

**Your 2017 Medical Benefit Chart
HMO Plan 4
Auxiliary Organizations Association
Effective January 1, 2017**

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| Covered services | What you must pay for these covered services |
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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.

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| Inpatient services | |
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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.

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 at a distant location, you may choose to go locally or distant as long as the local transplant providers are willing to accept the Original Medicare rate. 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.
- 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 <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.

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 per admission

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.

Covered services

What you must pay for these covered services

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 your medical plan includes Part D prescription drug coverage, some drugs may be covered by your plan's Part D benefit. Drugs are never covered by both hospice and your 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. Getting your non-hospice care through our in-network providers will lower your share of the costs for 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 |
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| Outpatient services | |
| <p>Physician services, including doctor’s office visits</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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 • 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>\$10 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services</p> <p>\$10 copay per visit to an in-network specialist for Medicare-covered services</p> <p>\$10 copay per visit for Medicare-covered allergy testing and treatment, including the office visit</p> <p>See antigen cost share in Part B drug section.</p> |

| Covered services | What you must pay for these covered services |
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| <p>Chiropractic services</p> <p>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).</p> <ul style="list-style-type: none"> • We cover only manual manipulation of the spine to correct subluxation. | <p>\$10 copay for each Medicare-covered visit</p> |
| <p>Podiatry services</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 | <p>\$10 copay for each Medicare-covered 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</p> <p>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).</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>\$10 copay for each Medicare-covered professional individual therapy visit</p> <p>\$10 copay for each Medicare-covered professional group therapy visit</p> <p>\$10 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> |


| Covered services | What you must pay for these covered services |
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| <p>Outpatient substance abuse services, including partial hospitalization services</p> <p>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).</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>\$10 copay for each Medicare-covered professional individual therapy visit</p> <p>\$10 copay for each Medicare-covered professional group therapy visit</p> <p>\$10 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> |

| Covered services | What you must pay for these covered services |
|---|--|
| <p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>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).</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>\$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery</p> <p>\$0 copay for each Medicare-covered outpatient observation room visit</p> |
| <p>Outpatient hospital services, non-surgical</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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>\$10 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>\$10 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services</p> <p>\$0 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>Ambulance services</p> <p>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).</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, water, and ground ambulance services to the nearest appropriate facility that can provide care 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. | <p>\$0 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. <p>Emergency outpatient copay is waived if the member is admitted to the hospital within 72 hours for the same condition.</p> <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>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>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.</p> | <p>\$50 copay for each Medicare-covered emergency room visit</p> |

| Covered services | What you must pay for these covered services |
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| <p>Urgently needed services</p> <ul style="list-style-type: none"> Urgently needed services are available on a worldwide basis. <p>The urgently needed services copay is waived if the member is admitted to the hospital within 72 hours for the same condition.</p> <p>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.</p> | <p>\$10 copay for each Medicare-covered urgently needed care visit</p> |
| <p>Outpatient rehabilitation services</p> <p>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).</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>\$0 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits</p> |
| <p>Cardiac rehabilitation services</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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 also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p> | <p>\$0 copay for Medicare-covered cardiac rehabilitation therapy visits</p> |

| Covered services | What you must pay for these covered services |
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| <p>Pulmonary rehabilitation services</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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>\$0 copay for Medicare-covered pulmonary rehabilitation therapy visits</p> |
| <p>Durable medical equipment (DME) and related supplies</p> <p>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).</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>\$0 copay on all Medicare-covered DME</p> |

| Covered services | What you must pay for these covered services |
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| <p>Prosthetic devices and related supplies</p> <p>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).</p> <p>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.</p> | <p>\$0 copay on all Medicare-covered prosthetics and orthotics</p> |
| <p> Diabetes self-management training, diabetic services, and supplies</p> <p>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).</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 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 | <p>\$10 copay 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>\$0 copay for Medicare-covered blood glucose monitor</p> <p>\$0 copay for Medicare-covered therapeutic shoes and inserts</p> <p>\$0 copay for Medicare-covered diabetes self-management training</p> |

