

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**
**Coverage for: Employee or Family | Plan Type: HMO**


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, at [www.capitalhealth.com/sbc](http://www.capitalhealth.com/sbc). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-850-383-3311 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <u>deductible</u> ?                             | \$ 0   | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.  |
| Are there services covered before you meet your <u>deductible</u> ? | Not Applicable   | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.  |
| Are there other <u>deductibles</u> for specific services?           | <b>Yes. \$60</b> per child for pediatric dental services (if purchased through the alliance dental plan). There are no other specific <u>deductibles</u> .                                   | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.  |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | Combined for medical and pharmacy: \$3,000 single coverage / \$6,000 family coverage<br>Pediatric dental: \$350 single coverage / \$700 family coverage                                      | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , prescription drug brand additional charges, and health care this <u>plan</u> doesn't cover.  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.capitalhealth.com">www.capitalhealth.com</a> or call 850-383-3311 for a list of <u>network providers</u> .  | Be aware your <u>network provider</u> might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.  |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | Yes. Some specialists require a referral. For a list of specialists that require a referral go to <a href="http://capitalhealth.com/ReferralAndAuth">capitalhealth.com/ReferralAndAuth</a> . | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a referral before you see the <u>specialist</u> .   |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event  | Services You May Need  | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|--|---|--|--|
|   |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>   | <a href="#">Primary care</a> visit to treat an injury or illness | \$15 / visit  | Not Covered  | —————none—————   |
|   | <a href="#">Specialist</a> visit                                 | \$40 / visit  | Not Covered  | Prior authorization required for certain specialist visits. Your benefits/services may be denied.  |
|   | <a href="#">Preventive care/screening/immunization</a>           | No Charge for covered services  | Not Covered  | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.  |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)              | No Charge   | Not Covered  | Diagnostic tests other than x-ray or blood work may incur a cost share.  |
|   | Imaging (CT/PET scans, MRIs)                                     | \$100 / visit   | Not Covered  | Prior authorization required for certain imaging services. Your benefits/services may be denied.   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.capitalhealth.com/MedCenter">www.capitalhealth.com/MedCenter</a> | Tier 1 drugs   | \$15/30-day supply<br>\$30/60-day supply<br>\$45/90-day supply<br>(retail & mail order)   | Not Covered  | If a generic drug is available, and a more expensive brand name drug is dispensed at the request of the member or the prescriber, the member must pay the copayment amount for the brand name drug plus pay the pharmacist 100% of the additional cost for the more expensive brand name prescription drug. This additional cost does not count towards your out-of-pocket limit. Prior authorization and or quantity limit may apply. Your benefits/services may be denied. |
|   | Tier 2 drugs   | \$30/30-day supply<br>\$60/60-day supply<br>\$90/90-day supply<br>(retail & mail order)   | Not Covered  | Prior authorization and or quantity limit may apply. Your benefits/services may be denied.   |
|   | Tier 3 drugs   | \$50/30-day supply<br>\$100/60-day supply<br>\$150/90-day supply<br>(retail & mail order) | Not Covered  | Prior authorization and or quantity limit may apply. Your benefits/services may be denied.   |
|   | <a href="#">Specialty drugs</a>                                  | \$50 /30-day supply   | Not Covered  | Limited to 30 day supply and may be limited to certain pharmacies. Prior authorization and or quantity limit may apply. Your benefits/services   |

