

Co-Payment Book



SILVER PLAN

Beginning on and after January 1, 2023

This booklet shows the copayments for
In-Network benefits.

For more information on
**Out-of-Network benefits, please review
your Summary Plan Description (SPD)
or call 855-405-3863.**

The information in this Copay Book is based on the Plan Document. However, in the event of a conflict between the Copay Book and the Plan Document, **the Plan Document will govern.**

For the latest information, please visit www.hospitalityplan.org
or call the Customer Service Office at **855-405-3863.**

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Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
<p>The Maximum yearly amount you have to pay out of your pocket for your deductible, co-pays and coinsurance is \$2,000 per person or \$6,000 per family for medical services and \$1,600 per person or \$3,200 for family for prescription drug services. (Excludes dental copays). Annual deductible of \$750 per person and \$1,500 per family is the amount you must pay before your health plan pays for certain services. The deductible does not apply to services with Copays, such as doctor visits or to the pharmacy.</p>						
<p>Preventive Services</p>	<p>Immunizations for adults (age appropriate) and children (birth to age 18)</p>	<p>\$0</p>	<p>No coinsurance</p>	<p>100% of allowable charges</p>	<p>No maximum benefit</p>	<p>For a complete list of preventive services covered by the Affordable Care Act please visit http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/</p> <p>You can also contact the Customer Service Office at 855-405-3863 if you have any questions. (No out of network benefits)</p>
	<p>Well baby/child exams (birth to age 21)</p>					
	<p>Annual physical exams</p>					
	<p>Nutritional counseling</p>					
	<p>Osteoporosis screening (women age 65 and older)</p>					
	<p>Mammography (women age 35 and older); 1 per calendar year (women under age 35 who are at high risk for breast cancer); 1 per calendar year</p>					
	<p>Women's well check</p>					
<p>Colonoscopy and Sigmoidoscopy (Ages 45 to 75)</p>						

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Doctor Office Services	Primary doctor	\$25	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
	Teladoc	\$0				
	Specialist	\$50				
	In-patient services	\$0	No coinsurance	100% of allowable charges		
	Injection					
	IV treatment					
	Pulmonary treatment					
	Pulmonary test					
	Chiropractor	\$25	No coinsurance	100% of allowable charges after copay	Up to 12 visits per year	No out of Network benefits.
	Urgent care	\$50	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
	X-ray/ultrasound	\$25				
	Radiology-CT, MRI, PET	\$175 per visit				
	Lab	\$25				

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Doctor Office Services (continued)	Ophthalmologist/Optomtrist (eye exam)	\$0	No coinsurance	100% of allowable charges	No maximum benefit	Covered under the vision plan. Coverage for lenses and frames are listed in the "Other Services" section of this book.
	Chemotherapy	\$25	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
	Radiation therapy	\$0	30% after deductible	70% of allowable charges after deductible		
	Hearing and speech exam	\$0	No coinsurance	100% of allowable charges		
	Allergy testing					
	Allergy immunotherapy					
	Surgery in the physician's office					
	Nerve conduction studies					
	Dialysis management					
	All other physician office procedures					
Sleep study performed in a doctor's office	\$0					

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Prescriptions	Generic and Some Brand Drugs	\$5	No coinsurance	100% after copay	No maximum benefit	For a complete list of retail pharmacies included in the Network, contact Hospitality Rx at 844-813-3860.
	Preferred Drugs	\$15	No coinsurance	100% after copay	No maximum benefit	For a complete list of retail pharmacies included in the Network, contact Hospitality Rx at 844-813-3860. Quantity limits, prior authorization requirements and other cost containment programs may apply.
	Non-Preferred Drugs	\$30				
	Select Specialty and Select Biosimilar Drugs	Generic:	\$5	No coinsurance	100% after copay	No maximum benefit
Brand name:		\$0	25% of allowable charges	75% of allowable charges		
Ambulatory Surgery Center	Surgery	\$0	20% after deductible	80% of allowable charges after deductible	No maximum benefit	No other information.

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Therapy at an Outpatient Free Standing Facility (Not at a hospital)	Physical therapy and occupational therapy	\$30	No coinsurance	100% of allowable charges after copay	Up to 60 visits per year, combined	Maximum visit limits apply to Network and Non-Network care combined.
	Speech therapy	\$30	No coinsurance	100% of allowable charges after copay	Up to 30 visits per year	
Free-Standing Facility Services (Not at a hospital)	Lab	\$25	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
	X-ray/ultrasound					
	CT Scan, MRI, MRA, PET	\$175				
	Dialysis	\$0	No coinsurance	100% of allowable charges	No maximum benefit	Some services require prior authorization (approval).
	Sleep study	\$0	30% after deductible	70% of allowable charges after deductible	No maximum benefit	
Cardiac/pulmonary rehabilitation	\$0	30% after deductible	70% of allowable charges after deductible	30 visits annual limit		