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, 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
- 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 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 beneficiaries 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 |
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| <p> Colorectal cancer screening and colorectal services</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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 <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years</p> <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"> • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam | <p>There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.</p> |
| <p> HIV screening</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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>There is no coinsurance, copayment, or deductible for beneficiaries eligible for the Medicare-covered preventive HIV screening.</p> |

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

| Covered services | What you must pay for these covered services |
|--|---|
| <p> Cervical and vaginal cancer screening</p> <p>You can get this service on your own, without a referral from your provider.</p> <p>Covered services include:</p> <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. | <p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p> |
| <p> Prostate cancer screening exams</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</p> <p>For men age 50 and older the following are covered once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test | <p>There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.</p> |
| <p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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>There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.</p> |
| <p> Cardiovascular disease testing</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 2 years (24 months).</p> | <p>There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every two years.</p> |

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

| Covered services | What you must pay for these covered services |
|---|---|
| <p> Diabetes screening</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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>There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.</p> |
| <p> Obesity screening and therapy to promote sustained weight loss</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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>There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.</p> |
| <p> Screening and counseling to reduce alcohol misuse</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p> |

| Covered services | What you must pay for these covered services |
|---|--|
| <p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>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.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> 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.</p> | <p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.</p> |
| <p> Medical nutrition therapy</p> <p>All services must be coordinated by your Primary Care Physician (PCP).</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>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.</p> |

Covered services

What you must pay for these covered 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 | |
| <p>Services to treat outpatient kidney disease and conditions</p> <p>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).</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 and outpatient 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>\$0 copay for each Medicare-covered kidney disease education session</p> <p>\$0 copay for Medicare-covered outpatient dialysis</p> <p>\$0 copay for Medicare-covered home dialysis or home support services</p> <p>\$0 copay for Medicare-covered self-dialysis training</p> <p>\$0 copay for Medicare-covered home dialysis equipment and supplies</p> <p>\$0 copay for Medicare-covered outpatient dialysis equipment and supplies</p> |

| Covered services | What you must pay for these covered services |
|---|---|
| <p>Medicare Part B prescription drugs covered under your medical plan (Part B drugs)</p> <p>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).</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” 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 <p>If Part D prescription drug coverage is included with your medical plan, please refer to your <i>Evidence of Coverage</i> for information on your Part D prescription drug benefits.</p> | <p>\$0 copay for Medicare-covered Part B drugs</p> <p>\$0 copay for Medicare-covered Part B drug administration</p> <p>\$0 copay for Medicare-covered Part B chemotherapy drugs</p> <p>\$0 copay for Medicare-covered Part B chemotherapy drug administration</p> |

| Covered services | What you must pay for these covered services |
|--|--|
| Additional benefits | |
| <p>Routine hearing services</p> <ul style="list-style-type: none"> • Routine hearing exams <p>Routine hearing exams are limited to 1 every 12 months. Routine hearing exams are limited to a \$70 maximum benefit every 12 months.</p> <ul style="list-style-type: none"> • Hearing aid fitting evaluations are limited to 1 per covered hearing aid • Hearing aids <p>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.</p> <p>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.</p> <p>Hearing benefit management administered by HearUSA, an independent company.</p> | <p>Must use a HearUSA participating provider.</p> <p>\$0 copay for routine hearing exams</p> <p>\$0 copay for hearing aid fitting evaluations</p> <p>\$0 copay for hearing aids</p> <p>Members receive a free battery supply during the first 3 years with a 48-cell limit per year, per hearing aid.</p> <p>After the plan pays benefits for routine hearing exams, hearing aids and hearing aid fitting evaluations, you are responsible for the remaining cost.</p> |

