



## City of Tallahassee Selection Retiree Advantage (HMO)

### Schedule of Copayments

Benefits	Unit	Your Cost (Copayment)
<b>Office Visits (including maternity care)</b>		
<b>Primary Care:</b> Office visit for services provided by your primary care physician during regular office hours	Per Visit	\$10
<b>Specialty Care:</b> Office visit for services provided by a participating provider when authorized by your primary care physician	Per Visit	\$40
<b>Urgent Care:</b> Office visit for services provided by your primary care physician, or other Capital Health Plan personnel or participating providers including after regular office hours	Per Visit	\$25
<b>Preventive Services:</b> Tests, immunizations and services as defined in "Section 2713 - Coverage for Preventive Health Services" of the Patient Protection and Affordable Care Act and preventive services covered under Original Medicare.	Covered in full	
Chiropractic Care	Per Visit	\$20
Dermatology Care	Per Visit	\$40
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 primary care physician	Per Procedure	\$40
Podiatry Care	Per Visit	\$40
Routine eye exams (one every 12 months)	Per Visit	\$10
Visits for short-term physical/speech or other rehabilitation therapies	Per Visit	\$40
<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	\$250
Outpatient procedures performed in a hospital	Per Procedure	\$250
Mental health inpatient hospital care	Per Admission	\$250

Benefits	Unit	Your Cost
<b>Outpatient Prescription Drugs</b> (Copayment)		
Retail (30 day supply) <i>(Capital Health Plan reserves the right to add, remove or reclassify any prescription drug between tiers at any time. Covered prescription drugs must be medically necessary, prescribed by a medical professional acting within the scope of his/her license, and dispensed by a pharmacist.)</i>	Tier 1 Tier 2 Tier 3 Tier 4	\$7 \$30 \$50 \$50
Retail (90 day supply)	Tier 1 Tier 2 Tier 3 Tier 4	\$21 \$90 \$150 N/A
Mail order (90 day supply)	Tier 1 Tier 2 Tier 3 Tier 4	\$17.50 \$75 \$125 N/A
<b>Emergency Services</b>		
Emergency room visit	Per Visit	\$50
Medically necessary ambulance service	Per Transport	\$100
<b>Other Health Services</b>		
Home health services	Per Occurrence	\$0
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 Procedure	\$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 Scan	\$100
<b>Exclusions</b>		
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"> <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 Schedule of Copayments.</li> <li>The maximum amount of copayment required in any calendar year is limited to \$3,400 per member, excluding copayments for prescription drugs.</li> <li>It is the member's responsibility to retain receipts and to notify and document to the satisfaction of Capital Health Plan that the copayment limit has been reached. After notification, services will be provided with no copayment charge for the remainder of the calendar year.</li> </ul>		