




Standard Option I - \$10/\$30/\$50

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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the deductible amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,000 single coverage \$6,000 family coverage.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , prescription drug copayments and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.capitalhealth.com">www.capitalhealth.com</a> or call 850-383-3311 for a list of <a href="#">network providers</a> .	Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your provider before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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 <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	Office: \$25 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth – Services provided by <a href="#">network providers</a> through remote access technology including the web and mobile devices.
	<a href="#">Specialist</a> visit	Office: \$50 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain <a href="#">specialist</a> visits. Your benefits/services may be denied. Telehealth – Services provided by <a href="#">network providers</a> through remote access technology including the web and mobile devices.
	<a href="#">Preventive care/screening/immunization</a>	No Charge for covered services	Not Covered	You may have to pay for services that aren't <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.
If you have a test	<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.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at	Tier 1 – Preferred Generic Tier 2 – Non-Preferred Generic	\$10 / 30-day supply	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied. Retail or mail order, one copay per 30 day supply
	Tier 3 – Preferred Brand	\$30 / 30-day supply	Not Covered	

<a href="https://capitalhealth.com/members/about-your-medications">https://capitalhealth.com/members/about-your-medications</a>	Tier 4 – Non-Preferred Brand	\$50 / 30-day supply	Not Covered	up to 90 days
	<a href="#">Specialty drugs</a> Tier 5 – Preferred Specialty Tier 6 – Non-Preferred Specialty	\$50 / 30-day supply	Not Covered	Limited to 30-day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: \$100 / visit 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	\$50 / provider	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 / visit \$200 / observation	\$150 / visit \$200 / observation	Copayment 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>	\$100 / transport	\$100 / transport	Covered if medically necessary.
	<a href="#">Urgent care</a>	Urgent care center: \$75 / visit Telehealth: \$75 / visit Amwell: \$15 / visit	Urgent care center: \$75 / visit Telehealth: \$75 / visit Amwell: \$15 / visit	Telehealth – Services are provided by <u>network providers</u> through remote access technology including the web and mobile devices.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$300 / day for first 5 days \$200 / observation	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted \$50 /provider for observation	Not Covered	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 / visit	Not Covered	Mental/Behavioral health limited to 20 visits per calendar year. Substance abuse services limited to 44 visits per calendar year. Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Inpatient services	Mental/Behavioral Health: \$100 / day  Substance use	Not Covered	Mental/Behavioral health limited to 10 days per calendar year. Substance abuse services limited to coverage for inpatient detoxification only,

		disorder: \$300/day for first 5 days		limited to the time necessary for the removal of toxic substances from the blood.
<b>If you are pregnant</b>	Office visits	\$50 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, etc.
	Childbirth/delivery professional services	No Charge	Not Covered	—————none—————
	Childbirth/delivery facility services	\$300 / day for first 5 days	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>	\$25 / visit	Not Covered	Limited to 60 visits per calendar year.
	<a href="#">Rehabilitation services</a>	\$25 / visit	Not Covered	Rehabilitative service is limited to a combined 20 visits year. Cost share applies regardless of place of service, including office telehealth, school, etc.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	—————none—————
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	Limited to 100 days per lifetime. Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	Limited coverage applies. See Member handbook for list of covered items. 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	Not Covered	Not Covered	—————none—————
	Children’s glasses	Not Covered	Not Covered	—————none—————
	Children’s dental check-up	Not Covered	Not Covered	—————none—————

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Cosmetic Surgery</li><li>• Dental care (Adult)</li><li>• Dental care (Child)</li><li>• Glasses</li></ul>	<ul style="list-style-type: none"><li>• Habilitation services</li><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency when traveling outside the US</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li><li>• Routine eye care (Child)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Chiropractic care – Limited to 10 visits per calendar year</li></ul>		

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

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

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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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

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

### Language Access Services:

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

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

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

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

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



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

### Peg is Having a Baby

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$300
■ Other <a href="#">copayment</a>	\$0

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,800
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,860</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$300
■ Other <a href="#">copayment</a>	\$50

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,120</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$300
■ Other <a href="#">copayment</a>	\$0

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>

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