Medical Plan Comparison Chart

Plan Features	Capital Health Plan Big Bend Choice Retiree Advantage HMO		Florida Blue Medicare Advantage PPO1Rx1	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (per calendar year)	$0		$0	$1,000
Maximum Out-of-Pocket Responsibility	$2,000 (Single) $4,500 (Family)	N/A	$1,000	$3,000 (in and out-of-network combined)
Member Coinsurance	N/A	N/A	N/A	20%
Preventive Care				
Routine annual physicals, wellness visits, screenings, and immunizations	No charge	Not covered	No charge	20% coinsurance
Physician Services				
Office Visits to PCP	$10 copay	Not covered	$10 copay	20% after $1,000 out-of-network deductible
Specialist Office Visits	$40 copay		$30 copay	
Diagnostic Services/Labs/Imaging				
Laboratory Services	No charge	Not covered	$0 copay (Independent Clinical Laboratory) $15 copay (Outpatient Hospital Facility)	20% after $1,000 out-of-network deductible
X-Rays			$50 copay (Independent Diagnostic Testing Facility) $150 copay (Outpatient Hospital Facility)	
Advanced Imaging Services[1]	$100 copay		$125 copay (Physician's Office/ Independent Diagnostic Testing Facility) $150 copay (Outpatient Hospital Facility)	
Radiation Therapy	N/A		$50 copay (All Locations)	
Hospital Care				
Inpatient Coverage	$250 copay per admission/ observation	Not covered	$150 copay per day (days 1-7) $0 copay per day (after day 7)	20% after $1,000 out-of-network deductible
Outpatient Services	$250 copay per visit		$75 copay per visit (Medicare-covered Observation Services) $150 copay (all other services)	

[1] *Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan.*

Plan Features	Capital Health Plan Big Bend Choice Retiree Advantage HMO		Florida Blue Medicare Advantage PPO1Rx1	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Medical Care				
Ambulatory Surgical Center	$100 copay	N/A	$100 copay	20% after $1,000 out-of-network deductible
Emergency Care	$120 copay per visit[2]	N/A	$75 copay per visit[2] (Medicare-covered Emergency Care) $75 copay per visit[3] (Worldwide Emergency Care Services)	
Emergency Room Care	$300 per visit $250 per observation		N/A	N/A
Urgently Needed Services[4]	$25 copay per visit (Office Visit) $15 copay per visit (Telehealth)		$30 copay per visit[5] (Medicare-covered Urgently Needed Services) $75 copay per visit[3] (Worldwide Urgently Needed Services)	
Ambulance	$100 copay per transport		$150 copay for each Medicare-covered trip (one-way)	
Transportation	N/A		Not covered	
Mental Health Care				
Inpatient Coverage[6]	$250 per admission	Not covered	$200 copay per day (days 1-7) $0 copay per day (days 8-90)	20% after $1,000 out-of-network deductible
Outpatient Coverage	$40 copay		$35 copay	20% after $1,000 out-of-network deductible
Special Health Needs				
Cardiac and Intensive Cardiac Rehabilitation Services	$40 per visit	Not covered	N/A	
Pulmonary Rehabilitation Services	$25 per visit			
Diabetic Supplies	$0 copay (Preferred) $7 copay (Retail)		$0 copay[7]	20% after $1,000 out-of-network deductible
Medicare Diabetes Prevention Program	N/A		$0 copay (Medicare-covered Services)	
Podiatry			$30 copay (Medicare-covered Podiatry Visit)	20% after $1,000 out-of-network deductible
Chiropractic	$20 copay	Not covered	$20 copay (Medicare-covered Chiropractic Visit)	

[2] Copay waived if admitted to the hospital within 48 hours of an emergency room visit.
[3] There is a $25,000 combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services. Does not include emergency transportation.
[4] Under Florida Blue, urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.
[5] Includes services provided at an urgent care center or convenient care center, in- or out-of-network.
[6] Florida Blue includes a 190-day lifetime benefit maximum in a psychiatric hospital for both in- and out-of-network.
[7] Includes an in-network retail or mail-order pharmacy for Diabetic Supplies such as LifeScan (One Touch) Glucose Meters, Lancets, and Test Strips.

