# Capital Health Plan
# Silver Advantage (HMO)
## Schedule of Copayments

| Covered Service | Unit | Your Cost (Copayments/Coinsurance) |
|---|---|---|
| Premium/ Part B Give Back- Capital Health Plan will reduce your Medicare Part B Premium | Monthly | $0/$36 |
| **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 | $45 |
| **Urgent Care:**<br>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<br>Telehealth – Amwell urgent care services provided by network physicians through remote access technology including the web and other mobile devices | Per Visit<br><br>Per Visit | $20<br><br>$15 |
| Preventive services covered under Original Medicare | Per Visit | $0 |
| Acupuncture- For chronic low back pain under certain circumstances | Per Visit | $45 |
| 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 | $45 |
| Visits for physical therapy, occupational therapy, and speech language therapy | Per Visit | $30 |
| **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 | $275/day<br>days 1-6<br>$1,650 Max |
| Outpatient procedures performed in a hospital | Per Visit | $350 |
| Mental health inpatient hospital care | Per Admission | $275/day<br>days 1-6<br>$1,650 Max |
| **Emergency Services** | | |
| Emergency room visit | Per Visit | $135 (waived if admitted) |
| Medically necessary ambulance service | Per Transport | $250/$250(air) |
| **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<br>$150/day days 21-100 |
| Outpatient procedures performed in an ambulatory surgical center | Per Visit | $250 |
| 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 | $10 or $45 |
| Visits for cardiac and intensive cardiac rehabilitation services | Per Visit | $40 |
| Visits for pulmonary rehabilitation services | Per Visit | $20 |
| Part B Drugs | Of the Cost | 20% |

## Outpatient Prescription Drugs

| | | Preferred /Non Preferred Pharmacy |
|---|---|---|
| **Initial Coverage Limit**<br>30 day retail supply<br>(Prior to reaching the Initial Coverage Limit of $5,030) | Tier 1<br>Tier 2<br>Tier 3<br>Tier 4<br>Tier 5<br>Select Care Drugs | $0 $10<br>$7 $14<br>$40 $47<br>$93 $100<br>33%<br>$0 |
| 90 day retail supply<br>(Prior to reaching the Initial Coverage Limit of $5,030)<br><br>100 day mail order supply for Select Care Drugs | Tier 1<br>Tier 2<br>Tier 3<br>Tier 4<br>Tier 5<br>Select Care Drugs | $0 $30<br>$21 $42<br>$120 $141<br>$279 $300<br>N/A<br>$0 |
| 90 day mail order supply<br>(Prior to reaching the Initial Coverage Limit of $5,030)<br><br>100 day mail order supply for Select Care Drugs | Tier 1<br>Tier 2<br>Tier 3<br>Tier 4<br>Tier 5<br>Select Care Drugs | $0<br>$17.50<br>$100<br>$232.50<br>N/A<br>$0 |
| **Coverage Gap**<br>(After reaching the Initial Coverage Limit of $5,030) | Select Care Drugs | $0<br>25% for all other tiers |
| **Catastrophic Coverage** (After spending $8,000)<br>During this payment stage, the plan pays the full cost for your covered Part D drugs. | | $0<br>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. Limitations, copayments, and restrictions may apply.
- 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.
- 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. Silver Advantage has a Preferred vs non-Preferred difference in cost share.
- See the Capital Health Plan Silver Advantage Evidence of Coverage or the Capital Health Plan Silver Advantage, Advantage Plus and 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.
- Benefits, premiums, and/or copayments/co-insurance may change on January 1 of each year.
- CHP Choice Card may be used to reduce $200 of your out-of-pocket expenses towards Dental, Hearing Aids, and Over the Counter (OTC) items.