



Capital Health P L A N



An Independent Licensee of the
Blue Cross and Blue Shield Association

CITY OF TALLAHASSEE SELECTION SCHEDULE OF COPAYMENTS

COVERED SERVICE	UNIT	COPAYMENT
Physician Services (including maternity care)		
Primary Care: Office visit for services provided by your primary care physician during regular office hours	Per visit	\$10
Urgent Care: Office visit for services provided by your primary care physician, or other CHP personnel or participating providers including after regular office hours	Per visit	\$25
Specialty Care: Office visit for services provided by a participating provider when authorized by your primary care physician	Per visit	\$40
Outpatient procedures, surgical services, and other medical care provided by the primary care physician or by a participating provider when authorized by primary care physician	Per visit	\$40
Mental Health and Substance Use Disorder outpatient care when medically necessary and authorized by the primary care physician	By Endorsement Only	
	Per visit	\$40
Hospital Services (including maternity care)		
All hospital benefits covered under this agreement	Per admission	\$250
Outpatient procedures performed in a hospital	Per visit	\$250
Mental health inpatient care	By Endorsement Only	
	Per admission	\$250
Preventive Services		
As defined in "Section 2713. Coverage for Preventive Health Services" of the Patient Protection and Affordable Care Act	Varies	\$0

COVERED SERVICE	UNIT	COPAYMENT
Emergency Services		
Emergency room visit	Per visit	\$250
Medically necessary ambulance service	Per transport	\$100
Other Benefits		
Home health services	Per occurrence	\$0
Hospice home care	Per occurrence	\$0
Hospice outpatient care	Per occurrence	\$0
Hospice inpatient care	Per occurrence	\$0
Skilled nursing facility for up to 60 days per admission with subsequent admission available following 180 days from discharge date of the previous admission	Per confinement	\$0
Outpatient procedures performed in an ambulatory surgical center	Per visit	\$100
Durable medical equipment	Per device	\$0
Orthotic and Prosthetic medical appliances	Per appliance	\$0
Diagnostic Imaging including MRI, PET, and CT Scan	Per scan	\$100
Outpatient prescription drugs	Covered by endorsement only	
Visits for short-term physical/speech or other rehabilitation therapies	Per visit	\$40
Routine eye exam	Per visit	\$10

Exclusions – Copayments not applicable

- This copay sheet does not include everything covered under this plan. Please see Member handbook for additional information. 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 Schedule of Copayments.
- The maximum amount of copayment required from any member in any contract year is limited to an amount equal to twice the annual Prepayment Free applicable to each member or contract.
- The maximum amount of copayment required in any calendar year is limited to \$2,000 per member and \$4,500 per family, excluding copayments for prescription drugs.
- It is the member's responsibility to retain receipts and to notify and document to the satisfaction of CHP that the copayment limit has been reached. After notification, services will be provided with no copayment charge for the remainder of the contract year.

www.capitalhealth.com

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