

Your 2014 Medical Benefit Chart Local PPO Plan 5P

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Doctor and Hospital Choice</p> <p>You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral. However, some benefits may require authorization.</p>		
<p>Annual Deductible</p> <ul style="list-style-type: none"> The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied. 	<p>\$0</p> <p>Combined in-network and out-of-network</p>	
Inpatient services		
<p>Inpatient hospital care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Semi-private room (or a private room if medically necessary) Meals including special diets Regular nursing services Costs of special care units (such as intensive or coronary care units) Drugs and medications Lab tests X-rays and other radiology services Necessary surgical and medical supplies Use of appliances, such as wheelchairs Operating and recovery room costs 	<p>Prior authorization is required for elective inpatient acute and long term admissions as well as rehabilitation, substance abuse, and Medicare-covered inpatient transplant admissions.</p> <p>For Medicare-covered hospital stays:</p> <p>\$100 copay per admission</p>	<p>Providers are encouraged to call the plan for a predetermination of coverage for elective, inpatient acute and long term admissions as well as rehabilitation, substance abuse, and Medicare-covered inpatient transplant admissions.</p> <p>For Medicare-covered hospital stays:</p> <p>\$100 copay per admission</p>

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<p>Inpatient hospital care (con't)</p> <ul style="list-style-type: none"> Physical therapy, occupational therapy, and speech language therapy Inpatient substance abuse services Inpatient dialysis (if you are admitted as an inpatient to a hospital for special care) <p>Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.</p> <p>If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If the plan provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) \$50 per day per covered person up to a maximum of \$100 per day per covered person consistent with IRS guidelines.</p> <ul style="list-style-type: none"> Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. Physician services <p>In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital or acute rehabilitation center.</p>	<p>The inpatient hospital out-of-pocket maximum is \$300 per year combined with inpatient mental health care and combined in-network and out-of-network.</p> <p>No limit to the number of days covered by the plan each benefit period</p> <p>\$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay</p>	<p>The inpatient hospital out-of-pocket maximum is \$300 per year combined with inpatient mental health care and combined in-network and out-of-network.</p> <p>No limit to the number of days covered by the plan each benefit period</p> <p>\$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.</p>

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<p>Inpatient hospital care (con't)</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.</p> <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>		

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<p>Inpatient mental health care</p> <p>Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital.</p> <p>In-network providers should notify us within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital or acute rehabilitation center.</p>	<p>For Medicare-covered hospital stays:</p> <p>Prior authorization is required for mental nervous and mental nervous rehabilitation admissions.</p> <p>\$100 copay per admission</p> <p>The inpatient mental health care out-of-pocket maximum is \$300 per year combined with inpatient hospital care and combined in-network and out-of-network.</p> <p>No limit to the number of days covered by the plan each benefit period</p> <p>\$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay</p>	<p>For Medicare-covered hospital stays:</p> <p>Providers are encouraged to call the plan for a predetermination of coverage for elective inpatient admissions.</p> <p>\$100 copay per admission</p> <p>The inpatient mental health care out-of-pocket maximum is \$300 per year combined with inpatient hospital care and combined in-network and out-of-network.</p> <p>No limit to the number of days covered by the plan each benefit period</p> <p>\$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay</p>

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<p>Skilled nursing facility (SNF) care</p> <p>Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A “benefit period” begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech language therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors) • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will receive your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn’t a plan provider, if the facility accepts our plan’s amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) 	<p>Prior authorization is required for SNF services.</p> <p>For Medicare-covered SNF stays:</p> <p>\$125 copay per admission</p> <p>No prior hospital stay required.</p>	<p>Providers are encouraged to call the plan for a predetermination of coverage for SNF.</p> <p>For Medicare-covered SNF stays:</p> <p>\$125 copay per admission</p> <p>No prior hospital stay required.</p>

