care as an outpatient at a hospital, including observation as well as doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$500 per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-plan providers that has not been approved by the Plan or provided by Plan providers.*	*All charges*

Benefit Description	You pay
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$50 per visit
• Telehealth through Amwell (call 1-844-733-3627) for urgent care services.	$15 per visit
• Emergency care as an outpatient at a hospital, including observation as well as doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$500 per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	$175 per transport
Not covered: Air ambulance - unless medically necessary and approved by the Plan's Medical Director.	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- **YOUR MENTAL HEALTH PROFESSIONAL MUST GET CERTIFICATION FOR SOME MENTAL HEALTH VISITS AND SERVICES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, or licensed professional counselors.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. $15 per primary care visit $60 per specialist office visit
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Applied Behavior Analysis • Extensive treatment such as intensive outpatient substance use disorder	$15 per primary care visit $60 per specialist visit

Benefit Description	You pay
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$15 per primary care visit $60 per specialist visit
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Members needing extensive treatment such as intensive outpatient substance use disorder or residential treatment for substance use disorders or eating disorders must request these services through their PCP and will be expected to meet clinical criteria for approval.	$250 copay per days 1-6/maximum $1500 per admission
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility	$250 copay per day/maximum 2 days per admission
Not covered	**High Option**
• *Treatment specific to, and solely for, learning, communication and motor skills disorders, academic or career counseling* • *Scholastic/Educational Testing, Intelligence, and Learning disability testing and evaluations should be requested and conducted by the child's school district* • *Court-ordered counseling or treatment, as a condition of release or probation, such as residential substance misuse disorder treatment, intensive outpatient counseling and individual or family counseling* • *Work or school ordered assessment and treatment in the absence of a clinical need* • *Counseling for marital and relationship enhancement and religious purposes including counseling provided by a religious counselor* • *Experimental/investigational or unproven treatment and services, including biofeedback, hypnotherapy, non-network or non-participating clinics specifically for methadone maintenance, neurofeedback, light boxes for phototherapy and outward bound or other wilderness type therapies* • *Cognitive remediation except for the following conditions and if criteria is met: traumatic brain injury or brain injury due to cerebrovascular accident (stroke), intracranial aneurysm, anoxia, encephalitis, brain tumors, or brain toxins*	All charges

Not covered - continued on next page

Benefit Description	You pay
Not covered (cont.)	**High Option**
• *Elective therapies such as Gestalt, Transactional Analysis, Transcendental Meditation, Z-therapy, Mind expansion therapy and Erhard Seminar Training (EST)* • *Custodial Care or basic care provided in a residential, institutional or assisted living setting. Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aids, and personal care designed to help the member in activities of daily living or to keep the member from continuing unhealthy activities* • *Transitional living centers, non-licensed programs, therapeutic boarding schools, and services typically provided by community mental health services program settings*	All charges

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically. For instructions on how to obtain prior authorization, please contact Member Services at 850-383-3311 Monday through Friday, 8 a.m. to 5 p.m.
- Federal law prevents the pharmacy from accepting unused medications.
- The maximum out of pocket expense for member's prescription drugs is $4,600 Self / $8,700 Self Plus One / $8,700 Self and Family.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about Coordinating benefits with Medicare and other coverage.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them**. You must fill the prescription at a participating plan pharmacy.

  Capital Health Plan will cover certain kinds of drugs through the plan's network mail-order service. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long term medical condition. Tier 5 and 6 specialty medications are limited to a 30-day supply and may require the use of a specialty mail-order service.

  CHP's mail-order service allows you to order up to a 90-day supply of certain medications. Members can expect to receive their drugs within 14 days. Call Member Services with questions or if your drugs to not arrive within this time frame.

  To get order forms and information about filling your prescriptions by mail contact Member Services at https://www.capitalhealth.com/contact or you can fill out and print the form online at http://www.primetherapeutics.com/.

