### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>Medical: $2,000 single coverage / $4,500 family coverage Pharmacy: $4,600 single coverage / $8,700 family coverage</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, prescription drug brand additional charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.capitalhealth.com">www.capitalhealth.com</a> or call 850-383-3311 for a list of network providers.</td>
<td>Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 / visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 / visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge for covered services</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 / visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 drugs</td>
<td>$15/30-day supply $30/60-day supply $45/90-day supply (retail &amp; mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2 drugs</td>
<td>$30/30-day supply $60/60-day supply $90/90-day supply (retail &amp; mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 drugs</td>
<td>$50/30-day supply $100/60-day supply $150/90-day supply (retail &amp; mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Service Category</td>
<td>Details</td>
<td>Cost</td>
<td>Covered</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>------</td>
<td>---------</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>$50 / 30-day supply</td>
<td>Not Covered</td>
<td>Limited to 30 day supply and may be limited to certain pharmacies. Prior authorization and or quantity limit may apply. Your benefits/services may be denied.</td>
</tr>
</tbody>
</table>

### If you have outpatient surgery
- **Facility fee (e.g., ambulatory surgery center)**: Ambulatory Surgical Center: $100 / visit Hospital: $100 / visit Not Covered Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
- **Physician/surgeon fees**: $30 / provider Not Covered

### If you need immediate medical attention
- **Emergency room care** | $100 / visit | $100 / visit | Copayment is waived if inpatient admission occurs; however if moved to observation status an additional copayment may apply based on services rendered. 
- **Emergency medical transportation** | $100 / transport | $100 / transport | Covered if medically necessary. 
- **Urgent care**
  - Urgent care: $25 / visit
  - Telehealth: $15 / visit
  - Urgent care: $25 / visit
  - Telehealth: $15 / visit
  - Telehealth services are available through our contracted vendor in all states where telehealth services are permitted.

### If you have a hospital stay
- **Facility fee (e.g., hospital room)**: $200 / day for first 5 days / admission $100 / observation Not Covered Prior authorization required. Your benefits/services may be denied.
- **Physician/surgeon fees**
  - No Charge if admitted.
  - $30 / provider for observation Not Covered

### If you need mental health, behavioral health, or substance abuse services
- **Outpatient services** | $30 / visit | Not Covered | ————none———
- **Inpatient services** | $200 / day for first 5 days / admission | Not Covered | Prior authorization required. Your benefits/services may be denied. 

### If you are pregnant
- **Office visits** | $30 / visit | Not Covered | ————none———
- **Childbirth/delivery professional services**
  - No Charge Not Covered
  - **Childbirth/delivery facility services**
    - $200 / day for first 5 days / admission Not Covered Prior authorization required. Your benefits/services may be denied. 

### If you need help recovering or have other special health needs
- **Home health care**
  - No Charge Not Covered
  - **Rehabilitation services**
    - $30 / visit Not Covered Limited to the consecutive 62-day period immediately following the first service date. 
  - **Habilitation services**
    - Not Covered Not Covered
### Skilled nursing care
- **No Charge**
- **Not Covered**
- Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.

### Durable medical equipment
- **No Charge**
- **Not Covered**
- Prior authorization required for certain devices. Your benefits/services may be denied.

### Hospice services
- **No Charge**
- **Not Covered**
- Prior authorization required for inpatient services. Your benefits/services may be denied.

### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
<th>Coverage</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>$15 / visit</td>
<td>Not Covered</td>
<td>none</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>none</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>none</td>
</tr>
</tbody>
</table>

### 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)
- Dental care (Child)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- 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 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about limitations and exceptions, see plan or policy document at www.capitalhealth.com/sbc.

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. 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.

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:

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $0
- Specialist copayment: $30
- Hospital (facility) copayment: $200
- Other copayment: $0

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost: $13,200

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is: $1,060

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

Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $0
- Specialist copayment: $30
- Hospital (facility) copayment: $200
- Other copayment: $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)

Total Example Cost: $7,500

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$55</td>
</tr>
</tbody>
</table>

The total Joe would pay is: $1,055

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

- The plan’s overall deductible: $0
- Specialist copayment: $30
- Hospital (facility) copayment: $200
- Other copayment: $0

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost: $2,100

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$55</td>
</tr>
</tbody>
</table>

The total Mia would pay is: $600

2017.065.Premier.15/30/50.SBC For more information about limitations and exceptions, see plan or policy document at www.capitalhealth.com/sbc. Page 7 of 7
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 at one of the numbers listed below.

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 850-383-3534 or 1-877-870-8943, Fax: 850-523-7419, Email: memberservices@chp.org. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - February 14; 8:00 a.m. - 8:00 p.m., Monday - Friday, February 15 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 8:00 p.m.

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
800–368–1019, 800–537–7697 (TDD)

Have a disability? Speak a language other than English? Call to get help for free.
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. 1 877 247 6512, Téléscripteur/ATME 850 383 3534 ou 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. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - February 14; 8:00 a.m. - 8:00 p.m., Monday - Friday, February 15 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 8:00 p.m.

Capital Health Plan contact information is located on our website: http://www.capitalhealth.com/Capital-Health-Plan/contact-us

Approved by Compliance Committee: 8/23/2016; Revised 5/3/17