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<p>Skilled nursing facility (SNF) care (con't)</p> <ul style="list-style-type: none"> • A SNF where your spouse is living at the time you leave the hospital. • In-network providers should notify us within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility. 		
<p>Inpatient services covered when the hospital or SNF days are not covered or are no longer covered</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF) stay.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetic and orthotic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back and neck braces; trusses and artificial legs, arms and eyes including adjustments, repairs and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, occupational therapy and speech language therapy 	<p>After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefit chart at the deductible and/or cost share amounts indicated.</p>	

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<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech language therapy • Medical and social services • Medical equipment and supplies 	<p>Prior authorization may be required for home health therapy services.</p> <p>\$0 copay for Medicare-covered home health visits</p> <p>DME copay or coinsurance, if any, may apply.</p>	<p>Prior authorization is requested for home health therapy services.</p> <p>\$0 copay for Medicare-covered home health visits</p> <p>DME copay or coinsurance, if any, may apply.</p>

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Important information	In-Network	Out-of-Network
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be an in-network provider or an out-of-network provider.</p> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal condition:</u> Original Medicare (rather than this plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Medicare for the services that Original Medicare pays for.</p> <p>Services covered by Original Medicare include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal condition:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a provider in our plan's network:</p> <ul style="list-style-type: none"> • If you obtain the covered services from an in-network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services <p><u>For services that are covered by this plan but are not covered by Medicare Part A or B:</u> This plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your plan cost-sharing amount for these services.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our in-network providers will lower your share of the costs for the services.</p>	<p>You must receive care from a Medicare-certified hospice.</p> <p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not this plan.</p> <p>\$20 copay for the one time only hospice consultation</p>	<p>You must receive care from a Medicare-certified hospice.</p> <p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not this plan.</p> <p>\$20 copay for the one time only hospice consultation</p>

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Important information		
Outpatient services		
<p>Physician services, including doctor’s office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Office visits, including medical and surgical services in a physician’s office • Consultation, diagnosis and treatment by a specialist • Retail health clinics • Basic diagnostic hearing and balance exams, if your doctor orders it to see if you need medical treatment, when furnished by a physician, audiologist, or other qualified provider • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion by another in-network provider prior to surgery • Physician services rendered in the home • Outpatient hospital services • Non–routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Allergy testing and allergy injections 	<p>\$5 copay per visit to an in-network primary care physician (PCP) for Medicare-covered services</p> <p>\$20 copay per visit to an in-network specialist for Medicare-covered services</p> <p>\$5 copay per visit to an in-network retail health clinic for Medicare-covered services</p> <p>\$0 copay for Medicare-covered allergy testing</p> <p>\$0 copay for Medicare-covered allergy injections</p>	<p>\$5 copay per visit to an out-of-network primary care physician (PCP) for Medicare-covered services</p> <p>\$20 copay per visit to an out-of-network specialist for Medicare-covered services</p> <p>\$5 copay per visit to an out-of-network retail health clinic for Medicare-covered services</p> <p>\$0 copay for Medicare-covered allergy testing</p> <p>\$0 copay for Medicare-covered allergy injections</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation 	<p>Prior authorization may be required for chiropractic services.</p> <p>\$20 copay for each Medicare-covered visit</p>	<p>Prior authorization may be requested for chiropractic services.</p> <p>\$20 copay for each Medicare-covered visit</p>

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Important information	In-Network	Out-of-Network
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment in an office setting, of injuries and disease of the feet (such as hammer toe or heel spurs) • Medicare-covered routine foot care for members with certain medical conditions affecting the lower limbs. • A foot exam is covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations. 	<p>\$20 copay for each Medicare-covered visit</p>	<p>\$20 copay for each Medicare-covered visit</p>
<p>Outpatient mental health care, including partial hospitalization services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>Prior authorization is required for intensive outpatient mental health service. Prior authorization is required for partial hospitalization services related to mental health.</p> <p>\$5 copay for each Medicare-covered professional individual therapy visit</p> <p>\$5 copay for each Medicare-covered professional group therapy visit</p>	<p>Prior authorization is requested for intensive outpatient mental health service. Prior authorization is requested for partial hospitalization services related to mental health.</p> <p>\$5 copay for each Medicare-covered professional individual therapy visit</p> <p>\$5 copay for each Medicare-covered professional group therapy visit</p>