- **We have a tiered closed formulary**. If your provider believes a name brand product is necessary or there is no generic available, your provider may prescribe a name brand drug from a CHP formulary list. To request a prescription drug brochure, call 850-383-3311 or go to www.capitalhealth.com.

  The CHP Prescription Drug Benefit provides covered prescription drugs and supplies. Each covered prescription drug, when purchased from a participating pharmacy, will be subject to a member cost sharing amount. The member cost sharing amount is determined by the tier level or type of the prescription drug dispensed [i.e., Tier 1, Tier 2, Tier 3, or Tier 4 (specialty drug)].

  In general, most generic drugs and competitively priced brand drugs are included on Tier 1 and typically represent the lowest cost to plan members. Tier 2 represents the intermediate plan member cost share and generally includes preferred drug products. A Tier 2 preferred prescription drug on the Commercial Formulary may be reclassified as a Tier 3 non-preferred prescription drug on the date the FDA approves a bioequivalent generic prescription drug. Tier 3 represents a higher member cost share than Tier 2 and generally includes most brand name drugs not selected for Tier 1 or 2 and some generic drugs (i.e. non-preferred drug products). Tier 4 prescription drugs are classified as specialty drugs (Please see your Summary of Benefits and Coverage document for additional details).

If a member or the prescriber requests a prescription drug not listed on the formulary as Tier 1, Tier 2 or Tier 3, if approved the member must pay the Tier 4-member cost share.

Covered prescription drugs must be medically necessary, prescribed by a medical professional acting within the scope of his or her license, and dispensed by a pharmacist.

If you choose to receive a brand name prescription drug and a FDA generic drug is available, you may be subject to a reduced benefit and a higher out-of-pocket expense.