| Covered services | What you must pay for these covered services |
|---|--|
| <p>Routine vision services</p> <ul style="list-style-type: none"> • 1 routine vision exam, every 12 months • Eyewear (excludes Medicare-covered eyewear following cataract surgery) <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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). <ul style="list-style-type: none"> • Elective conventional lenses • Elective disposable lenses • Non-elective contact lenses <p>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.</p> | <p>Must use a participating Blue View Vision provider.</p> <p>\$10 copay for routine vision exam</p> <p>\$75 allowance towards the purchase of frames</p> <p>\$0 copay for covered eyeglass lenses</p> <p>\$95 allowance towards the purchase of elective contact lenses</p> <p>Non-elective contact lenses covered in full</p> <p>\$65 copay for progressive lenses</p> |
| <p>Routine foot care</p> <ul style="list-style-type: none"> • Up to 12 covered visits per year <p>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>\$10 copay for each visit to an in-network primary care physician for routine foot care</p> <p>\$10 copay for each visit to an in-network specialist for routine foot care</p> <p>After the plan pays benefits for routine foot care, you are responsible for the remaining cost.</p> |

| Covered services | What you must pay for these covered services |
|---|--|
| <p>Annual routine physical exam</p> <p>The annual routine physical exam benefit covers a standard physical exam in addition to the Medicare-covered “Welcome to Medicare” or “Annual Wellness Visit.”</p> | <p>\$0 copay for an annual physical exam</p> |
| <p>LiveHealth Online</p> <p>Provides convenient access to interact with a doctor via live, two-way video on a computer or mobile device (tablet or smartphone) using a free application. It can be accessed by visiting www.livehealthonline.com.</p> <p>Go to www.livehealthonline.com and click Sign Up</p> <ul style="list-style-type: none"> You must enter your health insurance information during enrollment, so have your card ready when you sign up. <p>LiveHealth Online is intended to complement face-to-face visits with a board certified physician and is available for most types of care. LiveHealth Online is available for use in two different ways:</p> <ul style="list-style-type: none"> For conditions such as colds and flu, infections, rashes, and allergies when you cannot get in to see your regular doctor, a doctor will be quickly available to see you. If you need to discuss feelings of depression, stress, or anxiousness (mood), you can schedule a future on-line appointment with a psychologist or social worker. <p>Some of the most common conditions covered through LiveHealth Online include:</p> <ul style="list-style-type: none"> - Cold & Flu symptoms such as cough, fever, and headaches - Allergies - Sinus infections - Bronchitis - Urinary tract infections - Family Health Questions | <p>\$0 copay for LiveHealth Online</p> |

Covered services

What you must pay for these covered services

LiveHealth Online (con't)

Access to this service may not be available in all states. For the most up to date list of states go to www.livehealthonline.com. If you are temporarily outside of your service area, benefits are available while in the following states: Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, and the District of Columbia.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this plan.

Covered services

What you must pay for these covered services

 **Health and wellness education programs**

Healthways SilverSneakers® Fitness

You can enroll in this free fitness program provided by Healthways, an independent company.

As a member, you can participate in SilverSneakers or SilverSneakers® Steps at no additional cost. SilverSneakers also includes FLEX – instructor-led activities that bring fitness to your favorite places outside a traditional fitness center. SilverSneakers, 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 basic membership with access to a variety of participating fitness centers throughout the country. Many sites offer amenities such as:

- Fitness equipment, free weights, and pools
- The signature SilverSneakers Fitness program classes, designed specifically for older adults and taught by certified instructors
- Additional signature classes, such as BOOM, SilverSneakers Yoga, and SilverSneakers Splash, available at select locations
- A designated staff member to help you along the way

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.

For more information on this program or to find your closest location, contact SilverSneakers at 1-888-423-4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. EST, or visit www.SilverSneakers.com.

The SilverSneakers Fitness Program provided by Healthways, Inc., an independent company. SilverSneakers® is a registered mark of Healthways, Inc.

