Your 2018 Medical Benefit Chart
Local PPO Plan 15P

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Doctor and hospital choice You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral. However, some benefits may require authorization.		
Annual deductible • The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	$150 Combined in-network and out-of-network	
Inpatient services		
Inpatient hospital care 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	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.	You or your provider are encouraged to get prior 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. Claims received without approval are subject to review and may include a medical necessity evaluation.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • Operating and recovery room costs • Physical therapy, occupational therapy, and speech language therapy • Inpatient substance abuse services • 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	For Medicare-covered hospital stays: $500 copay per admission Deductible applies. The inpatient hospital out-of-pocket maximum is $1,500 per year combined with inpatient mental health care and combined in-network and out-of-network. 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 Deductible applies.	For Medicare-covered hospital stays: $500 copay per admission Deductible applies. The inpatient hospital out-of-pocket maximum is $1,500 per year combined with inpatient mental health care and combined in-network and out-of-network. 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 Deductible applies. 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	
	In-Network	Out-of-Network
Inpatient hospital care (con't) 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/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	
	In-Network	Out-of-Network
Inpatient mental health care 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.	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. For Medicare-covered hospital stays: $500 copay per admission Deductible applies. The inpatient mental health care out-of-pocket maximum is $1,500 per year combined with inpatient hospital care and combined in-network and out-of-network. No limit to the number of days covered by the plan.	You or your provider are encouraged to get prior approval from the plan before you are admitted to a hospital for a mental condition, drug or alcohol abuse, or rehabilitation. Claims received without approval are subject to review and may include a medical necessity evaluation. For Medicare-covered hospital stays: $500 copay per admission Deductible applies. The inpatient mental health care out-of-pocket maximum is $1,500 per year combined with inpatient hospital care and combined in-network and out-of-network. No limit to the number of days covered by the plan.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient mental health care (con't)	$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay Deductible applies.	$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care 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)	Your provider must get an approval from the plan before you get skilled nursing care. This is called getting prior authorization. For Medicare-covered SNF stays: $0 copay for days 1-20 and $25 copay per day for days 21-100 per benefit period Deductible applies. No prior hospital stay required.	You or your provider are encouraged to get prior approval from the plan before you get skilled nursing care. Claims received without approval are subject to review and may include a medical necessity evaluation. For Medicare-covered SNF stays: $0 copay for days 1-20 and $25 copay per day for days 21-100 per benefit period Deductible applies. No prior hospital stay required.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (con't) • 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.		
Inpatient services covered when the hospital or SNF days are not covered or are no longer covered 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	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. After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefit chart at the deductible and/or cost share amounts indicated.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home health agency care 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	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. $0 copay for Medicare-covered home health visits Deductible applies. Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	You or your provider are encouraged to get prior approval from the plan before you get home health care. Claims received without approval are subject to review and may include a medical necessity evaluation. $0 copay for Medicare-covered home health visits Deductible applies. Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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 your 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 plan cost-sharing for out-of-network 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. $30 copay for the one time only hospice consultation Deductible does not apply.	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. $30 copay for the one time only hospice consultation Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Hospice care (con't) <u>For services that are covered by this plan but are not covered by Medicare Part A or B:</u> This plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal 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.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient services		
Physician services, including doctor's office visits Covered services include: • Office visits, including medical and surgical services in a physician's office • Consultation, diagnosis, and treatment by a specialist • Retail health clinics • Basic diagnostic hearing and balance exams, if your doctor orders it to see if you need medical treatment, when furnished by a physician, audiologist, or other qualified provider	You may need an approval from the plan before you get care. This is called getting prior authorization. Ask your provider or call the plan to learn more.	You or your provider are encouraged to get prior approval from the plan before you get care. Claims received without approval are subject to review and may include a medical necessity evaluation.
• 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	$15 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services Deductible applies. $30 copay per visit to an in-network specialist for Medicare-covered services Deductible applies. $15 copay per visit to an in-network retail health clinic for Medicare-covered services Deductible applies. $0 copay for Medicare-covered allergy testing Deductible applies.	$15 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services Deductible applies. $30 copay per visit to an out-of-network specialist for Medicare-covered services Deductible applies. $15 copay per visit to an out-of-network retail health clinic for Medicare-covered services Deductible applies. $0 copay for Medicare-covered allergy testing Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Physician services, including doctor's office visits (con't)	$0 copay for Medicare-covered allergy injections Deductible applies. See antigen cost share in Part B drug section.	$0 copay for Medicare-covered allergy injections Deductible applies. See antigen cost share in Part B drug section.
