




2024-2025 Benefit Rates

		
Per Pay-Period 85% Employer Contribution employee only	26 Pay-Periods	22 Pay-Periods
Employee	\$54.36	\$64.24
Employee + Spouse	\$416.85	\$492.60
Employee + Child(ren)	\$308.08	\$364.09
Family	\$779.26	\$920.95

				
Per Pay-Period 0% Employer Contribution	26 Pay-Periods		22 Pay-Periods	
Dental Plan	Value KA	Preferred BD	Value KA	Preferred BD
Employee	\$10.82	\$16.86	\$12.79	\$19.92
Employee + Spouse	\$21.94	\$34.16	\$25.93	\$40.37
Employee + Child(ren)	\$24.31	\$37.86	\$28.73	\$44.73
Family	\$32.97	\$51.33	\$38.96	\$60.65

		
Per Pay-Period 0% Employer Contribution	26 Pay-Periods	22 Pay-Periods
Employee	\$3.89	\$4.59
Employee + Spouse	\$7.36	\$8.69
Employee + Child(ren)	\$7.50	\$8.56
Family	\$11.87	\$14.02


Additional Benefits	
Group Term Life / AD&D	1 X Annual Salary Max of \$150,000
Short Term Disability	60% of Salary Max. \$1,000 a week
Voluntary Life Insurance	Plan Information Attached
Flexible Spending Account	Complete Enrollment Form
Colonia Life	Plan Information Attached

Employee Assistance Program We all need a little support every now and then. For more information or support, you can reach out by phoning 1800 386 7055. The team is available 24 hours a day, 7 days a week.



Premier Selection \$15/\$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. 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 <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes.	This <u>plan</u> 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 <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: \$2,000 single coverage / \$4,500 family coverage. Pharmacy: \$4,600 single coverage \$8,700 family coverage.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.capitalhealth.com or call 850-383-3311 for a list of <u>network providers</u> .	Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes. Some <u>specialists</u> require a <u>referral</u> . For a list of <u>specialists</u> that require a <u>referral</u> go to capitalhealth.com/ReferralAndAuth	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

! 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 are provided by network providers through remote access technology including the web and mobile devices.
	<u>Specialist</u> visit	Office: \$30 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain <u>specialist</u> visits. Your benefits/services may be denied. Telehealth – Services are provided by <u>network providers</u> through remote access technology including the web and mobile devices.
	<u>Preventive care/screening/immunization</u>	No Charge for covered services	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Not Covered	<u>Diagnostic tests</u> 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.
	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.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.capitalhealth.com/MemberCenter	Tier 3 – Preferred Brand	\$30 / 30-day supply	Not Covered	
	Tier 4 – Non-Preferred Brand	\$50 / 30-day supply	Not Covered	

