Your 2018 Medical Benefit Chart
HMO Plan 4
Auxiliary Organizations Association
Effective January 1, 2018

Covered services	What you must pay for these covered services
Doctor and hospital choice It is important to know which providers are part of our network because, with limited exceptions, you must use in-network providers while you are a member of our plan.	
Inpatient services	
Inpatient hospital care Your provider must get an approval from the plan before you are admitted to a hospital for a procedure, rehabilitation, substance abuse, or transplant that you and your doctor planned ahead. This is called getting prior authorization. All services must be coordinated by your Primary Care Physician (PCP). Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • 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 • Physical therapy, occupational therapy, and speech language therapy • Inpatient substance abuse services	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay If you receive 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.

Covered services	What you must pay for these covered services
Inpatient hospital care (con't) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • 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. 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 our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If the plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose 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. • 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 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. **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. 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 https://www.medicare.gov/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.	

Covered services	What you must pay for these covered services
Inpatient mental health care Your provider must get an approval from the plan before you are admitted to a hospital for a mental condition, drug or alcohol abuse, or rehabilitation. This is called getting prior authorization. All services must be coordinated by your Primary Care Physician (PCP). Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general 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, long term acute care hospital, or acute rehabilitation center.	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Covered services	What you must pay for these covered services
Skilled nursing facility (SNF) care Your provider must get an approval from the plan before you get skilled nursing care. This is called getting prior authorization. All services must be coordinated by your Primary Care Physician (PCP). 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. Covered services include but are not limited to: • 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 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. • 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) • 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, long term acute care hospital, or acute rehabilitation center.	For Medicare-covered SNF stays: $0 copay for days 1-100 per benefit period A three (3) day minimum prior inpatient hospital stay for a related illness is required.

Covered services	What you must pay for these covered services
Inpatient services covered when the hospital or SNF days are not covered or are no longer covered Your provider may need an approval from the plan before you get services. This is called getting prior authorization. Ask your provider or call the plan to learn more. All services must be coordinated by your Primary Care Physician (PCP). 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 a skilled nursing facility (SNF). Covered services include, but are not limited to: • 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	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 cost share amounts indicated.
Home health agency care Your provider may need an approval from the plan before you get home health care. This is called getting prior authorization. Ask your provider or call the plan to learn more. All services must be coordinated by your Primary Care Physician (PCP). 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. Covered services include, but are not limited to: • 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	$0 copay for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.

Covered services	What you must pay for these covered services
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be an in-network provider or an out-of-network provider. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than this plan) will pay for hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Medicare for the services that Original Medicare pays for. Services covered by Original Medicare include: • Drugs for symptom control and pain relief • Short-term respite care • Home care Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need nonemergency, nonurgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • 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 cost-sharing under Fee-for-Service Medicare (Original Medicare). For services that are covered by this plan but are not covered by Medicare Part A or B: 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 prognosis. You pay your plan cost-sharing amount for these services. If you have Part D prescription drug coverage, some drugs may be covered under your Part D benefit. Drugs are never covered by both hospice and your Part D plan at the same time. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $10 copay for the one time only hospice consultation

Covered services	What you must pay for these covered services
Outpatient services	
Physician services, including doctor's office visits All services must be coordinated by your Primary Care Physician (PCP). Covered services include: • Office visits, including medical and surgical services in a physician's office • Consultation, diagnosis, and treatment by a specialist • 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	$10 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services $10 copay per visit to an in-network specialist for Medicare-covered services $10 copay per visit for Medicare-covered allergy testing and treatment, including the office visit See antigen cost share in Part B drug section.

Covered services	What you must pay for these covered services
Chiropractic services Your provider may need an approval from the plan before you get chiropractic services. This is called getting prior authorization. Ask your provider or call the plan to learn more. All services must be coordinated by your Primary Care Physician (PCP). • We cover only manual manipulation of the spine to correct subluxation.	$10 copay for each Medicare-covered visit
Podiatry services All services must be coordinated by your Primary Care Physician (PCP). Covered services include: • Diagnosis and the medical or surgical treatment of injuries and disease of the feet (such as hammer toe or heel spurs), in an office setting • Medicare-covered routine foot care for members with certain medical conditions affecting the lower limbs • A foot exam covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations	$10 copay for each Medicare-covered visit

Covered services	What you must pay for these covered services
Outpatient mental health care, including partial hospitalization services Your provider must get an approval from the plan before you get intensive outpatient mental health services or partial hospitalization for mental health. This is called getting prior authorization. All services must be coordinated by your Primary Care Physician (PCP). Covered services include: • 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 "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$10 copay for each Medicare-covered professional individual therapy visit $10 copay for each Medicare-covered professional group therapy visit $10 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit

Covered services	What you must pay for these covered services
Outpatient substance abuse services, including partial hospitalization services Your provider must get an approval from the plan before you get intensive outpatient substance abuse services or partial hospitalization for substance abuse. This is called getting prior authorization. All services must be coordinated by your Primary Care Physician (PCP). "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$10 copay for each Medicare-covered professional individual therapy visit $10 copay for each Medicare-covered professional group therapy visit $10 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit

Covered services	What you must pay for these covered services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Your provider must get an approval from the plan before you get select outpatient surgeries and procedures. This is called getting prior authorization. Ask your provider or call the plan to learn more. All services must be coordinated by your Primary Care Physician (PCP). Facilities where surgical procedures are performed and the patient is released the same day. **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." 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 https://www.medicare.gov/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.	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered outpatient observation room visit
Outpatient hospital services, non-surgical All services must be coordinated by your Primary Care Physician (PCP). Covered services include medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. **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. 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 https://www.medicare.gov/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.	$10 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $10 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $0 copay for each Medicare-covered outpatient observation room visit

Covered services	What you must pay for these covered services
Ambulance services Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. This is called getting prior authorization. All nonemergent ambulance services must be coordinated by your Primary Care Physician (PCP). • Covered ambulance services include fixed wing, rotary wing, water, 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 could endanger the person's health or if authorized by the plan. • Nonemergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. • Ambulance service is not covered for physician office visits.	$0 copay for Medicare-covered ambulance services Cost share, if any, is applied per one-way trip for Medicare-covered ambulance services.
Emergency care Emergency care refers to services that are: • 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. 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. 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. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. If you receive inpatient care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at an in-network hospital.	$50 copay for each Medicare-covered emergency room visit

Covered services	What you must pay for these covered services
Urgently needed services • Urgently needed services are available on a worldwide basis. The urgently needed services copay is waived if the member is admitted to the hospital within 72 hours for the same condition. If you are outside of the service area for your plan, your plan covers urgently needed services, including urgently required renal dialysis. Urgently needed services are services provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. 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.	$10 copay for each Medicare-covered urgently needed care visit
Outpatient rehabilitation services Your provider must get an approval from the plan before you get physical therapy, occupational therapy, and speech language therapy visits. This is called getting prior authorization. All services must be coordinated by your Primary Care Physician (PCP). Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$0 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits
Cardiac rehabilitation services All services must be coordinated by your Primary Care Physician (PCP). 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 also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copay for Medicare-covered cardiac rehabilitation therapy visits

Covered services	What you must pay for these covered services
Pulmonary rehabilitation services All services must be coordinated by your Primary Care Physician (PCP). 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.	$0 copay for Medicare-covered pulmonary rehabilitation therapy visits
Durable medical equipment (DME) and related supplies Your provider must get an approval from the plan before you get DME including, but not limited to, power operated vehicles, power wheelchairs and accessories, nonstandard wheelchairs, nonstandard beds, and continuous glucose monitoring systems. This is called getting prior authorization. All services must be coordinated by your Primary Care Physician (PCP). Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital bed ordered by a provider for use at home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. 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. 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.	$0 copay on all Medicare-covered DME

Covered services	What you must pay for these covered services
Prosthetic devices and related supplies Your provider must get an approval from the plan before you get prosthetics and the supplies that go with them. This is called getting prior authorization. All services must be coordinated by your Primary Care Physician (PCP). Devices (other than dental) that replace all or a body part or function. These include, but are 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.	$0 copay on all Medicare-covered prosthetics and orthotics
Diabetes self-management training, diabetic services, and supplies Your provider must get an approval from the plan before you get continuous glucose monitoring systems. This is called getting prior authorization. All services must be coordinated by your Primary Care Physician (PCP). For all people who have diabetes (insulin and non-insulin users) Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors • Blood glucose monitors are limited to one every six months • Up to 200 blood glucose test strips for a 30-day supply • 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 inserts • Diabetes self-management training is covered under certain conditions	$10 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors $0 copay for Medicare-covered blood glucose monitor $0 copay for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training