Chiropractic services • We cover only manual manipulation of the spine to correct subluxation.	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. $20 copay for each Medicare-covered visit Deductible applies.	You or your provider are encouraged to get prior approval from the plan before you get chiropractic services. Claims received without approval are subject to review and may include a medical necessity evaluation. $20 copay for each Medicare-covered visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Podiatry services 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	Your provider must get an approval from the plan before you get podiatry services. This is called getting prior authorization. $30 copay for each Medicare-covered visit Deductible applies.	You or your provider are encouraged to get prior approval from the plan before you get podiatry services. Claims received without approval are subject to review and may include a medical necessity evaluation. $30 copay for each Medicare-covered visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services 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.	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. $30 copay for each Medicare-covered professional individual therapy visit Deductible applies. $30 copay for each Medicare-covered professional group therapy visit Deductible applies. $30 copay for each Medicare-covered professional partial hospitalization visit Deductible applies.	You or your provider are encouraged to get prior approval from the plan before you get intensive outpatient mental health services or partial hospitalization for mental health. Claims received without approval are subject to review and may include a medical necessity evaluation. $30 copay for each Medicare-covered professional individual therapy visit Deductible applies. $30 copay for each Medicare-covered professional group therapy visit Deductible applies. $30 copay for each Medicare-covered professional partial hospitalization visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services (con't)	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies. $0 copay for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies. $0 copay for each Medicare-covered partial hospitalization facility visit Deductible applies.	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies. $0 copay for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies. $0 copay for each Medicare-covered partial hospitalization facility visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient substance abuse services, including partial hospitalization services "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.	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. $30 copay for each Medicare-covered professional individual therapy visit Deductible applies. $30 copay for each Medicare-covered professional group therapy visit Deductible applies. $30 copay for each Medicare-covered professional partial hospitalization visit Deductible applies.	You or your provider are encouraged to get prior approval from the plan before you get intensive outpatient substance abuse services or partial hospitalization for substance abuse. Claims received without approval are subject to review and may include a medical necessity evaluation. $30 copay for each Medicare-covered professional individual therapy visit Deductible applies. $30 copay for each Medicare-covered professional group therapy visit Deductible applies. $30 copay for each Medicare-covered professional partial hospitalization visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient substance abuse services, including partial hospitalization services (con't)	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies. $0 copay for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies. $0 copay for each Medicare-covered partial hospitalization facility visit Deductible applies.	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies. $0 copay for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies. $0 copay for each Medicare-covered partial hospitalization facility visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers 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/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.	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. $150 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery Deductible applies. $150 copay for each Medicare-covered outpatient observation room visit Deductible applies.	You or your provider are encouraged to get prior approval from the plan before you get select outpatient surgeries and procedures. Claims received without approval are subject to review and may include a medical necessity evaluation. $150 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery Deductible applies. $150 copay for each Medicare-covered outpatient observation room visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient hospital services, non-surgical 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/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.	You may need an approval from the plan before you get care. This is called getting prior authorization. Ask your provider or call the plan to learn more. $15 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies. $30 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies. $150 copay for each Medicare-covered outpatient observation room visit Deductible applies.	You or your provider are encouraged to get prior approval from the plan before you get care. Claims received without approval are subject to review and may include a medical necessity evaluation. $15 copay for a visit to an out-of-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies. $30 copay for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies. $150 copay for each Medicare-covered outpatient observation room visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Ambulance services • 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.	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. $75 copay for Medicare-covered ambulance services Deductible does not apply. Cost share, if any, is applied per one-way trip for Medicare-covered ambulance services.	For out-of-network providers, you or your provider are encouraged to get prior approval from the plan for ground, air, or water transportation that is not an emergency. Claims received without approval are subject to review and may include a medical necessity evaluation.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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 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.	$75 copay for each Medicare-covered emergency room visit Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	$30 copay for each Medicare-covered urgently needed care visit Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient rehabilitation services 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).	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. $30 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits Deductible applies.	You or your provider are encouraged to get prior approval from the plan before you get physical therapy, occupational therapy, and speech language therapy visits. Claims received without approval are subject to review and may include a medical necessity evaluation. $30 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Cardiac rehabilitation services 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.	Your provider may need an approval from the plan before you get cardiac rehabilitation services. This is called getting prior authorization. Ask your provider or call the plan to learn more. $30 copay for Medicare-covered cardiac rehabilitation therapy visits Deductible applies.	You or your provider are encouraged to get prior approval from the plan before you get cardiac rehabilitation services. Claims received without approval are subject to review and may include a medical necessity evaluation. $30 copay for Medicare-covered cardiac rehabilitation therapy visits Deductible applies.