Plan Features	Capital Health Plan Big Bend Choice Retiree Advantage HMO		Florida Blue Medicare Advantage PPO1Rx1	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Special Health Needs (continued)				
Hearing Services (Includes exams to diagnose and treat hearing and balance issues.)	N/A		$30 copay (Medicare-covered Services)	20% after $1,000 out-of-network deductible
Additional Hearing Services	N/A		$45 copay (routine exam per year) $0 copay (evaluation/fitting of hearing aids) $699 or $999 copay per aid (two hearing aids per year, one per ear)	40% coinsurance (routine exam per year) 40% coinsurance (evaluation/fitting of hearing aids) $699 or $999 copay per aid (two hearing aids per year, one per ear)
Medical Equipment and Supplies	$0 copay per device	Not covered	20% coinsurance (Plan approved, Medicare-covered motorized wheelchairs and electric scooters) 0% coinsurance (all other plan approved, Medicare-covered durable medical equipment)	20% after $1,000 out-of-network deductible
Orthotic and Prosthetic Medical Appliances	$0 copay per appliance	Not covered	N/A	
Occupational and Speech Therapy	$40 copay per visit	Not covered	$30 copay per visit	20% after $1,000 out-of-network deductible
Physical Therapy	$40 copay per visit		$30 copay per visit	
Home Health Services	$0 copay per occurance		N/A	
Rehabilitative Services	$40 per visit			
Habilitation Services	Not covered			
Skilled Nursing Care (Limits: 100 days in a Skilled Nursing Facility per benefit period)	$0 copay per confinement		$0 copay per day (days 1-20) $75 copay per day (days 21-100)	20% after $1,000 out-of-network deductible
Hospice Care	$0 copay per occurance		N/A	
Pregnancy Services				
Office Visit	$40 copay per visit	Not covered	N/A	
Childbirth/delivery Professional Services	No charge			
Childbirth/delivery Facility Services	$250 per admission			
Dental Services				
Exams (Non-Routine Dental Care)	N/A		$30 copay (Medicare-covered Dental Sevices)	20% after $1,000 out-of-network deductible
Additional Dental Services (Preventive/ Comprehensive Dental Services)			$0 copay	50% reimbursement

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	In-Network	Out-of-Network	In-Network	Out-of-Network
Vision Services				
Exams[8] (Annual Routine Eye Examinations)	$10 copay	Not covered	$0 copay	50% reimbursement
Exams (Physician Services to Diagnose/Treat Eye Diseases/Conditions)	N/A		$30 copay (Medicare-covered Dental Services)	20% after $1,000 out-of-network deductible
Glaucoma Screening (Limits: once per year for members at high risk)			$0 copay	
Diabetic Retinal Exam (Limits: one exam per year)			$0 copay	
Cataract Surgery (Limits: one pair of eyeglasses/contact lenses after each cataract surgery)			$0 copay	
Additional Benefits				
HealthyBlue Rewards	N/A		Includes gift card rewards for completing and reporting preventive care and screenings.	
SilverSneakers Fitness Program			Includes College Save, gym memberships, classes, walking groups, and dance classes.	
Medicare Part B Drugs	$0 copay	N/A	$5 copay (allergy injections) 20% coinsurance (chemotherapy drugs and other Medicare Part B-covered drugs)	20% after $1,000 out-of-network deductible
Medicare Part D Prescription Drugs				
Maximum Out-of-Pocket Responsibility	$4,600 (Single) $8,700 (Family)	N/A	$0	
Retail (31-day supply)				
• **Tier 1 - Preferred Generic**	$7 copay	Not covered	$10 copay	Not covered
• **Tier 2 - Generic**				
• **Tier 3 - Preferred Brand**	$30 copay		$40 copay	
• **Tier 4 - Non-Preferred Brand/Drug**	$50 copay		$70 copay	
• **Tier 5 - Specialty Tier**			25% of the cost	
Mail Order (90-day supply)				
• **Tier 1 - Preferred Generic**	$17.50 copay	Not covered	$0 copay	Not covered
• **Tier 2 - Generic**				
• **Tier 3 - Preferred Brand**	$75 copay		$80 copay	
• **Tier 4 - Non-Preferred Brand/Drug**	$125 copay		$140 copay	
• **Tier 5 - Specialty Tier**	Not covered		Not covered	

[8] *Florida Blue provides an in-network $100 maximum allowance per year applies towards the purchase of lenses, frames or contact lenses. For out-of-network, members are reimbursed up to $45 for lenses, frames or contact lenses.*