Covered services	What you must pay for these covered services	
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<p>Outpatient mental health care, including partial hospitalization services (con't)</p>	<p>\$5 copay for each Medicare-covered professional partial hospitalization visit</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility group therapy visit</p> <p>\$0 copay for each Medicare-covered partial hospitalization facility visit</p>	<p>\$5 copay for each Medicare-covered professional partial hospitalization visit</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility group therapy visit</p> <p>\$0 copay for each Medicare-covered partial hospitalization facility visit</p>

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<p>Outpatient substance abuse services, including partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>Prior authorization is required for intensive outpatient substance abuse service. Prior authorization is required for partial hospitalization services related to substance abuse.</p> <p>\$5 copay for each Medicare-covered professional individual therapy visit</p> <p>\$5 copay for each Medicare-covered professional group therapy visit</p> <p>\$5 copay for each Medicare-covered professional partial hospitalization visit</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit</p>	<p>Prior authorization is requested for intensive outpatient substance abuse service. Prior authorization is requested for partial hospitalization services related to substance abuse.</p> <p>\$5 copay for each Medicare-covered professional individual therapy visit</p> <p>\$5 copay for each Medicare-covered professional group therapy visit</p> <p>\$5 copay for each Medicare-covered professional partial hospitalization visit</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Outpatient substance abuse services, including partial hospitalization services (con't)</p>	<p>\$0 copay for each Medicare-covered outpatient hospital facility group therapy visit</p> <p>\$0 copay for each Medicare-covered partial hospitalization facility visit</p>	<p>\$0 copay for each Medicare-covered outpatient hospital facility group therapy visit</p> <p>\$0 copay for each Medicare-covered partial hospitalization facility visit</p>
<p>Outpatient surgery including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Facilities where surgical procedures are performed and the patient is released the same day.</p> <p>Note: If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>Prior authorization is required for select outpatient surgeries and procedures.</p> <p>\$50 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery</p> <p>\$50 copay for each Medicare-covered outpatient observation room visit</p>	<p>Prior authorization is requested for select outpatient surgeries and procedures.</p> <p>\$50 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery</p> <p>\$50 copay for each Medicare-covered outpatient observation room visit</p>

Covered services	What you must pay for these covered services	
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<p>Outpatient hospital services, non-surgical</p> <p>Covered services include medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>\$5 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services</p> <p>\$20 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services</p> <p>\$50 copay for each Medicare-covered outpatient observation room visit</p>	<p>\$5 copay for a visit to an out-of-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services</p> <p>\$20 copay for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services</p> <p>\$50 copay for each Medicare-covered outpatient observation room visit</p>

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	In-Network	Out-of-Network
<p>Important information</p> <p>Ambulance services</p> <ul style="list-style-type: none"> Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if the services are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health) or if authorized by the plan. Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required. Ambulance service is not covered for physician office visits. 		<p>Prior authorization for non-emergent air and water transportation is required for in-network providers and requested for out-of-network providers.</p> <p>\$50 copay for Medicare-covered ambulance services</p> <p>Cost share, if any, is applied per one-way trip for Medicare-covered ambulance services.</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> Furnished by a provider qualified to furnish emergency services, and Needed to evaluate or stabilize an emergency medical condition Emergency outpatient copay is waived if the member is admitted to the hospital within 72 hours for the same condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.</p>		<p>\$50 copay for each Medicare-covered emergency room visit</p>

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<p>Urgently needed care</p> <ul style="list-style-type: none"> • Urgently needed care is available on a worldwide basis. • The urgently needed care copay is waived if the member is admitted to the hospital within 72 hours for the same condition. <p>If you are outside of the service area for your plan, your plan covers urgently needed care, including urgently required renal dialysis. Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible. Generally, however, if you are in the plan’s service area and your health is not in serious danger, you should obtain care from an in-network provider.</p>		<p>\$20 copay for each Medicare-covered urgently needed care visit</p>

