Capital Health PLAN℠
An Independent Licensee of the Blue Cross and Blue Shield Association

# Dual Eligible Medicare Advantage (HMO)

## Schedule of Copayments

| Covered Service | Unit | Your (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 | $0 |
| **Specialty Care:** Office visit/Telehealth for services provided by a participating provider when authorized by your primary care physician | Per Visit | $2 |
| **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 | $2<br><br>$2 |
| **Preventive Services:** Preventive services covered under Original Medicare | Per Visit | $0 |
| Acupuncture- For chronic low back pain under certain circumstances | Per Visit | $2 |
| Chiropractic Care- if medically necessary under certain circumstances | Per Visit | $1 |
| Mental health and Substance Use Disorder outpatient care when medically necessary and authorized by the primary care physician | Per Visit | $2 |
| 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 | $2 |
| **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 | $3 |
| Outpatient procedures performed in a hospital | Per Visit | $3 |
| Mental health inpatient hospital care | Per Admission | $3 |
| **Emergency Services** | | |
| Emergency room visit | Per Visit | $0 |
| Medically necessary ambulance service | Per Transport | $0 |
| **Other Benefits** | | |
| Home health services | Per Occurrence | $0 |
| Hospice Care | Per Occurrence | $0 |

| Covered Service | Unit | Your Cost |
|---|---|---|
| **Other Benefits** | | (Copayment) |
| 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 | $0 |
| Durable medical equipment | Per Device | $0 |
| Orthotic and Prosthetic medical appliances | Per Appliance | $0 |
| Renal Dialysis | Of the Cost | $0 |
| Diagnostic Imaging including MRI, PET, CT, Thallium and Nuclear Cardiology Scans | Per Visit | $1 |
| Routine eye exams (one every 12 months) | Per Visit | $2 |
| Visits for physical therapy, occupational therapy, and speech language therapy | Per Visit | $0 |
| Visits for cardiac and intensive cardiac rehabilitation services | Per Visit | $0 |
| Visits for pulmonary rehabilitation services | Per Visit | $0 |
| Part B Drugs | Of the Cost | $0 |
| **Outpatient Prescription Drugs** | | |
| Retail (Up to a 90 day supply) | Refer to your Evidence of Coverage Rider | |
| Mail order (Up to a 90 day supply) | Refer to your Evidence of Coverage Rider | |

- 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 the calendar year is $5,500per 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, prescribed by a qualified medical professional acting within the scope of his/her license, and dispensed by a pharmacist. Supplies other than 30, 60, or 90 days may be available.
- See the Capital Health Plan Silver Advantage, Capital Health Plan Advantage Plus, Capital Health Plan Preferred Advantage, or Capital Health Plan Retiree Advantage Evidence of Coverage; or the Capital Health Plan Silver Advantage, Capital Health Plan Advantage Plus, and Capital Health Plan Preferred Advantage Summary of Benefits or the Retiree Advantage Summary of Benefits for additional information.
- 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/coinsurance may change on January 1 of each year.
- Silver Advantage Advantage Plus and Preferred Advantage offer a Spend Card of $200, $600 or $800 for Dental, Hearing and OTC items.