Capital Health PLAN

State of Florida Standard HMO Plan
(Medicare II Enrollment Coverage Tier)

Coverage for: Employee, Employee + 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, www.capitalhealth.com/sof-spd. 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. Preventive Care.	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: $1,500 individual / $3,000 / family. Global In- Network: $10,150 individual / $20,300 family. (Met by Rx Only or Medical and Rx).	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?	Copayments on certain services, premiums, prescription drug brand additional charges 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/network or call 850-383-3311 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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	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.

*For more information about limitations and exceptions, see the plan or policy document at www.capitalhealth.com/sof-spd.

Important Questions	Answers	Why This Matters:
	capitalhealth.com/ReferralAndAuth	

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	$20/visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices. Exception: Amwell telehealth is a $0 copay.
	Specialist visit	$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. Exception: Amwell telehealth is a $0 copay.
	Preventive care/screening/ immunization	No charge	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)	No charge	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	Tier 1 – Preferred Generic Tier 2 – Non-Preferred Generic	$7 retail 30-day supply $14 mail order 90-day supply	Not covered	Consider using mail order or a participating 90-Day Maintenance at Retail Pharmacy after three refills at a 30-day retail pharmacy.

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)	
prescription drug coverage is available at https://capitalhealth.com/members/about-your-medications or call # 1-850-383-3311.	Tier 3 – Preferred Brand	$30 retail 30-day supply $60 mail order 90 -day supply	Not covered	Consider using mail order or a participating 90-Day Maintenance at Retail Pharmacy after three refills at a 30-day retail pharmacy.
	Tier 4 – Non-Preferred Brand	$50 retail 30-day supply $100 mail order 90-day supply	Not covered	
	Specialty drugs Tier 5 – Preferred Specialty Tier 6 – Non-Preferred Specialty	$60 Preferred $100 Non-preferred	Not covered	Must obtain through specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: No Charge Hospital: No Charge	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	$100/visit	$100/visit	Copayment is waived if admission occurs.
	Emergency medical transportation	No charge	No charge	Covered if medically necessary.
	Urgent care	Urgent care center: $25/ visit Telehealth: $25/visit Amwell: No charge	Urgent care center: $25/ visit Telehealth: $25/visit Amwell: No charge	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	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	$20/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/initial visit to the OB/GYN	Not covered	Basic obstetrical services from an OB/GYN. All other specialist copays will apply. Cost share applies regardless of place of service, including office, telehealth, etc.

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)	
	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.
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	The covered person's condition should improve significantly within 60 days of the date on which therapy begins. Limited to 60 visits per condition. Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Habilitation services	$40/visit	Not covered	Prior authorization required. Your benefits/ services may be denied. Limited to treatment of Autism Spectrum Disorder, treatment of Developmental Disabilities, and Down syndrome. Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Skilled nursing care	No charge	Not covered	Limited to 60 days per calendar year.
	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	$40/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.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Weight loss programs

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

- Annual routine eye care (Adult)
- Bariatric surgery (see criteria)
- Chiropractic Care
- Routine foot care (when associated with the treatment of diabetes)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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, kwiijigo 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:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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	**0**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
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 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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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