- **Why use generic drugs**? Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.
- **When you do have to file a claim**. When you see Plan provider, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment. See page 66.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy. • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies limited to needles, syringes, and test strips. • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see *Prior Authorization*) • Drugs to treat gender dysphoria - Hormone products may require prior authorization and quantity limits may apply - CHP provides treatment prescribed by a medical provider for gender dysphoria. Drug treatments for all covered members may be subject to certain coverage limitations such as prior authorization or quantity limits as listed on the Commercial formulary. • Oral and injectable contraceptive drugs • Fertility drugs or any drugs used for the purpose of enhancing the probability of conception. Limited to 3 cycles each year. Oral and self-injectable drugs as part of in vitro fertilization (IVF). • Artificial Insemination (AI) may be covered when deemed medically necessary and prior authorization requirements are met. Quantity limits may apply. Note:	Tier 1 Drugs Preferred (Retail and Mail order): • $15 per prescription Tier 1 drugs (30-day supply) • $30 per prescription Tier 1 drugs (60-day supply) • $45 per prescription Tier 1 drugs (90-day supply) Tier 2 Drugs Non-Preferred (Retail and Mail order): • $15 per prescription Tier 1 drugs (30-day supply) • $30 per prescription Tier 1 drugs (60-day supply) • $45 per prescription Tier 1 drugs (90-day supply) Tier 3 Drugs Preferred (Retail and Mail order) • $40 per prescription Tier 2 drugs (30-day supply) • $80 per prescription Tier 2 drugs (60-day supply) • $120 per prescription Tier 2 drugs (90-day supply) Tier 4 Drugs Non-Preferred(Retail and Mail order): • $100 per prescription Tier 3 drugs (30-day supply) • $200 per prescription Tier 3 drugs (60-day supply) • $300 per prescription Tier 3 drugs (90-day supply) Tier 5 Preferred Specialty Drugs are limited to a 30-day supply. • $100 per prescription Tier 5 drugs (30-day supply) Tier 6 Non-Preferred Specialty Drugs are limited to a 30-day supply. • $100 per prescription Tier 6 drugs (30-day supply) Note: If there is no generic equivalent available, you will still have to pay the brand name copay.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• A prescription unit or refill will be covered up to a 90-day supply for generic and brand drugs (at 3 times the member's cost share per 90-day supply) at retail and mail order pharmacies. Specialty drugs are limited up to a 30-day supply. • Refills that are authorized by the prescriber must be filled within six months or one year from the original prescription date, depending on federal law designations. Refills on prescriptions shall not be covered until at least 75% of the previous prescription has been used by the member based on the dosage schedule prescribed. • Syringes and needles will be covered only when prescribed and obtained with a prescription for administration of diabetic products. • Certain prescription drugs, require prior authorization. For a list of these drugs, refer to www.capitalhealth.com. For instructions about how to get prior authorization, call Member Services at 850-383-3311 (toll-free 1-877-247-6512); TTY 850-383-3534 (1-877-870-8943). • If a member or the prescriber requests a prescription drug not listed on the posted formulary as Tier 1, Tier 2 or Tier 3, if approved, the member must pay the Tier 4 member cost share. • CHP retains the right to limit coverage of the quantities of prescribed drugs. Prescription Drugs - The Plan will limit the prescription for controlled substances in Schedules II-V to a 3-day supply for the initial fill for patients with acute conditions unless there is medical documentation for a 7-day supply due to a Florida State statute.	Tier 1 Drugs Preferred (Retail and Mail order): • $15 per prescription Tier 1 drugs (30-day supply) • $30 per prescription Tier 1 drugs (60-day supply) • $45 per prescription Tier 1 drugs (90-day supply) Tier 2 Drugs Non-Preferred (Retail and Mail order): • $15 per prescription Tier 1 drugs (30-day supply) • $30 per prescription Tier 1 drugs (60-day supply) • $45 per prescription Tier 1 drugs (90-day supply) Tier 3 Drugs Preferred (Retail and Mail order) • $40 per prescription Tier 2 drugs (30-day supply) • $80 per prescription Tier 2 drugs (60-day supply) • $120 per prescription Tier 2 drugs (90-day supply) Tier 4 Drugs Non-Preferred(Retail and Mail order): • $100 per prescription Tier 3 drugs (30-day supply) • $200 per prescription Tier 3 drugs (60-day supply) • $300 per prescription Tier 3 drugs (90-day supply) Tier 5 Preferred Specialty Drugs are limited to a 30-day supply. • $100 per prescription Tier 5 drugs (30-day supply) Tier 6 Non-Preferred Specialty Drugs are limited to a 30-day supply. • $100 per prescription Tier 6 drugs (30-day supply) Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Contraceptive drugs and devices as listed on the ACA/HRSA site. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not on the formulary can be requested through the contraceptive exceptions process described below: • Contraceptive medication exception can be requested by the prescribing physician/provider for contraceptive formulations not available on the formulary. • Reimbursement for over-the-counter contraceptives can be submitted by submitting a reimbursement request form with appropriate receipts and proof of payment. The form may be found at www.capitalhealth.com/sites/default/files/uploaded-documents/Non-Medicare%20Prescription%20Drug%20Reimbursement%20Request_0.pdf .	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Note: Must be prescribed by a physician and purchased at a network pharmacy. (Please refer to CHP formulary.)	Nothing
Not covered: • Drugs that can be purchased over the counter without a prescription, even though a prescription was provided by prescriber with the exclusion of Insulin and over the counter medications covered under the Preventive Services as defined by the Patient Protection and Affordable Care Act (ACA). • Drugs that are dispensed before the effective date, or after the termination date, of this brochure. • All syringes and needles except as otherwise covered. • Mineral supplements or vitamins, except as mandated by Federal, State and local regulations and noted above. • Drugs that are not approved by the FDA. • Certain generic drugs when competitively priced brand drugs are covered on the formulary. • Drugs purchased from a non-participating pharmacy, except as a result of an emergency medical condition or when authorized by CHP. • Any drug administered by intravenous infusion or injection, regardless of the setting in which it is administered or the type of provider administering the drug, except as specified in the Covered Items section. • Vitamins, nutrients, and food supplements not listed as a covered benefit even if a physician prescribes or administers them. • • Nonprescription medications.	All charges
Preventive care medications	**High Option**
The following are covered. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 6 months -1 year • Vitamin D supplements (prescription strength-400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0 - 6 • Statins for the primary prevention of Cardiovascular Disease (CVD) for adults aged 40 to 75 years with no history of CVD, 1 or more CVD risk factors and a calculated 10-year CVD event risk of 10% or greater. Note: To receive this benefit a prescription from a doctor must be presented to a network pharmacy.	Nothing