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<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>Prior authorization may be required for physical therapy, occupational therapy and speech language therapy visits.</p> <p>\$20 copay for Medicare-covered physical therapy, occupational therapy and speech language therapy visits</p>	<p>Prior authorization is requested for physical therapy, occupational therapy and speech language therapy visits.</p> <p>\$20 copay for Medicare-covered physical therapy, occupational therapy and speech language therapy visits</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>\$20 copay for Medicare-covered cardiac rehabilitation therapy visits</p>	<p>\$20 copay for Medicare-covered cardiac rehabilitation therapy visits</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.</p>	<p>\$20 copay for Medicare-covered pulmonary rehabilitation therapy visits</p>	<p>\$20 copay for Medicare-covered pulmonary rehabilitation therapy visits</p>

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<p>Durable medical equipment (DME) and related supplies</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p> <p>Copay or coinsurance only applies when you are not currently receiving inpatient care. If you are receiving inpatient care your DME will be included in the copay or coinsurance for those services.</p> <p>We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</p>	<p>Prior authorization is required for DME, including, but not limited to, power operated vehicles, power wheelchairs and accessories, non-standard wheelchairs, non-standard beds, and continuous glucose monitoring systems.</p> <p>10% coinsurance on all Medicare-covered DME</p>	<p>Prior authorization is requested for DME, including, but not limited to, power operated vehicles, power wheelchairs and accessories, non-standard wheelchairs, non-standard beds and continuous glucose monitoring systems.</p> <p>10% coinsurance on all Medicare-covered DME</p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace all or a body part or function. These include, but not limited to, colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery, see “Vision care” later in this section for more detail.</p>	<p>Prior authorization is required for prosthetics and orthotics.</p> <p>10% coinsurance on all Medicare-covered prosthetics and orthotics</p>	<p>Prior authorization is requested for prosthetics and orthotics.</p> <p>10% coinsurance on all Medicare-covered prosthetics and orthotics</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
 <p>Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users).</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, urine test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors One pair per year of therapeutic custom molded shoes (including inserts provided with such shoes) and two additional pairs of inserts or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or insert. Diabetes self-management training is covered under certain conditions. 	<p>Prior authorization is required for continuous glucose monitoring systems.</p> <p>10% coinsurance for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, urine test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors</p> <p>10% coinsurance for Medicare-covered blood glucose monitor</p> <p>10% coinsurance for Medicare-covered therapeutic shoes</p> <p>\$0 copay for Medicare-covered self-management training</p>	<p>Prior authorization is requested for continuous glucose monitoring systems.</p> <p>10% coinsurance for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, urine test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors</p> <p>10% coinsurance for Medicare-covered blood glucose monitor</p> <p>10% coinsurance for Medicare-covered therapeutic shoes</p> <p>\$0 copay for Medicare-covered self-management training</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Complex diagnostic tests and X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Testing to confirm chronic obstructive pulmonary disease (COPD) • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Other outpatient diagnostic tests <p>Certain diagnostic tests and X-rays are considered complex and include heart catheterizations, and sleep studies computed tomography (CT), magnetic resonance procedures (MRIs and MRAs) and nuclear medicine studies, which includes PET scans.</p>	<p>Prior authorization may be required for complex imaging and limited diagnostic and therapeutic radiology services, including, but not limited to radiation therapy, PET, CT, SPECT, MRI scans and echocardiograms, diagnostic laboratory tests, genetic testing, sleep studies, and related sleep study equipment and supplies.