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

# Big Bend Choice Retiree Advantage (HMO)

## Schedule of Copayments

| Covered Service | Unit | Your Cost (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 | $10 |
| **Specialty Care:** Office visit/ telehealth for services provided by a participating provider when authorized by your primary care | Per Visit | $40 |
| **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 | $25<br><br>$15 |
| Preventive services covered under Original Medicare | Per Visit | $0 |
| Acupuncture- For chronic low back pain under certain circumstances | Per Visit | $40 |
| 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 | $40 |
| **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 | $250 |
| Outpatient procedures performed in a hospital | Per Visit | $250 |
| Mental health inpatient hospital care | Per Admission | $250 |
| **Emergency Services** | | |
| Emergency room visit | Per Visit | $120 (waived if admitted) |
| Medically necessary ambulance service | Per Transport | $100 |
| **Other Benefits** | | |
| Home health services | Per Occurrence | $0 |

| Covered Service | Unit | Your Cost (Copayment) |
|---|---|---|
| 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 Visit | $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 Visit | $100 |
| Routine eye exams (one every 12 months) and $200 eyewear/1 yr | Per Visit | $10 |
| Visits for physical therapy, occupational therapy, and speech language therapy | Per Visit | $40 |
| Visits for cardiac and intensive cardiac rehabilitation services | Per Visit | $40 |
| Visits for pulmonary rehabilitation services | Per Visit | $20 |
| Diabetic testing supplies (Preferred Mail Order J&B Medical Supply) | Of the Cost | Preferred $0<br>Retail $7 |
| Part B Drugs | Of the Cost | $0 |

| | | 30 day supply | 60 day supply | 90 day supply |
|---|---|---|---|---|
| Retail | Tier 1 | $7 | $14 | $21 |
| | Tier 2 | $7 | $14 | $21 |
| | Tier 3 | $30 | $60 | $90 |
| | Tier 4 | $50 | $100 | $150 |
| | Tier 5 | $50 | N/A | N/A |
| | Tier 6 | $0 | $0 | $0 |
| Mail order | Tier 1 | $7 | $14 | $17.50 |
| | Tier 2 | $7 | $14 | $17.50 |
| | Tier 3 | $30 | $60 | $75 |
| | Tier 4 | $50 | $100 | $125 |
| | Tier 5 | N/A | N/A | N/A |
| *100 day supply | Tier 6* | $0 | $0 | $0 |

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.

- Your maximum out-of-pocket amount for medical services in the calendar year is $3,400 per 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 and prescribed by a qualified medical professional acting within the scope of his/her license and dispensed by a pharmacist. See the Capital Health Plan Retiree Advantage Evidence of Coverage or the Capital Health Plan Retiree Advantage Summary of Benefits for additional information.
- Eyewear Benefit $200 each year/Fitness reimbursement $150 each year.

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