| Common Medical Event   | Services You May Need                            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|--|--|---|--|--|
|  |  | Network Provider<br>(You will pay the least)                        | Out-of-Network Provider<br>(You will pay the most)   |  |
|  |  |   |  | may be denied.   |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | Ambulatory Surgical Center:\$200 / visit<br>Hospital: \$200 / visit | Not Covered  | Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.                                      |
|  | Physician/surgeon fees                           | \$40 / provider   | Not Covered  |  |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>              | \$250 / visit   | \$250 / visit  | <u>Copayment</u> is waived if inpatient admission occurs; however if moved to observation status an additional copayment may apply based on services rendered. |
|  | <a href="#">Emergency medical transportation</a> | No Charge   | No Charge  | Covered if medically necessary.  |
|  | <a href="#">Urgent care</a>                      | Urgent care: \$25 / visit<br>Telehealth :\$15 / visit               | Urgent care:\$25 / visit<br>Telehealth :\$15 / visit | Telehealth services are available through our contracted vendor in all states where telehealth services are permitted.   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)               | \$250 / admission<br>\$200 / observation                            | Not Covered  | Prior authorization required. Your benefits/services may be denied.  |
|  | Physician/surgeon fees                           | No Charge if admitted.<br>\$40 /provider for observation            | Not Covered  | —————none—————   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | \$40 / visit  | Not Covered  | —————none—————   |
|  | Inpatient services                               | \$250 / admission   | Not Covered  | Prior authorization required. Your benefits/services may be denied.  |
| <b>If you are pregnant</b>   | Office visits                                    | \$40 / visit  | Not Covered  | —————none—————   |
|  | Childbirth/delivery professional services        | No Charge   | Not Covered  | —————none—————   |
|  | Childbirth/delivery facility services            | \$250 / admission   | Not Covered  | Prior authorization required. Your benefits/services may be denied.  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>                 | No Charge   | Not Covered  | Limited to 20 visits per calendar year.  |
|  | <a href="#">Rehabilitation services</a>          | \$40 / visit  | Not Covered  | Limited to 35 visits per calendar year.  |
|  | <a href="#">Habilitation services</a>            | \$40 / visit  | Not Covered  | Limited to 35 visits per calendar year.  |
|  | <a href="#">Skilled nursing care</a>             | No Charge   | Not Covered  | Limited to 60 days per calendar year.  |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|   | <a href="#">Durable medical equipment</a> | No Charge                                    | Not Covered  | Prior authorization required for certain devices. Your benefits/services may be denied.  |
|   | <a href="#">Hospice services</a>          | No Charge                                    | Not Covered  | Prior authorization required for inpatient services. Your benefits/services may be denied.   |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | \$15 / visit                                 | Not Covered  | Limited to 1 visit per calendar year.  |
|   | Children's glasses                        | Covered                                      | Not Covered  | Limited to 1 pair of glasses (lenses and frames) per calendar year, provided at Capital Health Plan's Eye Care Centers.  |
|   | Children's dental check-up                | Covered                                      | Not Covered  | Covered through our alliance dental plan, a standalone dental plan, or the insurance marketplace (for an additional premium, billed directly by the dental carrier). |

**Excluded Services & Other Covered Services:**

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)**

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Chiropractic care –Limited to 26 visit per calendar year; limit combined with Rehabilitation services
- Non-emergency care when traveling outside the US
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the Capital Health Plan at 1-850-383-3311. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or [www.dol.gov/ebsa/consumer\\_info\\_health.html](http://www.dol.gov/ebsa/consumer_info_health.html).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 850-383-3311, 1-877-247-6512

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 850-383-3311, 1-877-247-6512.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 850-383-3311, 1-877-247-6512.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 850-383-3311, 1-877-247-6512.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|  |       |
|--|-------|
| ■ The <u>plan's overall deductible</u> | \$0   |
| ■ <u>Specialist copayment</u>          | \$40  |
| ■ <u>Hospital (facility) copayment</u> | \$250 |
| ■ <u>Other copayment</u>               | \$0   |

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$13,400</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$1,000        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,060</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|  |       |
|--|-------|
| ■ The <u>plan's overall deductible</u> | \$0   |
| ■ <u>Specialist copayment</u>          | \$40  |
| ■ <u>Hospital (facility) copayment</u> | \$250 |
| ■ <u>Other copayment</u>               | \$15  |

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,500</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$1,100        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$1,155</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|  |       |
|--|-------|
| ■ The <u>plan's overall deductible</u> | \$0   |
| ■ <u>Specialist copayment</u>          | \$40  |
| ■ <u>Hospital (facility) copayment</u> | \$250 |
| ■ <u>Other copayment</u>               | \$0   |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,300</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$1,200        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,200</b> |

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

## Nondiscrimination and Accessibility Notice (ACA §1557)

Capital Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Capital Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Capital Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact: Member Services 1-850-383-3311 or 1-877-247-6512, TTY/TDD- 850-383-3534 or 1-877-870-8943.

If you believe that Capital Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Capital Health Plan's Compliance and Privacy Officer:

2140 Centerville Place

Tallahassee, FL 32308

Phone: Member Services 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943, Fax 850-523-7419, Email [memberservices@chp.org](mailto:memberservices@chp.org)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Member Services Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human  
Services, 200 Independence Avenue SW

Room 509F, HHH Building

Washington, DC 20201

800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Have a disability? Speak a language other than English? Call to get help for free.**

**850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943**

**Vous souffrez d'un handicap ? Vous parlez une autre langue que l'anglais ? Appelez pour obtenir une aide gratuite. 850 383 3311, 1 877 247 6512, Téléscripneur/ATME 850 383 3534 ou 1 877 870 8943**