</p> <p>\$20 copay for each Medicare-covered X-ray visit and/or simple diagnostic test</p> <p>\$50 copay for Medicare-covered complex diagnostic test and/or radiology visit</p> <p>\$20 copay for each Medicare-covered radiation therapy treatment</p> <p>\$0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease</p>	<p>Prior authorization is requested for complex imaging, and limited diagnostic and therapeutic radiology services including but not limited to, radiation therapy, PET, CT, SPECT, MRI scans and echocardiograms, diagnostic laboratory tests, genetic testing, sleep studies and related sleep study equipment and supplies.</p> <p>\$20 copay for each Medicare-covered X-ray visit and/or simple diagnostic test</p> <p>\$50 copay for Medicare-covered complex diagnostic test and/or radiology visit</p> <p>\$20 copay for each Medicare-covered radiation therapy treatment</p> <p>\$0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Outpatient diagnostic tests and therapeutic services and supplies (con't)</p>	<p>10% coinsurance for Medicare-covered supplies</p> <p>\$0 copay for each Medicare-covered clinical/diagnostic lab test</p> <p>\$0 copay per Medicare-covered pint of blood</p>	<p>10% coinsurance for Medicare-covered supplies</p> <p>\$0 copay for each Medicare-covered clinical/diagnostic lab test</p> <p>\$0 copay per Medicare-covered pint of blood</p>
<p>Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes and African-Americans who are age 50 and older: glaucoma screening once per year. • An eye exam to check for diabetic retinopathy once every 12 months. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. 	<p>\$5 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye</p> <p>\$20 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye</p> <p>\$0 copay for Medicare-covered glaucoma screening</p> <p>\$5 copay for glasses/contacts following Medicare-covered cataract surgery</p>	<p>\$5 copay for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye</p> <p>\$20 copay for visits to an out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye</p> <p>\$0 copay for Medicare-covered glaucoma screening</p> <p>\$5 copay for glasses/contacts following Medicare-covered cataract surgery</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Preventive services and screening tests</p> <p> You will see this apple next to preventive services throughout this chart. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you in-network. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received. In addition, if an office visit is billed for the existing medical condition or an additional non-preventive service received, the applicable in-network primary care physician or in-network specialist copay or coinsurance will apply.</p>		
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” preventive visit.</p>	<p>\$0 copay for Medicare-covered screening</p>	<p>\$0 copay for Medicare-covered screening</p>
<p> Bone mass measurements</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months, or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>\$0 copay for Medicare-covered bone mass measurement</p>	<p>\$0 copay for Medicare-covered bone mass measurement</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p> Colorectal cancer screening and colorectal services</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy <p>Colorectal services</p> <ul style="list-style-type: none"> • Includes the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam 	<p>\$0 copay for Medicare-covered screenings and services</p>	<p>\$0 copay for Medicare-covered screenings and services</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>\$0 copay for Medicare-covered screening</p>	<p>\$0 copay for Medicare-covered screening</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
 <p>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>\$0 copay for Medicare-covered services</p>	<p>\$0 copay for Medicare-covered services</p>
 <p>Medicare Part B immunizations</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, including H1N1, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>If Part D prescription drug coverage is included with your medical plan, we also cover some vaccines under our outpatient prescription drug benefit, for example the Shingles vaccine. Please refer to your outpatient prescription drug benefits.</p>	<p>\$0 copay for Medicare-covered immunizations</p>	<p>\$0 copay for Medicare-covered immunizations</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
 Breast cancer screening (mammograms) Covered services include: <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	\$0 copay for Medicare-covered screening exams	\$0 copay for Medicare-covered screening exams
 Cervical and vaginal cancer screening Covered services include: <ul style="list-style-type: none"> • For all women, Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age, 1 Pap test every 12 months. 	\$0 copay for Medicare-covered screening exams	\$0 copay for Medicare-covered screening exams
 Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	\$0 copay for Medicare-covered screening exams	\$0 copay for Medicare-covered screening exams