	<p>Specialty drugs Tier 5 – Preferred Specialty Tier 6 – Non-Preferred Specialty</p>	<p>\$50 / 30-day supply</p>	<p>Not Covered</p>	<p>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.</p>
<p>If you have outpatient surgery</p>	<p>Facility fee (e.g., ambulatory surgery center)</p>	<p>Ambulatory Surgical Center: \$100 / visit Hospital: \$100 / visit</p>	<p>Not Covered</p>	<p>Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.</p>
	<p>Physician/surgeon fees</p>	<p>\$30 / provider</p>	<p>Not Covered</p>	
	<p>Emergency room care</p>	<p>\$300 / visit \$100 / observation</p>	<p>\$300 / visit \$100 / observation</p>	<p><u>Copayment</u> is waived if inpatient admission occurs; however, if moved to observation status, an additional <u>copayment</u> may apply based on services rendered.</p>
<p>If you need immediate medical attention</p>	<p>Emergency medical transportation</p>	<p>\$100 / transport</p>	<p>\$100 / transport</p>	<p>Covered if medically necessary.</p>
	<p>Urgent care</p>	<p>Urgent care center: \$25 / visit Telehealth: \$25 / visit Amwell: \$15 / visit</p>	<p>Urgent care center: \$25 / visit Telehealth: \$25 / visit Amwell: \$15 / visit</p>	<p>Telehealth – Services are provided by <u>network providers</u> through remote access technology including the web and mobile devices.</p>
	<p>Facility fee (e.g., hospital room)</p>	<p>\$200 / day for first 5 days / admission \$100 / observation</p>	<p>Not Covered</p>	<p>Prior authorization required. Your benefits /services may be denied.</p>
<p>If you have a hospital stay</p>	<p>Physician/surgeon fees</p>	<p>No Charge if admitted \$30 / provider for observation</p>	<p>Not Covered</p>	<p>—————none—————</p>
	<p>Outpatient services</p>	<p>\$30 / visit</p>	<p>Not Covered</p>	<p>Cost share applies regardless of place of service, including office, telehealth, school, etc.</p>
	<p>Inpatient services</p>	<p>\$200 / day for first 5 days / admission</p>	<p>Not Covered</p>	<p>Prior authorization required. Your benefits /services may be denied.</p>
<p>If you are pregnant</p>	<p>Office visits</p>	<p>\$30 / visit</p>	<p>Not Covered</p>	<p>Cost share applies regardless of place of service, including office, telehealth, etc.</p>
	<p>Childbirth/delivery professional services</p>	<p>No Charge</p>	<p>Not Covered</p>	<p>—————none—————</p>

	Childbirth/delivery facility services	\$200 / day for first 5 days / 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	\$30 / 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.
	Habitatation 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
- 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.ccio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.healthcare.gov). For more information about the [Marketplace](http://www.healthcare.gov), 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](http://www.healthcare.gov) for a denial of a [claim](http://www.healthcare.gov). This complaint is called a [grievance](http://www.healthcare.gov) or [appeal](http://www.healthcare.gov). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](http://www.healthcare.gov). Your [plan](http://www.healthcare.gov) documents also provide complete information on how to submit a [claim](http://www.healthcare.gov), [appeal](http://www.healthcare.gov), or a [grievance](http://www.healthcare.gov) for any reason to your [plan](http://www.healthcare.gov). 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](http://www.healthcare.gov) generally includes [plans](http://www.healthcare.gov), [health insurance](http://www.healthcare.gov) available through the [Marketplace](http://www.healthcare.gov) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](http://www.healthcare.gov), you may not be eligible for the [premium tax credit](http://www.healthcare.gov).

Does this plan meet the Minimum Value Standards? Yes

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

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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 850-383-3311, 1-877-247-6512.

To see examples of how this [plan](http://www.healthcare.gov) 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 \$30
- Hospital (facility) copayment \$200
- 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	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,360

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 \$30
- Hospital (facility) copayment \$200
- 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 \$30
- Hospital (facility) copayment \$200
- 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:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$800

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

Certification and Authorization (This form must be signed and dated below by the member.)

Reimbursement subject to approval by Capital Health Plan. If approved, your reimbursement will be sent to the subscriber. The subscriber is the health plan policyholder. **Please allow 30 days from receipt for reimbursements.**

To the best of my knowledge and belief, my statements in the Health/Fitness Center Reimbursement Form are complete and true.

I am claiming reimbursement only for eligible expenses incurred during the applicable calendar year and for eligible members. I certify that these expenses have not previously been reimbursed in this or any calendar year.

Member's Signature

Date

Mail completed form to:
Capital Health Plan
Claims Department
P.O. Box 15349
Tallahassee, FL 32317-5349



Questions?

**850.383.3311
or 1.877.247.6512**

**8:00am - 5:00pm,
Monday - Friday**

Medicare members, please call:
850.523.7441 or 1.877.247.6512

October 1 - February 14:
8:00am-8:00pm, seven days a week

February 15 - September 30:
8:00am-8:00pm, Monday-Friday

TTY 850.383.3534 or 1.877.870.8943

State of Florida members, please call:
1.877.392.1532, 7:00am-8:00pm, Monday - Friday

Keep copies of all documentation before sending in your Health/Fitness Center form.