Capital Health Plan
Preferred Advantage (HMO)
Schedule of Copayments

Covered Service	Unit	Your Cost (Copayments/Coinsurance)
Premium	Monthly	$86
Physician Services (including maternity care)		
Primary Care: Office visit/Telehealth for services provided by your primary care physician during regular office hours	Per Visit	$10
Specialty Care: Office visit/Telehealth for services provided by a participating provider when authorized by your primary care physician	Per Visit	$25
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	$20 $15
Preventive services covered under Original Medicare	Per Visit	$0
Acupuncture- For chronic low back pain under certain circumstances	Per Visit	$25
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	$25
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	$25
Visits for physical therapy, occupational therapy, and speech language therapy	Per Visit	$20
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	$300 copay $300 Max
Outpatient procedures performed in a hospital	Per Visit	$200
Mental health inpatient hospital care	Per Admission	$300 copay $300 Max
Emergency Services		
Emergency room visit	Per Visit	$135 (waived if admitted)
Medically necessary ambulance service	Per Transport	$250
Other Benefits		
Home health services	Per Occurrence	$0
Hospice care	Per Occurrence	$0

Covered Service	Unit	Your Cost (Copayment/Coinsurance)
Skilled nursing facility services limited to 100 days of confinement per benefit period	Per Confinement	$20/day days 1-20 $75/day days 21-100
Outpatient procedures performed in an ambulatory surgical center	Per Visit	$100
Durable medical equipment	Per Device	20%
Orthotic and Prosthetic medical appliances	Per Appliance	20%
Renal dialysis	Of the Cost	20%
Diagnostic Imaging including MRI, PET, CT, Thallium, and Nuclear Cardiology scans	Per Visit	$100
Routine eye exams (one every 12 months)	Per Visit	$0 or $25
Visits for cardiac and intensive cardiac rehabilitation services	Per Visit	$25
Visits for pulmonary rehabilitation services	Per Visit	$20
Part B Drugs	Of the Cost	20%
Outpatient Prescription Drugs		
Initial Coverage Limit 30 day retail supply (Prior to reaching the Initial Coverage Limit of $5,030)	Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Select Care Drugs	$0 $7 $45 $95 33% $0
90 day retail supply (Prior to reaching the Initial Coverage Limit of $5,030) 100 day mail order supply for Select Care Drugs	Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Select Care Drugs	$0 $21 $135 $285 N/A $0
90 day Mail order supply (Prior to reaching the Initial Coverage Limit of $5,030) 100 day mail order supply for Select Care Drugs	Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Select Care Drugs	$0 $17.50 $112.50 $237.50 N/A $0
Coverage Gap (After reaching the Initial Coverage Limit of $5,030)	Tier 1 Tier 2 Select Care Drugs 25% for all other tiers	$0 $7 $0
Catastrophic Coverage (After spending $8,000) During this payment stage, the plan pays full cost for your covered Part D drugs.	$0 You pay nothing	

- 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 a calendar year is $3,850 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.
- CHP Choice Card is a debit card that may be used to reduce $800 of your out of pocket expenses towards Dental, Hearing Aids, and Over the Counter (OTC) items.
- 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. Supplies other than 30 or 90 days may be available.
- See the Capital Health Plan Preferred Advantage Evidence of Coverage or the Capital Health Plan Silver Advantage, Advantage Plus and Capital Health Plan Preferred Advantage Summary of Benefits for additional information and exclusions.
- This information is not a complete description of benefits. Contact the plan for more information.
- Limitations, copayments, and restrictions may apply.
- Benefits, premiums, and/or copayments/co-insurance may change on January 1 of each year.