

Tallahassee Memorial Healthcare Selection 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 | \$15 |
| Specialty Care: Office visit/ telehealth for services provided by a participating provider when authorized by your primary care | Per Visit | \$40 |
| Urgent Care: <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 | Per Visit | \$25 |
| <u>Telehealth</u> – Amwell urgent care services provided by network physicians through remote access technology including the web and other mobile devices | Per Visit | \$15 |
| Preventive Services: 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 | \$40 |
| 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 | \$40 |
| 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 | \$350 |
| Outpatient procedures performed in a hospital | Per Visit | \$250 |
| Mental health inpatient hospital care | Per Admission | \$350 |
| Emergency Services | | |
| Emergency room visit | Per Visit | \$120 (waived if admitted) |
| Medically necessary ambulance service | Per Transport | \$100 |
| 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 | \$100 | |
| 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 | \$100 | |
| Routine eye exams (one every 12 months) | | Per Visit | \$15 | |
| 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 | \$15 |
| Part B Drugs | | Of the Cost | \$0 | |
| Outpatient Prescription Drugs | | | | |
| | | 30 day supply | 60 day supply | 90 day supply |
| Retail | Tier 1 | \$15 | \$30 | \$45 |
| | Tier 2 | \$15 | \$30 | \$45 |
| | Tier 3 | \$30 | \$60 | \$90 |
| | Tier 4 | \$50 | \$100 | \$150 |
| | Tier 5 | 20% up to \$250 per Rx | N/A | N/A |
| | Tier 6 | \$0 | \$0 | \$0 |
| Mail order | Tier 1 | \$15 | \$30 | \$37.50 |
| | Tier 2 | \$15 | \$30 | \$37.50 |
| | Tier 3 | \$30 | \$60 | \$75 |
| | Tier 4 | \$50 | \$100 | \$125 |
| | Tier 5 | N/A | N/A | N/A |
| | Tier 6* | \$0 | \$0 | \$0 |
| *100 day supply | | | | |
| 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. | | | | |
| <ul style="list-style-type: none"> Your maximum out-of-pocket amount for medical services in the calendar year is \$3,400 per member, excluding your costs for covered Part D prescription drugs. After reaching your maximum out-of-pocket amount you generally pay nothing for covered Medicare Part A and Part B services for the remainder of the calendar year. Covered prescription drugs must be medically necessary and prescribed by a qualified medical professional acting within the scope of his/her license and dispensed by a pharmacist. See the Capital Health Plan Retiree Advantage Evidence of Coverage or the Capital Health Plan Retiree Advantage Summary of Benefits for additional information. Annual diabetic eye exams for members with diabetes is a \$0 copay at CHP's eye care center. Eyewear Benefit \$200 each year/Fitness reimbursement \$150 each year. 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). | | | | |