

# State of Florida Retiree Classic (HMO)

## Schedule of Copayments

Covered Service	Unit	Your Cost (Copayment)
<b>Physician Services (including maternity care)</b>		
<b>Primary Care:</b> Office visit/ telehealth for services provided by your primary care physician during regular office hours	Per Visit	\$10
<b>Specialty Care:</b> Office visit/ telehealth for services provided by a participating provider when authorized by your primary care	Per Visit	\$25
<b>Urgent Care:</b> <u>Office Visit/Telehealth</u> – Urgent care services provided by your primary care physician, or other Capital Health Plan personnel or participating providers including after regular office hours. <u>Telehealth</u> - Amwell urgent care services provided by network physicians through remote access technology including the web and other mobile devices.	Per Visit	\$20
	Per visit	\$0
Preventive services covered under Original Medicare	Per Visit	\$0
Acupuncture- For chronic low back pain under certain circumstances	Per Visit	\$25
Chiropractic Care- if medically necessary under certain circumstances	Per Visit	\$20
Mental health and Substance Use Disorder outpatient care when medically necessary and authorized by the primary care physician	Per Visit	\$25
Outpatient procedures, surgical services, and other medical care provided by the primary care physician or by a participating provider when authorized by the primary care physician	Per Visit	\$25
<b>Hospital Services (including maternity care)</b>		
Room and board in a semiprivate room, or private when medically necessary, and all services covered under this agreement	Per Admission	\$150 per day, days 1-10
Outpatient procedures performed in a hospital	Per Visit	\$200
Mental health inpatient hospital care	Per Admission	\$150 per day, days 1-10
<b>Emergency Services</b>		
Emergency room visit	Per Visit	\$120 (waived if admitted)
Medically necessary ambulance service	Per Transport	\$250
<b>Other Benefits</b>		
Home health services	Per Occurrence	\$0

Covered Service		Unit	Your Cost (Copayment)	
Hospice care		Per Occurrence	\$0	
Skilled nursing facility services limited to 100 days of confinement per benefit period		Per Confinement	\$0 days 1-20 \$75 days 21-100	
Outpatient procedures performed in an ambulatory surgical		Per Visit	\$100	
Durable medical equipment		Per Device	20%	
Orthotic and Prosthetic medical appliances		Per Appliance	20%	
Diagnostic Imaging including MRI, PET, CT, and Thallium		Per Visit	\$100	
Vision/routine eye exams (one every 12 months)		Per Visit	\$10 or \$25	
Visits for physical therapy, occupational therapy, and speech language therapy		Per Visit	\$25	
Visits for cardiac and intensive cardiac rehabilitation services		Per Visit	\$25	
Visits for pulmonary rehabilitation services		Per Visit	\$20	
Diabetic testing supplies		Of the Cost	20%	
Part B Drugs		Of the Cost	\$50	
Outpatient Prescription Drugs				
		30 day supply	60 day supply	90 day supply
Retail	Tier 1	\$7	\$7	\$7
	Tier 2	\$7	\$14	\$21
	Tier 3	\$45	\$90	\$135
	Tier 4	\$95	\$190	\$285
	Tier 5	\$95	N/A	N/A
	Tier 6	\$0	\$0	\$0
Mail order	Tier 1	\$7	\$7	\$7
	Tier 2	\$7	\$14	\$14
	Tier 3	\$45	\$90	\$90
	Tier 4	\$95	\$190	\$190
	Tier 5	N/A	N/A	N/A
	Tier 6*	\$0	\$0	\$0
*100 day supply				
Exclusions				
<p>Services not specifically listed in the Evidence of Coverage; service, which in our opinion was, or is, not medically necessary; hearing aids and devices; cosmetic surgery; nonprescription drugs and vitamins; and custodial care.</p> <ul style="list-style-type: none"> <li>You are responsible for the payment of charges for health care services that are not covered and for the payment of charges in excess of any maximum benefit limitation set forth in the Evidence of Coverage or Schedule of Copayments.</li> <li>Your maximum out-of-pocket amount for medical services in the calendar year is \$2,500 per member.</li> <li>Prescription maximum out of pocket is \$2000.</li> <li>The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December).</li> <li>See the Capital Health Plan Retiree Advantage Evidence of Coverage or the Capital Health Plan Retiree Advantage Summary of Benefits for additional information.</li> <li>Annual diabetic eye exams for members with diabetes is a \$0 copay at CHP's eye care center.</li> <li>Eyewear Benefit \$200 each year/Fitness reimbursement \$150 each year.</li> </ul>				