Covered services	What you must pay for these covered services
Outpatient diagnostic tests and therapeutic services and supplies Your provider must get an approval from the plan before you get complex imaging as well as limited diagnostic and therapeutic radiology services including, but not limited to, radiation therapy, PET, CT, SPECT, MRI scans, echocardiograms, diagnostic laboratory tests, genetic testing, sleep studies, and related sleep study equipment and supplies. This is called getting prior authorization. All services must be coordinated by your Primary Care Physician (PCP). Covered services include, but are not limited to: • X-rays • Complex diagnostic tests and radiology services • 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 Certain diagnostic tests and radiology services are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans.	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test $0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease $0 copay for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood

Covered services	What you must pay for these covered services
Vision care All services must be coordinated by your Primary Care Physician (PCP). Covered services include: • 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, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic-Americans who are age 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • 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.)	$10 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $10 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening $0 copay for glasses/contacts following Medicare-covered cataract surgery

Covered services	What you must pay for these covered services
Preventive services care and screening tests  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 care or an additional non-preventive service received, the applicable in-network primary care physician or in-network specialist copay or coinsurance will apply.	
Abdominal aortic aneurysm screening All services must be coordinated by your Primary Care Physician (PCP). A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. .	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.
Bone mass measurement All services must be coordinated by your Primary Care Physician (PCP). 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.

Covered services	What you must pay for these covered services
Colorectal cancer screening and colorectal services All services must be coordinated by your Primary Care Physician (PCP). For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy Colorectal services: • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.
HIV screening All services must be coordinated by your Primary Care Physician (PCP). For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.

Covered services	What you must pay for these covered services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs All services must be coordinated by your Primary Care Physician (PCP). 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. 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Medicare Part B immunizations All services must be coordinated by your Primary Care Physician (PCP). Covered services include: • 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 **If you have Part D prescription drug coverage, some vaccines are covered under your Part D benefit (for example, the shingles vaccine). Please refer to your Part D prescription drug benefits.**	There is no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, and Hepatitis B vaccines.
Breast cancer screening (mammograms) You can get this service on your own, without a referral from your provider. Covered services include: • 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	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.

Covered services	What you must pay for these covered services
Cervical and vaginal cancer screening You can get this service on your own, without a referral from your provider. Covered services include: • For all women, Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: 1 Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Prostate cancer screening exams All services must be coordinated by your Primary Care Physician (PCP). For men age 50 and older the following are covered once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) All services must be coordinated by your Primary Care Physician (PCP). 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing All services must be coordinated by your Primary Care Physician (PCP). Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 2 years (24 months).	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every two years.

Covered services	What you must pay for these covered services
"Welcome to Medicare" preventive visit All services must be coordinated by your Primary Care Physician (PCP). 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. **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.	There is no coinsurance, copayment, or deductible for the Medicare-covered "Welcome to Medicare" preventive visit.
Annual wellness visit All services must be coordinated by your Primary Care Physician (PCP). If you've had Medicare 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. **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" preventive visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.
Depression screening All services must be coordinated by your Primary Care Physician (PCP). 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.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.

Covered services	What you must pay for these covered services
Diabetes screening All services must be coordinated by your Primary Care Physician (PCP). 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. Based on the results of these tests, you may be eligible for up to 2 diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.
Medicare Diabetes Prevention Program (MDPP) All services must be coordinated by your Primary Care Physician (PCP). MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Obesity screening and therapy to promote sustained weight loss All services must be coordinated by your Primary Care Physician (PCP). 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.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.

Covered services	What you must pay for these covered services
Screening and counseling to reduce alcohol misuse All services must be coordinated by your Primary Care Physician (PCP). We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) All services must be coordinated by your Primary Care Physician (PCP). For qualified individuals, a LDCT is covered every 12 months. **Eligible enrollees are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the enrollee must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Covered services	What you must pay for these covered services
Medical nutrition therapy All services must be coordinated by your Primary Care Physician (PCP). This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. 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.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Smoking and tobacco use cessation (counseling to quit smoking) All services must be coordinated by your Primary Care Physician (PCP). If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered services	What you must pay for these covered services
Other services	
Services to treat outpatient kidney disease and conditions You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. All services must be coordinated by your Primary Care Physician (PCP). Covered services include: • 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 and outpatient dialysis equipment and supplies 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."	$0 copay for each Medicare-covered kidney disease education session $0 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $0 copay for Medicare-covered self-dialysis training $0 copay for Medicare-covered home dialysis equipment and supplies $0 copay for Medicare-covered outpatient dialysis equipment and supplies