Preventive care medications - continued on next page

Benefit Description	You pay
Preventive care medications (cont.)	**High Option**
Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy. These may include some over-the counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing
Not covered: • *Drugs that can be purchased over the counter without a prescription, even though a prescription was provided by prescriber with the exclusion of Insulin and over the counter medications covered under the Preventive Services as defined by the Patient Protection and Affordable Care Act (ACA).* • *Drugs that are dispensed before the effective date, or after the termination date, of this brochure.* • *All syringes and needles except as otherwise covered.* • *Mineral supplements or vitamins, except as mandated by Federal, State and local regulations and noted above.* • *Drugs that are not approved by the FDA.* • *Certain generic drugs when competitively priced brand drugs are covered on the formulary.* • *Drugs purchased from a non-participating pharmacy, except as a result of an emergency medical condition or when authorized by CHP.* • *Any drug administered by intravenous infusion or injection, regardless of the setting in which it is administered or the type of provider administering the drug, except as specified in the Covered Items section.* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them.* • *Nonprescription medications.* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit. (See page 41).	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating Benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly (within 62 days of an accidental dental injury) repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Note: Accidental dental injury means an injury to sound natural teeth (not previously compromised by decay), caused by a sudden unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.	Nothing

Dental benefits	You Pay
	High Option
We have no other dental benefits.	*All charges*

Section 5(h). Wellness and Other Special Features

Features	Description
Flexible Benefits Option	**High Option**
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf and hearing impaired	**High Option**
Services for deaf and hearing imparied	TDD Line: 850-383-3534 Toll Free TDD Line: 877-870-8943
CHPConnect	**High Option**
CHPConnect	CHP*Connect* a secure, online electronic personal health record • A personal history of your doctor's visits and procedures • Diagnoses • Current medications • Children's immunizations and visit dates • Referrals • Benefits, including copayments • Prescription drug information • View multiple lab test results • Online health risk appraisal

CHPConnect - continued on next page

Features	Description
CHPConnect (cont.)	**High Option**
	Call 850-383-3311 or go online to www.capitalhealth.com for additional information.
CHP Health Information Line	**High Option**
CHP Health Information Line	CHP Health Information Line 850-383-3400 is a 24/7 benefit staffed by health care professionals who are able to assist members with their health related questions. While not a substitute for a visit with the physician, the Health Information Line staff can provide members with tips, tools and resources to help members manage their health.
Foreign Language Assistance	**High Option**
Foreign Language Assistance	Contact Member Services at 850-383-3311 for foreign language assistance. Member Services representatives use interpreters to communicate with our members by telephone in many different languages.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB catastrophic protection (out-of-pocket maximums). These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 850-383-3311 or visit their website at www.capitalhealth.com.

Contact Lenses	Capital Health Plan offers services for contact lenses, and contact lenses on a fee for service basis.

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan* approval for certain services.**

- We do not cover the following:
  - Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents).
  - Services, drugs, or supplies you receive while you are not enrolled in this Plan.
  - Services, drugs, or supplies not medically necessary.
  - Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
  - Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
  - Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
  - Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
  - Services, drugs, or supplies you receive without charge while in active military service.
  - Services or supplies we are prohibited from covering under the Federal Law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical, hospital and prescription drug benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 850-383-3311, or at our website at www.capitalhealth.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Capital Health Plan
P. O. Box 15349
Tallahassee, Fl. 32317-5349

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The Disputed Claims Process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 If you disagree with our pre-service claim decision, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Capital Health Plan, Attn: Appeal Manager, P. O. Box 15349, Tallahassee, FL. 32317-5349; or calling 850-383-3311.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Capital Health Plan, ATTN: Grievance Manager, P. O. Box 15349, Tallahassee, FL. 32317-5349; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email address we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.

