Value Selection HDHP $15/$50/$100 Rx Coverage Period: Plans beginning on or after 1/1/2017
(this plan not an HSA qualifies plan)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services 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?	$2,500 single coverage $5,000 family coverage	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible. Retail pharmacy prescription drugs are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual 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: $4,000 single coverage / $8,500 family coverage Pharmacy: $2,850 single coverage / $5,200 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, 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 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	$15 / visit	Not Covered	————none————
	Specialist visit	$75 / visit	Not Covered	Prior authorization required for certain specialist visits. Your benefits/services may be denied.
	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)	$250 / 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 www.capitalhealth.com/MedCenter	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. This additional cost does not count towards your out-of-pocket limit. Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Tier 2 drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.

	Tier 3 drugs	$100/30-day supply $200/60-day supply $300/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Specialty drugs	$100 /30-day supply	Not Covered	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $250 / visit Hospital: $500 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$75 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$500 / visit	$500 / 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	$250 / transport	$250 / transport	Covered if medically necessary.
	Urgent care	Urgent care: $50 / visit Telehealth :$15 / visit	Urgent care:$50 / 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)	$500 / admission $500 / observation	Not Covered	Prior authorization required. Your benefits/services may be denied.
	Physician/surgeon fees	No Charge if admitted. $75 /provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 / visit	Not Covered	————none————
	Inpatient services	$500 / admission	Not Covered	Prior authorization required. Your benefits/services may be denied.
If you are pregnant	Office visits	$75 / visit	Not Covered	————none————
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	$500 / 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	$75 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date.
	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.)

- 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 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 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:
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， □ □ □ □ □ □ □ 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*	$75
Hospital (facility) *copayment*	$500
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	$14,000

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,960

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*	$75
Hospital (facility) *copayment*	$500
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:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,455

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

The plan's overall deductible	$0
Specialist *copayment*	$75
Hospital (facility) *copayment*	$500
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	$3,200

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,300

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

Capital Health Plan
An Independent Licensee of the Blue Cross and Blue Shield Association

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 1-850-383-3311 or 1-877-247-6512, TTY/TDD- 850-383-3534 or 1-877-870-8943.

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/TDD 850-383-3534 or 1-877-870-8943, Fax 850-523-7419, Email memberservices@chp.org

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
800–868–1019, 800–537–7697 (TDD)
Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Have a disability? Speak a language other than English? Call to get help for free.
850-383-3311, 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. 850 383 3311, 1 877 247 6512, Téléscripteur/ATME 850 383 3534 ou 1 877 870 8943

Hai una disabilità? Non parli inglese? Chiama uno di questi numeri per chiedere assistenza gratuita: 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 o 1-877-870-8943

هل تعاني من إعاقة؟ هل تتحدث لغة غير اللغة الإنجليزية؟ اتصل للحصول على المساعدة المجانية.
850-383-3311أو 1-877-247-6512 أو TTY الهاتف النصي/TDD جهاز الاتصال الهاتفي للصم850-383-3534أو 1-877-870-8943

Haben Sie eine Behinderung? Möchten Sie mit uns in einer anderen Sprache als Englisch kommunizieren? Rufen Sie an, um kostenlos

Unterstützung zu erhalten. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 oder 1-877-870-8943

¿Tiene una discapacidad? ¿Habla algún otro idioma que no sea inglés? Llame para obtener ayuda gratis. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 o al 1-877-870-8943

اتوانی خاصی دارید؟ به زبانی بجز انگلیسی صحبت می کنید؟ برای دریافت کمک رایگان با این شماره ها تماس بگیرید. 850-383-3311، 1-877-247-6512، TTY/TDD 850-383-3534 یا 1-877-870-8943

અપંગતા છે? ઇંગલિશ કરતાં અન્ય ભાષા બોલો છો? નિશુલ્ક મદદ મેળવવા કૉલ કરો.850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 અથવા 1-877-870-8943 પર

Ou gen yon andikap? Ou pale yon lang ki pa Anglè? Rele pou jwenn èd pou gratis?
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 oswa 1-877-870-8943

장애가 있으십니까? 영어가 아닌 다른 언어를 사용하십니까? 전화하십시오. 무료로 도와드립니다. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 또는 1-877-870-8943

Jesteś osobą niepełnosprawną? Mówisz w języku innym niż j. angielski? Zadzwoń, aby uzyskać bezpłatną pomoc. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 lub
1-877-870-8943

Tem algum tipo de incapacidade? Fala outra língua que não o inglês? Ligue para obter ajuda gratuitamente. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 ou 1-877-870-8943

Ваши возможности ограничены по состоянию здоровья? Вы не говорите по-английски? Обратитесь за бесплатной помощью по телефону: 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

您是残障人士吗？您不会说英语吗？请拨打电话以免费获取帮助。电话号码：850-383-3311、 1-877-247-6512；TTY/TDD（听障人士）：850-383-3534 或 1-877-870-8943

Ikaw ba ay may kapansanan? Ikaw ba ay nakakapagsalita ng ibang wika maliban sa Ingles? Tumawag upang makakuha ng libreng tulong. 850-383-3311, 1-877-247-6512, TTY/TTD 850-383-3534 o sa 1-877-870-8943.

您是否是障礙人士? 您是否不會講英語? 請撥打電話以取得免費協助。 850-383-3311、
1-877-247-6512，聽障者請使用 TTY/TDD 850-383-3534 或 1-877-870-8943

พิการหรือเปล่า? พูดภาษาอื่นที่ไม่ใช่ภาษาอังกฤษหรือเปล่า? โทรเพื่อขอความช่วยเหลือฟรี
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 **หรือ** 1-877-870-8943

Quý vị có khuyết tật? Quý vị nói ngôn ngữ khác mà không phải tiếng Anh? Vui lòng gọi để được trợ giúp miễn phí.850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 hoặc 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. State of Florida members can reach Member Services at 1-877-392-1532 from 7 am – 7 pm Monday-Friday. Medicare members please call Capital Health Plan Member Services Department at 850-523-7441 or 1-877-247-6512; October 1 – February 14: 8:00 a.m. – 8:00 p.m., seven days a week; February 15 – September 30: 8:00 a.m. – 8:00 p.m., Monday – Friday. TTY/TDD (Telecommunication Device for the Deaf) users should call 850-383-3534 or 1-877-870-8943.

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

Approved by Compliance Committee: 8/23/16