**Hai una disabilità? Non parli inglese? Chiama uno di questi numeri per chiedere assistenza gratuita: 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 o 1-877-870-8943**

**ةي ن ا ج م ل ا ة د ع ا س م ل ا ي ل ع ل و ص ح ل ل ل ص ت ا ؟ ة ي ز ي ل ج ن ا ل ا ة غ ل ل ا ر ي غ ة غ ل ث د ح ت ت ل ه ؟ ة ق ا ع ا ن م ي ن ا ع ت ل ه  
850-383-3311 و 1-877-870-8943 و 850-383-3534 م ر ص ل ل ي ف ت ا ه ل ا ل ا ص ت ا ل ا ز ا ه ج TTD ي ص ن ل ا ف ت ا ه ل ا و 1-877-247-6512 و 850-383-3311**

**Haben Sie eine Behinderung? Möchten Sie mit uns in einer anderen Sprache als Englisch kommunizieren? Rufen Sie an, um kostenlos**

Unterstützung zu erhalten. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 oder 1-877-870-8943

¿Tiene una discapacidad? ¿Habla algún otro idioma que no sea inglés? Llame para obtener ayuda gratis. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 o al 1-877-870-8943

دیگری گب سامت اه هرامش نی یا اب ناگیار کمک تفایرد یارب؟ دینک یم تبحص یسیلگنا زجب ی نابز هب؟ دیراد ی صاخ ی ناوتان  
850-383-3311، 1-877-247-6512، TTY/TDD 850-383-3534 اسی 1-877-870-8943

અનંગતા છે? ઇંગલેશિ કરતાં અન્ય ભાષા બોલો છો? નશ્ચિલ્ક મદદ મેળવવા કોલ કરો. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 અથવા  
1-877-870-8943 પર

Ou gen yon andikap? Ou pale yon lang ki pa Anglè? Rele pou jwenn èd pou gratis?  
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 oswa 1-877-870-8943

장애가 있으십니까? 영어가 아닌 다른 언어를 사용하십니까? 전화하십시오. 무료로 도와드립니다. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 또는 1-877-870-8943

Jesteś osobą niepełnosprawną? Mówisz w języku innym niż j. angielski? Zadzwoń, aby uzyskać bezpłatną pomoc. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 lub  
1-877-870-8943

Tem algum tipo de incapacidade? Fala outra língua que não o inglês? Ligue para obter ajuda gratuitamente. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 ou 1-877-870-8943

Ваши возможности ограничены по состоянию здоровья? Вы не говорите по-английски? Обратитесь за бесплатной помощью по телефону:  
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

您是殘障人士嗎？您不會說英語嗎？請撥打電話以免費獲取幫助。電話號碼：850-383-3311、1-877-247-6512；TTY/TDD（聽障人士）：850-383-3534 或 1-877-870-8943

Ikaw ba ay may kapansanan? Ikaw ba ay nakakapagsalita ng ibang wika maliban sa Ingles? Tumawag upang makakuha ng libreng tulong. 850-383-3311, 1-877-247-6512, TTY/TTD 850-383-3534 o sa 1-877-870-8943.

您是否是障礙人士？您是否不會講英語？請撥打電話以取得免費協助。850-383-3311、1-877-247-6512，聽障者請使用 TTY/TDD 850-383-3534 或 1-877-870-8943

พิการหรือเปล่า? พูดภาษาอื่นที่ไม่ใช่ภาษาอังกฤษหรือเปล่า? โทรเพื่อขอความช่วยเหลือฟรี  
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 หรือ 1-877-870-8943

Quý vị có khuyết tật? Quý vị nói ngôn ngữ khác mà không phải tiếng Anh? Vui lòng gọi để được trợ giúp miễn phí. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 hoặc 1-877-870-8943

If you have any questions or concerns related to this, please call our Member Services Department, Monday through Friday 8 am – 5 pm at 850-383-3311 or 1-877-247-6512. State of Florida members can reach Member Services at 1-877-392-1532 from 7 am – 7 pm Monday-Friday. Medicare members please call Capital Health Plan Member Services Department at 850-523-7441 or 1-877-247-6512; October 1 – February 14: 8:00 a.m. – 8:00 p.m., seven days a week; February 15 – September 30: 8:00 a.m. – 8:00 p.m., Monday – Friday. TTY/TDD (Telecommunication Device for the Deaf) users should call 850-383-3534 or 1-877-870-8943.

Capital Health Plan contact information is located on our website: <http://www.capitalhealth.com/Capital-Health-Plan/Contact-Us>