\$0 copay for the SilverSneakers fitness benefit

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

| Covered services | What you must pay for these covered services |
|--|---|
| <p>Foreign travel emergency and urgently needed services</p> <p>Emergency or urgently needed care services while traveling outside the United States 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.</p> <ul style="list-style-type: none"> • Emergency outpatient care • Urgently needed services • Inpatient care (90 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>If you are in need of emergency care outside of the United States, you should call the BlueCard Worldwide 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.</p> <p>When you are outside the United States, 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.</p> | <p>\$50 copay for emergency care</p> <p>\$10 copay for urgently needed services</p> <p>\$0 copay per admission for emergency inpatient care</p> |
| <p>Additional Chiropractic services</p> <p>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.</p> <p>For additional benefit information and to locate an ASH Plans participating chiropractor, please contact customer service.</p> <p>For Medicare non-covered chiropractic services rendered by a physician to treat a disease, illness or injury benefits include:</p> <ul style="list-style-type: none"> • 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. | <p>\$5 copay per visit</p> <p>\$5 copay for X-rays and laboratory tests</p> <p>\$0 copay for appliances</p> <p>After the plan pays benefits for chiropractic services and appliances, you are responsible for the remaining cost.</p> |

| Covered services | What you must pay for these covered services |
|---|---|
| <p>Additional Chiropractic services (con't)</p> <ul style="list-style-type: none"> • Appliances issued/billed by a chiropractor. <p>Medicare non-covered chiropractic services provided by ASH Plans are limited to 12 visits per year.</p> <p>Appliances prescribed by an ASH Plans participating chiropractor are limited to a maximum benefit of \$50 per year.</p> | |
| <p>Routine dental services</p> <p>Benefits include:</p> <p>Preventive Dental Services</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>Dental benefit management administered by Liberty Dental, an independent company.</p> | <p>To receive benefits, you must use a Liberty participating provider.</p> <p>\$0 copay for an oral evaluation</p> <p>\$0 copay for first cleaning</p> <p>\$40 copay for second cleaning</p> <p>\$10 copay for full mouth/panoramic X-rays</p> <p>\$0 copay for bitewing X-rays</p> |

| Covered services | What you must pay for these covered services |
|--|---|
| <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 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.</p> | <p>\$3,400</p> |

Benefit Chart

This Benefit Chart (sometimes called Schedule of Benefits) describes the costs you must pay after benefits are provided under this Certificate and your Group Part D plan. For a more detailed explanation of the benefits provided, please refer to the appropriate sections of this Certificate.

| | |
|-----------------------------|--|
| Benefit Period | January 1, 2017 – December 31, 2017 |
| Formulary | Open |
| Deductible | \$0 |
| Covered Services | What you pay |
| Part D Covered Drugs | |

After you have met your deductible, if you have one, and benefits have been paid by your Group Part D plan and this plan for covered drugs, you will be responsible for the amounts shown below.

| Retail Pharmacy | per 30-day supply (Specialty limited to a 30-day supply) |
|--|---|
| <ul style="list-style-type: none"> • Select Generics | \$0 copay |
| <ul style="list-style-type: none"> • Generics | \$10 copay |
| <ul style="list-style-type: none"> • Preferred Brands | \$20 copay |
| <ul style="list-style-type: none"> • Non-Preferred Brands and Non-Formulary Drugs | \$40 copay |

Typically retail pharmacies dispense a 30-day supply of medication. Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.

| Mail-Order Pharmacy | per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies) |
|--|--|
| <ul style="list-style-type: none"> • Select Generics | \$0 copay |
| <ul style="list-style-type: none"> • Generics | \$20 copay |
| <ul style="list-style-type: none"> • Preferred Brands | \$40 copay |
| <ul style="list-style-type: none"> • Non-Preferred Brands and Non-Formulary Drugs | \$80 copay |

Extra Covered Drugs

These drugs are excluded by law from Part D plans. These drugs are covered by your Senior Rx Plus plan. If you have a deductible, the deductible does not apply to these drugs.

| | |
|---|--|
| Cough and Cold DESI Vitamins and Minerals Lifestyle Drugs, including Erectile Dysfunction (ED) | Copay or coinsurance per 30-day supply |
| • Generics | \$10 copay |
| • Preferred Brands | \$20 copay |
| • Non-Preferred Brands | \$40 copay |