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
 <p>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.</p>	<p>\$0 copay for Medicare-covered visits</p>	<p>\$0 copay for Medicare-covered visits</p>
 <p>Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>\$0 copay for Medicare-covered tests</p>	<p>\$0 copay for Medicare-covered tests</p>
 <p>“Welcome to Medicare” preventive visit</p> <p>The plan covers a one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, measurements of height, weight, body mass index, blood pressure as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>\$0 copay for Medicare-covered exam</p>	<p>\$0 copay for Medicare-covered exam</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
 <p>Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>\$0 copay for Medicare-covered visits</p>	<p>\$0 copay for Medicare-covered visits</p>
 <p>Depression screening</p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</p>	<p>\$0 copay for Medicare-covered screening</p>	<p>\$0 copay for Medicare-covered screening</p>
 <p>Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to 2 diabetes screenings every 12 months.</p>	<p>\$0 copay for Medicare-covered diabetes screening including fasting plasma glucose tests</p>	<p>\$0 copay for Medicare-covered diabetes screening including fasting plasma glucose tests</p>
 <p>Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>\$0 copay for Medicare-covered services</p>	<p>\$0 copay for Medicare-covered services</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
 <p>Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>\$0 copay for Medicare-covered services</p>	<p>\$0 copay for Medicare-covered services</p>
 <p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another plan year.</p>	<p>\$0 copay for each Medicare-covered visit</p>	<p>\$0 copay for each Medicare-covered visit</p>
 <p>Smoking and tobacco use cessation (counseling to quit smoking)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.</p>	<p>\$0 copay for each Medicare-covered visit</p>	<p>\$0 copay for each Medicare-covered visit</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Other services		
<p>Services to treat outpatient kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area) • Home dialysis or certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies and check your dialysis equipment and water supply) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, “Medicare Part B prescription drugs.”</p>	<p>No prior authorization is required, however notice is requested for all members initiating dialysis treatment.</p> <p>\$0 copay for each Medicare-covered kidney education session</p> <p>\$5 copay for Medicare-covered outpatient or physician office dialysis</p> <p>\$0 copay for Medicare-covered home dialysis or home support services</p> <p>\$5 copay for Medicare-covered self-dialysis training</p> <p>10% coinsurance for Medicare-covered home dialysis equipment and supplies</p>	<p>No prior authorization is required, however notice is requested for all members initiating dialysis treatment.</p> <p>\$0 copay for each Medicare-covered kidney education session</p> <p>\$5 copay for Medicare-covered outpatient or physician office dialysis</p> <p>\$0 copay for Medicare-covered home dialysis or home support services</p> <p>\$5 copay for Medicare-covered self-dialysis training</p> <p>10% coinsurance for Medicare-covered home dialysis equipment and supplies</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Medicare Part B prescription drugs, covered under your medical plan (Part B drugs)</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan.</p> <p>Covered drugs include:</p> <ul style="list-style-type: none"> • “Drugs” includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected or infused while receiving physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoiesis-stimulating agents (such as Erythropoietin (Epogen®), Procrit® or Epoetin Alfa and Darboetin Alfa (Aranesp®)) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>If Part D prescription drug coverage is included with your medical plan, please refer to your Evidence of Coverage for information on your Part D prescription drug benefits.</p>	<p>Prior authorization may be required for certain injectable/infusible drugs.</p> <p>20% coinsurance for Medicare-covered Part B drugs</p> <p>20% coinsurance for Medicare-covered Part B drug administration</p> <p>20% coinsurance for Medicare-covered Part B chemotherapy drugs</p> <p>20% coinsurance for Medicare-covered Part B chemotherapy drug administration</p>	<p>Prior authorization is requested for certain injectable/infusible drugs.</p> <p>20% coinsurance for Medicare-covered Part B drugs</p> <p>20% coinsurance for Medicare-covered Part B drug administration</p> <p>20% coinsurance for Medicare-covered Part B chemotherapy drugs</p> <p>20% coinsurance for Medicare-covered Part B chemotherapy drug administration</p>

