

**Capital Health Plan Silver Advantage (HMO),
Capital Health Plan Advantage Plus (HMO),
Capital Health Plan Preferred Advantage (HMO), & Capital Health Plan
Giveback Advantage (HMO)**

Copayment/Coinsurance Comparison

Covered Service		Silver Advantage	Advantage Plus	Preferred Advantage	Giveback Advantage
Premium		\$0	\$34	\$96	\$0
Part B Give Back – Capital Health Plan will reduce your Medicare Part B premium		\$25	–	–	\$100
Physician Services (including maternity care)	Unit	Copayment/ Coinsurance	Copayment/ Coinsurance	Copayment/ Coinsurance	Copayment/ Coinsurance
Primary Care: Office visit/telehealth for services provided by your primary care physician during regular office hours	Per Visit	\$0	\$0	\$0	\$0
Specialty Care: Office visit/telehealth for services provided by a participating provider when authorized by your primary care physician	Per Visit	\$30	\$30	\$20	\$30
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.	Per Visit	\$20	\$20	\$20	\$20
Telehealth – Amwell urgent care services provided by network physicians through remote access technology including the web	Per Visit	\$15	\$15	\$15	\$15
Preventive Services: Preventive services covered under Original Medicare.	Per Visit	\$0	\$0	\$0	\$0
Acupuncture – for chronic low back pain under certain circumstances	Per Visit	\$30	\$30	\$20	\$30
Chiropractic Care – if medically necessary under certain circumstances	Per Visit	\$20	\$20	\$20	\$20
Mental Health and Substance Use Disorder – outpatient care when medically necessary and authorized by the primary care physician	Per Visit	\$30	\$30	\$20	\$30
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	\$30	\$30	\$20	\$30
Room and board in a semiprivate room, or private when medically necessary, and all services covered under this agreement (includes mental health inpatient hospital care)	Per Admission	\$275/day (days 1-6) \$1,650 Max	\$250/day (days 1-5) \$1,250 Max	\$400 copay \$400 Max	\$350/day (days 1-7) \$2,450 Max
Outpatient procedures performed in a hospital	Per Visit	\$350	\$300	\$200	\$350
Emergency room visit	Per Visit	\$125 (waived if admitted)	\$125 (waived if admitted)	\$125 (waived if admitted)	\$125 (waived if admitted)
Medically necessary ambulance service	Per Transport	\$290 or \$290 (air)	\$290 or \$290 (air)	\$290 or \$290 (air)	\$290 or \$290 (air)
Home Health Services	Per Occurrence	\$0	\$0	\$0	\$0

Covered Service		Silver Advantage	Advantage Plus	Preferred Advantage	Giveback Advantage
Other Benefits	Unit	Copayment/ Coinsurance	Copayment/ Coinsurance	Copayment/ Coinsurance	Copayment/ Coinsurance
Hospice Care	Per Occurrence	\$0	\$0	\$0	\$0
Skilled nursing facility services limited to 100 days of confinement per benefit period.	Per Confinement	\$10/day (days 1-20) \$200/day (days 21-100)	\$10/day (days 1-20) \$200/day (days 21-100)	\$10/day (days 1-20) \$200/day (days 21-100)	\$10/day (days 1-20) \$200/day (days 21-100)
Ambulatory Surgical Center	Per Visit	\$250	\$150	\$100	\$250
Durable Medical Equipment	Per Device	20%	20%	20%	20%
Orthotic and Prosthetic Appliances	Per Appliance	20%	20%	20%	20%
Renal Dialysis	Of the Cost	20%	20%	20%	20%
Therapeutic Radiology Services	Of the Cost	20%	20%	20%	20%
Diagnostic Imaging including MRI, PET, CT, Thallium and Nuclear Cardiology scans	Per Visit	\$100	\$100	\$100	\$100
Routine eye exams (one every 12 months)	Per Visit	\$10 or \$30	\$10 or \$30	\$10 or \$20	\$10 or \$30
Visits for cardiac and intensive cardiac rehabilitation services	Per Visit	\$40	\$40	\$25	\$40
Visits for pulmonary rehabilitation services	Per Visit	\$20	\$20	\$20	\$20
Part B Drugs	Of the Cost	20%	20%	20%	20%
Calendar year Out-of-Pocket Maximum (Medical Only)	Per Member	\$5,500	\$4,500	\$4,500	\$6,700
Part D Drugs (mail order and supplies other than 30 days are available)					
Deductible and Initial Coverage Limit					
\$250 Deductible for Silver, Advantage Plus, and Giveback Advantage Tiers 3-5 \$200 Deductible for Preferred Advantage Tiers 3-5		Tier 1 \$0/\$10 Tier 2 \$0/\$14 Tier 3 \$40/\$47 Tier 4 \$93/\$100 Tier 5 30% Select Care \$0	Tier 1 \$0 Tier 2 \$7 Tier 3 \$45 Tier 4 \$95 Tier 5 30% Select Care \$0	Tier 1 \$0 Tier 2 \$7 Tier 3 \$45 Tier 4 \$95 Tier 5 30% Select Care \$0	Tier 1 \$0/\$10 Tier 2 \$0/\$14 Tier 3 \$40/\$47 Tier 4 \$93/\$100 Tier 5 30% Select Care \$0
*Silver Advantage and Giveback Advantage have a separate formulary with Preferred/ Non-Preferred Pharmacy cost share					
The Medicare Prescription Payment Plan is a 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).		–	–	–	–
Catastrophic Coverage (After your yearly out-of-pocket drug costs reach \$2,100) During this payment stage, the plan pays the full cost for your covered Part D drugs.		\$0 You pay nothing	\$0 You pay nothing	\$0 You pay nothing	\$0 You pay nothing
Exclusions & General Information					
<ul style="list-style-type: none"> • See your plan's Evidence of Coverage for limitations and exclusions and a complete description of benefits. • Contact your plan for more information. Benefits, premiums, and/or copayments/coinsurance may change January 1 of each year. Limitations, copayments, and restrictions may apply. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. • Silver Advantage Advantage Plus and Preferred Advantage offer a Spend Card of \$625, \$725 or \$825 for Dental, Hearing and OTC items. 					