Capital Health Plan : 3101-Platinum $15/$30/$50 Rx

Coverage Period: Plans beginning on or after 01/01/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee or Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.capitalhealth.com/sbc or by calling 1-850-383-3311.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes, $60 per child for pediatric dental services (if purchased through the alliance dental plan). There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes, combined for medical and pharmacy: $2,500 single coverage / $5,000 family coverage Yes, for pediatric dental: $350 single coverage / $700 family coverage	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating **providers**, see www.capitalhealth.com **or call 850-383-3311**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Some **specialists** require a referral. For a list of **specialists** that require a written referral, see www.capitalhealth.com**.**	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 850-383-3311 or visit us at www.capitalhealth.com**.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.capitalhealth.com or call 850-383-3311 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	Not Covered	————————none————————
	Specialist visit	$35 / visit	Not Covered	Prior authorization required for certain specialist visits.
	Other practitioner office visit	$35 / visit for chiropractor	Not Covered	Limited to 26 visits per calendar year; limit combined with Rehabilitation services.
	Preventive care/screening/immunization	No charge	Not Covered	As defined in "Section 2713 - Coverage for Preventive Health Services" of the Patient Protection and Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Covered	————————none————————
	Imaging (CT/PET scans, MRIs)	$100 /visit	Not Covered	Prior authorization required for certain imaging services.

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If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.capitalhealth.com	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (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.
	Tier 2 Preferred drugs	$30/30-day supply $60/60-day supply $90/90-day supply (retail & mail order)	Not Covered	Excluding Preferred Specialty products. Additional rules may apply. See www.capitalhealth.com for more information.
	Tier 3 Non-preferred drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	Additional rules may apply. See www.capitalhealth.com for more information.
	Specialty drugs	$50 /30-day supply	Not Covered	Additional rules may apply.
If you have outpatient surgery	Facility fee (ambulatory surgery center)	$200 / visit	Not Covered	Prior authorization may be required. Cost share applies to all outpatient services.
	Facility fee (hospital)	$200 / visit	Not Covered	
	Physician/surgeon fees	$35 / provider	Not Covered	
If you need immediate medical attention	Emergency room services	$250 / visit	$250 / visit	Copayment is waived if admission occurs.
	Emergency medical transportation	No Charge	No Charge	Covered if medically necessary.
	Urgent care	$25 / visit	$25 / visit	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	Not Covered	Prior authorization required.
	Physician/surgeon fee	No Charge	Not Covered	————————none————————

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 / visit	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	$250 / admission	Not Covered	Prior authorization required.
	Substance use disorder outpatient services	$35 / visit	Not Covered	——————none——————
	Substance use disorder inpatient services	$250 / admission	Not Covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	$35 / visit	Not Covered	——————none——————
	Delivery and all inpatient services	$250 / admission	Not Covered	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to 20 visits per calendar year.
	Rehabilitation services	$35 / visit	Not Covered	Limited to 35 visits per calendar year.
	Habilitation services	$35 / visit	Not Covered	Limited to 35 visits per calendar year; limit combined with Rehabilitation services.
	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.
	Hospice service	No Charge	Not Covered	Prior authorization required for inpatient services.
If your child needs dental or eye care	Eye exam	$15 / visit	Not Covered	Limited to 1 visit per calendar year.
	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.
	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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Non-emergency care when traveling outside the US
- Routine eye care (Adult)
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 850-383-3311. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Capital Health Plan Member Services at 850-383-3311, or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or contact the Florida Department of Financial Services at 1-877-693-5236, the Agency for Health Care Administration at 1-888-419-3456, or the Federally Administered External Review Program at 1-877-549-8152.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,590
- **Patient pays** $950

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$800
Coinsurance	$0
Limits or exclusions	$150
Total	**$950**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,370
- **Patient pays** $1,030

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$950
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,030**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.