If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 850-383-3311. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0755 between 8 a.m. and 5 p. m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.capitalhealth.com.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. The Plan will not pay in a secondary position for visits beyond the benefit limits.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused by or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

- **When others are responsible for injuries**

The right to reimbursement means that if it is alleged that any third party caused or is responsible, in whole or in part, for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you receive for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

If a Member is injured or becomes ill as a result of another party's intentional act or negligence, the Member must notify Capital Health Plan concerning the circumstances under which the Member was injured. Under §768.76, Florida Statutes the Member or the Member's lawyer must notify Capital Health Plan, by certified or registered mail, if the Member intends to claim damages from someone for injuries or Illness. If the Member recovers money to compensate for the cost/expense of health care services to treat the Member's Illness or injury, Capital Health Plan is legally entitled to be reimbursed for payments made on the Member's behalf to the doctors, Hospitals, or other providers who treated the Member. Capital Health Plan's legal right to be reimbursed in such cases is called "subrogation." Normally, Capital Health Plan may recover the amount of any payments it made on the Member's behalf, minus its pro rata share, for any costs and attorney fees incurred by the Member in pursuing and recovering damages. Capital Health Plan may "subrogate" against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage.

- **When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)**

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on WWW.BENEFEDS.com, or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

- **Clinical Trials**

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient’s cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care. The plan does not cover these costs.

- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or a www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 850-383-3311 or see our website at www.capitalhealth.com. The plan will not pay in a secondary position for visits beyond the benefit limits.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use CHP providers who accept Medicare's assignment.

Benefit Description: Out of Pocket Maximum
High Option you pay without Medicare:Medical Services: $3,500/Self Only, $7,000/Self Plus One or $7,000/Self And Family and for Pharmacy**:** $4,600/Self Only, $8,700/Self Plus One or $8,700/Self and Family
High Option you pay with Medicare Part B:Medical Services: $3,500/Self Only, $7,000/Self Plus One or $7,000/Self And Family and for Pharmacy: $4,600/Self Only, $8,700/Self Plus One or $8,700/Self and Family

Benefit Description: Part B Premium Reimbursement Offered
High Option you pay without Medicare: N/A
High Option you pay with Medicare Part B: N/A

Benefit Description: Primary Care Provider
High Option you pay without Medicare: $15
High Option you pay with Medicare Part B: $15

Benefit Description: Specialist
High Option you pay without Medicare: $60
High Option you pay with Medicare Part B: $60

Benefit Description: Inpatient Hospital
High Option you pay without Medicare: $250 copay per day (1-6 day maximum/$1500 per admission)
High Option you pay with Medicare Part B: $250 copay per day (1-6 day maximum/$1500 per admission)

Benefit Description: Outpatient Hospital
High Option you pay without Medicare: $250
High Option you pay with Medicare Part B: $250

Benefit Description: Incentives Offered
High Option you pay without Medicare: N/A
High Option you pay with Medicare Part B: N/A

You can find more information about how our plan coordinates benefits with Medicare in Capital Health Plan's FEHB Brochure at capitalhealth.com/FEHB.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- Medicare Advantage (Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in CHP's Medicare Advantage plan and also remain enrolled in our FEHB plan. Your care must continue to be authorized by your CHP primary care physician, and we will not waive any of your copayments.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.

Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.

OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trail, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Copayment

See Section 4, page 29.

Cost-sharing

See Section 4, page 29.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Custodial care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, consideration is given to the level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of condition, degree of functional limitation, or rehabilitation potential. Custodial care that lasts 90 days or more is sometimes known as long term care.