Covered services	What you must pay for these covered services
Medicare Part B prescription drugs covered under your medical plan (Part B drugs) Your provider must get an approval from the plan before you get certain injectable/infusible drugs. This is called getting prior authorization. Ask your provider or call the plan to learn which drugs apply. All services must be coordinated by your Primary Care Physician (PCP). These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • "Drugs" include 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 and outpatient 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 **If you have Part D prescription drug coverage, please refer to your *Evidence of Coverage* for information on your Part D prescription drug benefits.**	$0 copay for Medicare-covered Part B drugs $0 copay for Medicare-covered Part B drug administration $0 copay for Medicare-covered Part B chemotherapy drugs $0 copay for Medicare-covered Part B chemotherapy drug administration

Covered services	What you must pay for these covered services
Additional benefits	
Routine hearing services • Routine hearing exams Routine hearing exams are limited to 1 every 12 months. Routine hearing exams are limited to a $70 maximum benefit every 12 months. • Hearing aid fitting evaluations are limited to 1 per covered hearing aid • Hearing aids Hearing aids are limited to a $500 maximum benefit every 12 months. Includes digital hearing aid technology and inner ear, outer ear and over the ear models. Fitting adjustment after hearing aid is received, if necessary. For additional benefit information and to locate a HearUSA participating provider, please contact customer service. You will be directed to the dedicated HearUSA customer service line. Hearing benefit management administered by HearUSA, an independent company.	Must use a HearUSA participating provider. $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Members receive a free battery supply during the first 3 years with a 48-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids and hearing aid fitting evaluations, you are responsible for the remaining cost.

Covered services	What you must pay for these covered services

Routine vision services
• 1 routine vision exam, every 12 months
• Eyewear (excludes Medicare-covered eyewear following cataract surgery)
  • Eyeglass Frames: Allowance towards the purchase of frames, once every 24 months.
  • Eyeglass Lenses. You may receive any 1 pair of the following lens options, once every 24 months:
  • Standard single vision lenses
  • Standard bifocal lenses
  • Standard trifocal lenses
  • Contact Lenses: Allowance towards the purchase of contact lenses, once every 24 months (in lieu of glasses).
  • Elective conventional lenses
  • Elective disposable lenses
  • Non-elective contact lenses
 	
For additional benefit information and to locate a participating Blue View Vision provider, please contact customer service. You will be directed to the dedicated Blue View Vision customer service line.
	Must use a participating Blue View Vision provider.
	
	$10 copay for routine vision exam
	
	$75 allowance towards the purchase of frames
	
	$0 copay for covered eyeglass lenses
	
	$95 allowance towards the purchase of elective contact lenses
	
	Non-elective contact lenses covered in full
	
	$65 copay for progressive lenses
	
	After the plan pays benefits for routine vision exams and eyewear, you are responsible for the remaining cost.

Covered services	What you must pay for these covered services
Routine foot care • Up to 12 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.	$10 copay for each visit to an in-network primary care physician for routine foot care $10 copay for each visit to an in-network specialist for routine foot care After the plan pays benefits for routine foot care, you are responsible for the remaining cost.
Annual routine physical exam The annual routine physical exam benefit covers a standard physical exam in addition to the Medicare-covered "Welcome to Medicare" or "Annual Wellness Visit."	$0 copay for an annual physical exam

Covered services	What you must pay for these covered services
Video Doctor Visits LiveHealth Online lets you see board-certified doctors and licensed therapists/psychologists through live, two-way video on your smartphone, tablet or computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your health insurance card ready – you'll need it to answer some questions. **Sign up for Free:** • You must enter your health insurance information during enrollment, so have your card ready when you sign up. **Benefits of a video doctor visit:** • The visit is just like seeing your regular doctor face-to-face, but just by web camera. • **It's a great** option for medical care when your doctor can't see you. Board-certified doctors can help **24/7 for most types of care** and common conditions like the flu, colds, pink eye and more. • The doctor can send prescriptions to the pharmacy of your choice, if needed.[1] • If you're feeling stressed, worried or having a tough time, you can make an appointment to talk to a licensed **therapist or psychologist from your home or on the road.** In most cases, you can make an appointment and see a therapist or psychologist in four days or less.[2] Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of the Plan. 1 Prescription is prescribed based on physician recommendations and state regulations (rules). LiveHealth Online is available in most states and is expected to grow more in the near future. Please see the map at livehealthonline.com for more service area details. 2 Appointments are based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications.	$0 copay for video doctor visits using LiveHealth Online