Extra Covered Drugs – California

These are drugs that are covered on plans issued in California. These drugs are often excluded from Part D plans. These drugs are covered by your Senior Rx Plus plan. If you have a deductible, the deductible does not apply to these drugs.

| | |
|------------------------------|---|
| Contraceptive Devices | Copay or coinsurance per Covered Device |
| • Prescription | \$20 copay |

Your 2017 Prescription Drug Benefit Chart 10/20/40 (with Senior Rx Plus)

Your retiree drug coverage includes Medicare Part D drug benefits and non-Medicare supplemental drug benefits. The cost shown below is what you pay after all benefits under your retiree drug coverage have been provided.

| | |
|-------------------------|---------------------|
| Formulary | Open |
| Deductible | \$0 |
| Covered Services | What you pay |

Part D Initial Coverage

Below is your payment responsibility from the time you meet your deductible, if you have one, until the amount paid by you and the Coverage Gap Discount Program for covered Part D prescriptions reaches your True Out of Pocket limit of \$4,950.

| Retail Pharmacy | per 30-day supply (Specialty limited to a 30-day supply) |
|--|---|
| <ul style="list-style-type: none"> • Select Generics • Generics | \$0 copay \$10 copay |
| <ul style="list-style-type: none"> • Preferred Brands | \$20 copay |
| <ul style="list-style-type: none"> • Non-Preferred Brands and Non-Formulary Drugs | \$40 copay |

Typically retail pharmacies dispense a 30-day supply of medication. Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.

| Mail-Order Pharmacy | per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies) |
|--|--|
| <ul style="list-style-type: none"> • Select Generics • Generics | \$0 copay \$20 copay |
| <ul style="list-style-type: none"> • Preferred Brands | \$40 copay |
| <ul style="list-style-type: none"> • Non-Preferred Brands and Non-Formulary Drugs | \$80 copay |

| Covered Services | What you pay |
|---|---|
| Part D Catastrophic Coverage | |
| Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of \$4,950. | |
| <ul style="list-style-type: none"> Select Generics | \$0 copay |
| <ul style="list-style-type: none"> Generic Drugs | 5% coinsurance with a minimum copay of \$3.30 and a maximum copay of \$10.00 (Specialty limited to a 30-day supply) |
| <ul style="list-style-type: none"> Brand-Name Drugs | 5% coinsurance with a minimum copay of \$8.25 and a maximum copay of \$20.00 (Specialty limited to a 30-day supply) |
| Extra Covered Drugs | |
| These are drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays. These drugs are covered by your Senior Rx Plus benefits. | |
| Cough and Cold DESI Vitamins and Minerals Lifestyle drugs, including Erectile Dysfunction (ED) | See Formulary for complete list of drugs covered |
| <ul style="list-style-type: none"> Generics | You pay your Retail or Mail-Order copay |
| <ul style="list-style-type: none"> Preferred Brands | You pay your Retail or Mail-Order copay |
| <ul style="list-style-type: none"> Non-Preferred Brands | You pay your Retail or Mail-Order copay |
| Extra Covered Drugs - California | |
| These are drugs that are covered on retiree drug plans issued in California. These drugs are often excluded from Part D coverage, but are covered by your Senior Rx Plus benefits. If you have a deductible, it does not apply to these drugs. | |
| Contraceptive Devices | Copay or coinsurance per Covered Device |
| <ul style="list-style-type: none"> Prescription | \$20 copay |

- Vaccines:** Medicare covers some vaccines under Part B medical coverage and other vaccines under Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever, and Hepatitis A are covered under Medicare drug coverage. Hepatitis B is covered under medical coverage if you fall into a high risk category and under drug coverage for everyone else. Other common vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65.
- Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits and the Coverage Gap Discount. The copay or coinsurance shown in this benefit chart is the amount you pay for covered drugs filled at network pharmacies.