Experimental or investigational service	When CHP determines that an evaluation, treatment, therapy, or device is experimental/ investigational, it will not be covered by the Plan. CHP makes these determinations based in part on information obtained from the United States Food and Drug Administration, the Florida Department of Health, and the most recently published medical literature in the United States, Canada, or Great Britain. A consensus of opinion among experts is sought that would show that the evaluation, treatment, therapy, or device is considered safe and effective as compared with the standard means for treatment or diagnosis of the condition in question.
Infertility	Infertility is defined as inability to: • conceive after 1 year of unprotected sex when female (or individual with female reproductive organs) is under 35 years of age, or 6 months for female (or individual with female reproductive organs) age 35 and older; • conceive after a period of artificial insemination (AI for a period of time, for example 12 months) • Or demonstration of a disease or condition of the reproductive tract such that unprotected sex or AI would be ineffective.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	Medical necessity means, for coverage and payment purposes, that a medical service or supply is required for the identification, treatment, or management of a condition, and is, in the opinion of CHP: 1) consistent with the symptom, diagnosis, and treatment of the member's condition; 2) widely accepted by the practitioners' peer group as efficacious and reasonably safe based on scientific evidence; 3) universally accepted in clinical use so that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment; 4) not experimental or investigational; 5) not for cosmetic purposes; 6) not primarily for the convenience of the member, the member's family, the physician, or other provider; and 7) the most appropriate level of service, care, or supply that safely can be provided to the member. When applied to inpatient care, medical necessity further means that the services cannot be provided safely to the member in an alternative setting.
Morbid obesity	A condition in which an individual's body mass index (BMI) exceeds 40 or is greater than 35 in conjunction with severe co-morbidities such as cardiopulmonary complications or severediabetes.
Plan Allowance	Plan allowance is the amount we use to determine our payment and your copayment for covered services. Plans determine their allowances in different ways. You should also see Important Notice About Surprise Billing-Know your Rights in Section 4 that describes your protections against surprise billing under the No Surprise Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise Bill	An unexpected bill you receive for • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims largely involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact Capital Health Plan Member Services Department at 850-383-3311. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and We refer to Capital Health Plan
You	You refers to the enrollee and each covered family member.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Benefits for the High Option of Capital Health Plan - 2024

- **Do not rely on this chart alone.** This is a summary. All benefits are provided are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at capitalhealth.com/FEHB.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan provider, except in emergencies.

Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $60 specialist	32
Services provided by a hospital: Inpatient	$250 copay per day (Days 1-6 only)/maximum $1500 per admission	49
Services provided by a hospital: Outpatient	$250 per visit ambulatory surgical center visit	50
Emergency benefits: In-area	$500 per emergency room visit	52
Emergency benefits: Out-of-area	$500 per emergency room visit	53
Mental health and substance use disorder treatment:	$60 per office visit	54
Prescription drugs: • **Retail Pharmacy and Mail Order**	$15 Tier 1 drugs (30 day supply) / $30 Tier 1 drugs (60 day supply) / $45 Tier 1 drugs (90 day supply) $40 Tier 2 drugs (30 day supply) / $80 Tier 2 drugs (60 day supply) / $120 Tier 2 drugs (90 day supply) $100 Tier 3 drugs (30 day supply) / $200 Tier 3 drugs (60 day supply) / $300 Tier 3 drugs (90 day supply) $100 Tier 4 Specialty drugs (30 day supply)	57
Dental care:	No benefit.	61
Vision care:	Limited benefit.	38
Wellness and Other Special features:	TDD Line: 850-383-3534	62
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $3,500/Self Only, $7,000/Self Plus One or $7,000/Family enrollment for Medical Services and $4,600/Self Only, $8,700/Self Plus One or $8,700/Family enrollment for Pharmacy per year.	27

2024 Rate Information for Capital Health Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/fehbpremiums or www.opm.gov/tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Florida					
High Option Self Only	EA1	$271.43	$105.09	$588.10	$227.69
High Option Self Plus One	EA3	$586.50	$236.90	$1,270.75	$513.28
High Option Self and Family	EA2	$646.18	$252.04	$1,400.06	$546.08