Covered services	What you must pay for these covered services
Health and wellness education programs **SilverSneakers® by Tivity Health** The SilverSneakers fitness program is your fitness benefit. It includes: • access to 13,000+ fitness locations • use of exercise equipment • group exercise classes designed for all levels and abilities • a member website • support all along the way SilverSneakers classes are offered in fitness locations' classrooms. More than 70 SilverSneakers FLEX® class options are offered in neighborhood locations. SilverSneakers FLEX classes include Latin dance, tai chi, yoga and walking groups. Three SilverSneakers BOOM™ classes, MIND, MUSCLE and MOVE IT, offer more intense workouts inside the gym. All classes are led by certified instructors. To get started: Simply show your personal SilverSneakers ID number at the front desk of any SilverSneakers fitness location. Visit **silversneakers.com** to: • get your SilverSneakers ID number • find locations • see class descriptions If you have questions, please call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. SilverSneakers is not just a gym membership, but a specialized program designed specifically for older adults. Gym memberships or other fitness programs that do not meet the SilverSneakers criteria are excluded. The SilverSneakers fitness program is provided by Tivity Health, an independent company. Tivity Health, SilverSneakers, SilverSneakers BOOM and SilverSneakers FLEX are registered trademarks or trademarks of Tivity Health, Inc. and/or its subsidiaries and/or affiliates in the USA and/or other countries. 	$0 copay for the SilverSneakers fitness benefit

Covered services	What you must pay for these covered services
Nurse HelpLine Also, as a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. When you call our nurse line, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the Nurse HelpLine at 1-800-700-9184. TTY users should call 711. Only Nurse HelpLine is included in our plan. All other nurse access programs are excluded.	$0 copay for Nurse HelpLine
Foreign travel emergency and urgently needed services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than 12 months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. • Emergency outpatient care • Urgently needed services • Inpatient care (90 days per lifetime) 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. If you are in need of emergency care outside of the United States or its territories, you should call the Blue Cross Blue Shield Global Core Program at 800-810 BLUE or collect at 804-673-1177. Representatives are available 24 hours a day, 7 days a week, 365 days a year to assist you. When you are outside the United States or its territories, this plan provides coverage for emergency/urgent services only. This is a Supplemental Benefit and not a benefit covered under the Federal Medicare program. For more coverage, you may have the option of purchasing additional travel insurance through an authorized agency.	$50 copay for emergency care $10 copay for urgently needed services $0 copay per admission for emergency inpatient care

Covered services	What you must pay for these covered services
Additional Chiropractic services You may seek care directly from "American Specialty Health Plans of California, Inc. (ASH Plans)" participating chiropractors. No referral is required from your PCP for this benefit. However, your treatment plan may require verification of medical necessity by ASH Plans. For additional benefit information and to locate an ASH Plans participating chiropractor, please contact customer service. For Medicare non-covered chiropractic services rendered by a physician to treat a disease, illness or injury benefits include: • Diagnostic services, other than diagnostic scanning, when provided during an initial examination or re-examination; • Spinal manipulation (Adjustments); • X-rays and laboratory tests; and • Medically necessary therapy when provided in conjunction with the visit specifically for spinal or joint adjustment. • Appliances issued/billed by a chiropractor. Medicare non-covered chiropractic services provided by ASH Plans are limited to 12 visits per year. Appliances prescribed by an ASH Plans participating chiropractor are limited to a maximum benefit of $50 per year.	$5 copay per visit $5 copay for X-rays and laboratory tests $0 copay for appliances After the plan pays benefits for Medicare non-covered chiropractic services and appliances, you are responsible for the remaining cost.

Covered services	What you must pay for these covered services
Routine dental services Benefits include: Preventive Dental Services • Oral Evaluation – 1 every year. • Cleanings – 1 every 6 months. • X-rays – full mouth or panoramic, 1 every 5 years. • X-rays – bitewings, 1 every year. For additional benefit information and to locate a Liberty participating provider, please contact customer service. You will be directed to the dedicated customer service line. Dental benefit management administered by Liberty Dental, an independent company.	To receive benefits, you must use a Liberty participating provider. $0 copay for an oral evaluation $0 copay for first cleaning $40 copay for second cleaning $10 copay for full mouth/panoramic X-rays $0 copay for bitewing X-rays After the plan pays benefits for routine dental services, you are responsible for the remaining cost.
Medicare-approved clinical research studies 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. 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. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.	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. Any remaining plan cost-sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.

Covered services	What you must pay for these covered services
Annual out-of-pocket maximum All copays, coinsurance, and deductibles listed in this benefit chart are accrued toward the medical plan out-of-pocket maximum with the exception of routine hearing services, routine vision services, routine dental services and the foreign travel emergency and urgently needed services copay or coinsurance amounts. Part D prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.	$3,400