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Outpatient Services in a Hospital	Lab for hospital based preoperative or diagnostic services only	\$100	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization (approval).
	X-ray/ultrasound	\$100				
	MRI, MRA, CT Scan PET and combined PET/CT	\$300				
	Chemotherapy	\$0	30% after deductible (\$250 max per visit)	70% of allowable charges, and 100% of allowable charges after max of \$250 per visit	No maximum benefit	No other information.
	Dialysis	\$0	30% after deductible (\$250 max per visit)		No maximum benefit	Some services require prior authorization (approval).
	Physical and occupational therapy	\$60	No coinsurance	100% of allowable charges after copay	Up to 60 visits per year, combined	Maximum visit limits apply to Network and Non-Network Care combined.
	Speech therapy (after discharge from inpatient Hospital admission)	\$60	No coinsurance	100% of allowable charges after copay	Up to 30 visits per year	Some services require prior authorization (approval).
	Cardio/pulmonary rehab (after discharge from inpatient hospital admission)	\$0	30% after deductible	70% of allowable charges after deductible	Up to 60 visits per year, combined	Some services require prior authorization (approval).

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Outpatient Services in a Hospital (continued)	Outpatient surgery	\$0	30% after deductible	70% of allowable charges after deductible	No maximum benefit	Some services require prior authorization (approval).
	Diabetes education	\$0	No coinsurance	100% of allowable charges		
	Sleep study	\$0	30% after deductible	70% of allowable charges after deductible		
	All other outpatient hospital services					
Ambulance	Ground	\$0	30% after deductible	70% of allowable charges after deductible	Limited to 2 trips per year	No other information.
	Air	\$0	20% after deductible	80% of allowable charges after deductible	No maximum benefit	
Emergency Room vs. Urgent Care	Emergency room	\$200 per visit	No coinsurance	100% of allowable charges after copay, including all other covered ER services, as well as lab and X-ray	No maximum benefit	Tip: please go to the Urgent Care for non-life threatening issues. Copay waived if admitted.
	Urgent care	\$50 per visit	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
In-Network Hospital (in-patient)	Inpatient stay	\$0	30% after deductible	70% of allowable charges after deductible	No maximum benefit	Some services require prior authorization (approval). Tip: Call the Customer Service Office at 855-405-3863 to make sure your hospital is in the BCBS Network.
	Obstetrics					
	Skilled nursing facility	\$0	30% after deductible	70% of allowable charges after deductible	30 days per year	
	Inpatient rehabilitation					
	Surgery/anesthesia	\$0	30% after deductible	70% of allowable charges after deductible	No maximum benefit	

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information	
Mental Health and Addictions	Outpatient therapy	\$25	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization (approval). Call the Customer Service Office at 855-405-3863 .	
	Inpatient	\$0	30% after deductible	70% of allowable charges after deductible			
	Residential treatment						
	Partial hospital admission	\$0	No coinsurance	100% of allowable charges			
	Intensive outpatient program						
Breast Care at a Free-Standing Facility*	Preventive (annual mammogram)	\$0	No coinsurance	100% of allowable charges	No maximum benefit	No other information.	
	Mammogram-Additional Views						
	Diagnostic mammogram	\$25	No coinsurance	100% of allowable charges after copay	No maximum benefit		
	Breast ultrasound	\$25					
	Breast MRI	\$175					
	Needle-guided breast biopsy under ultrasound	\$0	20% after deductible	80% of allowable charges after deductible			
	*Needle-guided breast biopsy under ultrasound when performed in a physician's office	\$0					
	Needle-guided breast biopsy under CT Scan	\$0					

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information	
Other Services	Home Healthcare	\$0	No coinsurance	100% of allowable charges	Maximum benefit of up to 30 visits per calendar year	Maximum visit limits apply to Network and Non-Network care, combined.	
	Home Infusion Therapy	\$0	No coinsurance	100% of allowable charges	No maximum benefit	No other information.	
	Hospice						
	Diabetic shoes	\$0	25% after deductible	75% of allowable charges after deductible	No maximum benefit		
	Mastectomy bras	\$0	25% after deductible	75% of allowable charges after deductible	Up to 6 per year		
	Compression stockings	\$0	25% after deductible	75% of allowable charges after deductible	Up to 12 pairs per year		Requires prior authorization if over \$500.
	Orthotic shoe inserts	\$0	No coinsurance	100% of allowable charges after copay	\$500 every 24 months		No out-of-network benefit.
	Durable medical equipment and medical supplies	\$0	25% after deductible	75% of allowable charges after deductible	No maximum benefit		Prior Authorization (approval) is required for items over \$500.

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Other Services (continued)	Medical Foods	\$0	No coinsurance	100% reimbursement	No maximum benefit	Same benefit for out-of-network services. Requires medical review.
	Prosthetic and orthotic appliances	\$0	30% after deductible	70% of allowable charges after deductible	No maximum benefit	Prior Authorization (approval) is required.
	Lenses and frames	\$25	No coinsurance	100% of allowable charges after copay \$175 maximum allowance will apply to frames and lenses	Every 12 months	Covered under the vision plan.
	Contact lenses (instead of glasses)	\$0 for contacts Up to \$50 for fitting and evaluation	No coinsurance	\$175 maximum allowance	Every 12 months	



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