




Capital Selection CHP \$15/\$30/\$50
(ER: 20% Coinsurance)

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. 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 deductible ? | \$0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | Medical: \$3,000 single coverage / \$6,000 family coverage. Pharmacy: \$4,000 single coverage \$8,000 family coverage. | 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. |
| What is not included in the out-of-pocket limit ? | Premiums and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers . | 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. |
| Do you need a referral to see a specialist ? | Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth | 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 . |

 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 provider's office or clinic | Primary care visit to treat an injury or illness | Office: \$15 / visit | Not Covered | Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth – Services provided by network providers through remote access technology including the web and mobile devices. |
| | Specialist visit | Office: \$40 / visit | Not Covered | Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain specialist visits. Your benefits/services may be denied. Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices. |
| | Preventive care/screening/immunization | No Charge for covered services | Not Covered | You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for. |
| If you have a test | Diagnostic test (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 prescription drug coverage is available at https://capitalhealth.com/members/about-your- | Tier 1 – Preferred Generic Tier 2 – Non-Preferred Generic | \$15 / 30-day supply | Not Covered | The formulary is a closed formulary. This means that all available covered medications are shown. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied. Retail or mail order, one copay per 30 day supply up to 90 days. |
| | Tier 3 – Preferred Brand | \$30 / 30-day supply | Not Covered | |
| | Tier 4 – Non-Preferred Brand | \$50 / 30-day supply | Not Covered | |

| | | | | |
|--|---|--|--|---|
| medications | Specialty drugs 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. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgical Center: \$100 / visit Hospital: \$250 / visit | Not Covered | Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services. |
| | Physician/surgeon fees | No Charge | Not Covered | |
| If you need immediate medical attention | Emergency room care | 20% Coinsurance / visit | 20% Coinsurance / visit | Coinsurance is waived if Inpatient admission occurs; however, if moved to Observation status you will pay 20% Coinsurance for the ER visit and 20% Coinsurance for services rendered while in Observation status. |
| | Emergency medical transportation | \$100 / transport | \$100 / transport | Covered if medically necessary. |
| | Urgent care | Urgent care center: \$25 / visit Telehealth: \$25 / visit Amwell: \$15 / visit | Urgent care center: \$25 / visit Telehealth: \$25 / visit Amwell: \$15 / visit | Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$250 / admission \$250 / observation | Not Covered | Prior authorization required. Your benefits /services may be denied. |
| | Physician/surgeon fees | No Charge | Not Covered | —————none————— |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$40 / visit | Not Covered | Cost share applies regardless of place of service, including office, telehealth, school, etc. |
| | Inpatient services | \$250 / admission | Not Covered | Prior authorization required. Your benefits /services may be denied. |
| If you are pregnant | Office visits | \$40 / 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 | \$250 / admission | Not Covered | Prior authorization required. Your benefits |

| | | | | |
|---|---|--------------|-------------|--|
| | services | | | /services may be denied. |
| If you need help recovering or have other special health needs | Home health care | No Charge | Not Covered | Prior authorization required. Your benefits/ services may be denied. |
| | Rehabilitation services | \$40 / visit | Not Covered | Limited to the consecutive 62-day period immediately following the first service date. Cost share applies regardless of place of service, including office, telehealth, school, etc. |
| | Habilitation services | Not Covered | Not Covered | —————none————— |
| | 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 | Children’s eye exam | \$15 / visit | Not Covered | —————none————— |
| | Children’s glasses | Not Covered | Not Covered | —————none————— |
| | Children’s dental check-up | Not Covered | Not Covered | —————none————— |

Excluded Services & Other Covered Services:

| | | |
|---|---|---|
| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
| <ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Cosmetic Surgery • Dental care (Adult) • Dental care (Child) | <ul style="list-style-type: none"> • Glasses • Habilitation services • Hearing aids • Infertility treatment • Long-term care | <ul style="list-style-type: none"> • 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.) | |
| <ul style="list-style-type: none"> • Chiropractic care | <ul style="list-style-type: none"> • Annual 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 the [Marketplace](#), visit 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. 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 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 plan's overall deductible | \$0 |
| ■ Specialist copayment | \$40 |
| ■ Hospital (facility) copayment | \$250 |
| ■ 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| | |
|-----------------------------------|--------------|
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$500 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$560 |

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 | \$40 |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other copayment | \$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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$1,000 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,020 |

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$40 |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other coinsurance | 20% |

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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| | |
|-----------------------------------|--------------|
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$600 |
| Coinsurance | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$700 |

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