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Important information		
Additional benefits		
<p>Hearing services</p> <ul style="list-style-type: none"> Routine hearing exams <p>Routine hearing exams are limited to a \$50 maximum benefit per year combined in-network and out-of-network. Routine hearing exams are limited to one per year combined in-network and out-of-network.</p>	<p>\$0 copay for routine hearing exams</p> <p>After plan paid benefits for routine hearing exams, you are responsible for the remaining cost.</p>	<p>\$0 copay for routine hearing exams</p> <p>After plan paid benefits for routine hearing exams, you are responsible for the remaining cost.</p>
<p>Routine vision care</p> <ul style="list-style-type: none"> Routine vision exams <p>Routine vision exams are limited to a \$50 maximum benefit per year combined in-network and out-of-network. Routine vision exams are limited to one per year combined in-network and out-of-network.</p>	<p>\$0 copay for routine vision exams</p> <p>After plan paid benefits for routine vision exams, you are responsible for the remaining cost.</p>	<p>\$0 copay for routine vision exams</p> <p>After plan paid benefits for routine vision exams, you are responsible for the remaining cost.</p>
<p>Routine foot care</p> <p>Up to four covered visits per year. Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails and other hygienic and preventive maintenance care.</p>	<p>\$5 copay for each visit to an in-network primary care physician for routine foot care</p> <p>\$20 copay for each visit to an in-network specialist for routine foot care</p> <p>After plan paid benefits for routine foot exams, you are responsible for the remaining cost.</p>	<p>\$5 copay for each visit to an out-of-network primary care physician for routine foot care</p> <p>\$20 copay for each visit to an out-of-network specialist for routine foot care</p> <p>After plan paid benefits for routine foot exams, you are responsible for the remaining cost.</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
 <p>Health and wellness education programs</p> <p><u>SilverSneakers®</u></p> <p>You can enroll in this fitness program provided by SilverSneakers, an independent company.</p> <p>As a member, you can participate in the SilverSneakers® Fitness Program or SilverSneakers® Steps at no additional cost. The SilverSneakers Fitness Program, designed exclusively for Medicare-eligible individuals, offers physical activity, health education and social events. With the SilverSneakers premier fitness center network, you'll have a complimentary membership with access to a variety of participating fitness centers throughout the country. Many sites offer amenities such as:</p> <ul style="list-style-type: none"> • Fitness equipment, treadmills and free weights • The signature SilverSneakers Fitness Program classes, designed specifically for older adults and taught by certified instructors • Additional signature classes, such as YogaStretch, SilverSplash®, CardioFit and WeightCircuit, available at select locations • A designated staff member to help you along the way. <p>The SilverSneakers Fitness Program is not a gym membership, but a specialized program designed specifically for seniors. Gym memberships or other fitness programs that do not meet the SilverSneakers Fitness Program criteria are excluded.</p> <p>Contact Customer Service for more information on this program, or visit www.SilverSneakers.com.</p>	<p>\$0 copay for the SilverSneakers fitness benefit</p>	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
<p>Important information</p> <p>Foreign travel emergency and urgently needed care</p> <p>Emergency or urgently needed care services while traveling outside the United States during a temporary absence of less than six months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition.</p> <ul style="list-style-type: none"> • Emergency outpatient care • Urgently needed care • Inpatient care (60 days per lifetime) <p>This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States.</p>		<p>\$50 copay for emergency care</p> <p>\$20 copay for urgently needed care</p> <p>\$100 copay per admission for emergency inpatient care</p>
<p>Medicare-approved clinical research studies</p> <p>A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study.</p> <p>If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study.</p> <p>Although not required, we ask that you notify us if you participate in a Medicare-approved research study.</p>		<p>After Original Medicare has paid its share of the Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's cost-sharing for like services.</p> <p>Any remaining plan cost-sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.</p>
<p>Annual out-of-pocket maximum</p> <p>All copays, coinsurance and deductibles listed in this benefit chart are accrued toward the medical plan out-of-pocket maximum with the exception of foreign travel emergency and urgently needed care copay or coinsurance amounts. Part D Prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.</p>		<p>\$3,400</p>