Capital Health Plan℠

An Independent Licensee of the Blue Cross and Blue Shield Association

State of Florida Retiree Advantage (HMO)

Schedule of Copayments

Covered Service	Unit	Your Cost (Copayment)
Physician Services (including maternity care)		
Primary Care: Office visit/ telehealth for services provided by your primary care physician during regular office hours	Per Visit	$20
Specialty Care: Office visit/ telehealth for services provided by a participating provider when authorized by your primary care	Per Visit	$40
Urgent Care: Office Visit/ Telehealth – Urgent care services provided by your primary care physician, or other Capital Health Plan personnel or participating providers including after regular office hours. Telehealth- Amwell urgent care services provided by network physicians through remote access technology including the web and other mobile devices.	Per Visit Per Visit	$25 $0
Preventive services covered under Original Medicare	Per Visit	$0
Acupuncture- For chronic low back pain under certain circumstances	Per Visit	$40
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	$20
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	$0
Hospital Services (including maternity care)		
Room and board in a semiprivate room, or private when medically necessary, and all services covered under this agreement	Per Admission	$250
Outpatient procedures performed in a hospital	Per Visit	$0
Mental health inpatient hospital care	Per Admission	$250
Emergency Services		
Emergency room visit	Per Visit	$100 (waived if admitted)
Medically necessary ambulance service	Per Transport	$0
Other Benefits		
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
Outpatient procedures performed in an ambulatory surgical center	Per Visit	$0
Durable medical equipment	Per Device	$0
Orthotic and Prosthetic medical appliances	Per Appliance	$0
Diagnostic Imaging including MRI, PET, CT, and Thallium Scans	Per Visit	$0
Vision/routine eye exams (one every 12 months)	Per Visit	$10 or $40
Visits for physical therapy, occupational therapy, and speech language therapy	Per Visit	$40
Visits for cardiac and intensive cardiac rehabilitation services	Per Visit	$40
Visits for pulmonary rehabilitation services	Per Visit	$20
Diabetic testing supplies (Preferred Mail Order J&B Medical Supply)	Of the Cost	Preferred $0 Retail $7
Part B Drugs	Of the Cost	$0

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	$30	$60	$90
	Tier 4	$50	$100	$150
	Tier 5	$50	N/A	N/A
	Tier 6	$0	$0	$0
Mail order *100 day supply	Tier 1	$7	$7	$7
	Tier 2	$7	$14	$14
	Tier 3	$30	$60	$60
	Tier 4	$50	$100	$100
	Tier 5	N/A	N/A	N/A
	Tier 6*	$0	$0	$0

Exclusions

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.

- 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.
- Your maximum out-of-pocket amount for medical services in the calendar year is $1,500 per member and $3,000 per family.
- Prescription maximum out of pocket is $2,400
- See the Capital Health Plan Retiree Advantage Evidence of Coverage or the Capital Health Plan Retiree Advantage Summary of Benefits for additional information.
- Eyewear Benefit $200 each year/Fitness reimbursement $150 each year.

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