Pulmonary rehabilitation services 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.	Your provider must get an approval from the plan before you get pulmonary rehabilitation services. This is called getting prior authorization. $30 copay for Medicare-covered pulmonary rehabilitation therapy visits Deductible applies.	You or your provider are encouraged to get prior approval from the plan for pulmonary rehabilitation services. Claims received without approval are subject to review and may include a medical necessity evaluation. $30 copay for Medicare-covered pulmonary rehabilitation therapy visits Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Durable medical equipment (DME) and related supplies 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.	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. 10% coinsurance on all Medicare-covered DME Deductible applies.	You or your provider are encouraged to get prior 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. Claims received without approval are subject to review and may include a medical necessity evaluation. 10% coinsurance on all Medicare-covered DME Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Prosthetic devices and related supplies 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.	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. 10% coinsurance on all Medicare-covered prosthetics and orthotics Deductible applies.	You or your provider are encouraged to get prior approval from the plan before you get prosthetics and the supplies that go with them. Claims received without approval are subject to review and may include a medical necessity evaluation. 10% coinsurance on all Medicare-covered prosthetics and orthotics Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Diabetes self-management training, diabetic services, and supplies 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	Your provider must get an approval from the plan before you get continuous glucose monitoring systems. This is called getting prior authorization. 10% coinsurance 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 Deductible applies except for items purchased at a pharmacy. 10% coinsurance for Medicare-covered blood glucose monitor Deductible applies except for items purchased at a pharmacy.	You or your provider are encouraged to get prior approval from the plan before you get continuous glucose monitoring systems. Claims received without approval are subject to review and may include a medical necessity evaluation. 10% coinsurance 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 Deductible applies except for items purchased at a pharmacy. 10% coinsurance for Medicare-covered blood glucose monitor Deductible applies except for items purchased at a pharmacy.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Diabetes self-management training, diabetic services and supplies (con't)	10% coinsurance for Medicare-covered therapeutic shoes and inserts Deductible applies. $0 copay for Medicare-covered diabetes self-management training Deductible does not apply.	10% coinsurance for Medicare-covered therapeutic shoes and inserts Deductible applies. $0 copay for Medicare-covered diabetes self-management training Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies 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.	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. $30 copay for each Medicare-covered X-ray visit and/or simple diagnostic test Deductible applies. $75 copay for Medicare-covered complex diagnostic test and/or radiology visit Deductible applies.	You or your provider are encouraged to get prior 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 and echocardiograms, diagnostic laboratory tests, genetic testing, sleep studies, and related sleep study equipment and supplies. Claims received without approval are subject to review and may include a medical necessity evaluation. $30 copay for each Medicare-covered X-ray visit and/or simple diagnostic test Deductible applies. $75 copay for Medicare-covered complex diagnostic test and/or radiology visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies (con't)	$30 copay for each Medicare-covered radiation therapy treatment Deductible applies. $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease Deductible does not apply. 10% coinsurance for Medicare-covered supplies Deductible applies. $0 copay for each Medicare-covered clinical/diagnostic lab test Deductible applies. $0 copay per Medicare-covered pint of blood Deductible does not apply.	$30 copay for each Medicare-covered radiation therapy treatment Deductible applies. $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease Deductible does not apply. 10% coinsurance for Medicare-covered supplies Deductible applies. $0 copay for each Medicare-covered clinical/diagnostic lab test Deductible applies. $0 copay per Medicare-covered pint of blood Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Vision care 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.)	$15 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye Deductible applies. $30 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye Deductible applies. $0 copay for Medicare-covered glaucoma screening Deductible does not apply. $0 copay for Medicare-covered diabetic retinopathy screening Deductible does not apply. 20% coinsurance for glasses/contacts following Medicare-covered cataract surgery Deductible applies.	$15 copay for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye Deductible applies. $30 copay for visits to an out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye Deductible applies. $0 copay for Medicare-covered glaucoma screening Deductible does not apply. $0 copay for Medicare-covered diabetic retinopathy screening Deductible does not apply. 20% coinsurance for glasses/contacts following Medicare-covered cataract surgery Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening. Deductible does not apply.
Bone mass measurement 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Colorectal cancer screening and colorectal services 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 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services. Deductible does not apply.
HIV screening 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. Deductible does not apply.
Medicare Part B immunizations 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, and Hepatitis B vaccines. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Breast cancer screening (mammograms) 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms. Deductible does not apply.
Cervical and vaginal cancer screening 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. Deductible does not apply.
Prostate cancer screening exams 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit. Deductible does not apply.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years. Deductible does not apply.	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years. Deductible does not apply.
"Welcome to Medicare" preventive visit 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered "Welcome to Medicare" preventive visit. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Annual wellness visit 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit. Deductible does not apply.
Depression screening 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit. Deductible does not apply.
Diabetes screening 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Diabetes Prevention Program (MDPP) 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the MDPP benefit. Deductible does not apply.
Obesity screening and therapy to promote sustained weight loss 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Screening and counseling to reduce alcohol misuse 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. Deductible does not apply.
Screening for lung cancer with low dose computed tomography (LDCT) 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medical nutrition therapy 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. Deductible does not apply.
Smoking and tobacco use cessation (counseling to quit smoking) 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. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Other services		
Services to treat outpatient kidney disease and conditions 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."	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. $0 copay for each Medicare-covered kidney disease education session Deductible does not apply. $15 copay for Medicare-covered outpatient dialysis Deductible does not apply. $0 copay for Medicare-covered home dialysis or home support services Deductible does not apply. $15 copay for Medicare-covered self-dialysis training Deductible does not apply.	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. $0 copay for each Medicare-covered kidney disease education session Deductible does not apply. $15 copay for Medicare-covered outpatient dialysis Deductible does not apply. $0 copay for Medicare-covered home dialysis or home support services Deductible does not apply. $15 copay for Medicare-covered self-dialysis training Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Services to treat outpatient kidney disease and conditions (con't)	10% coinsurance for Medicare-covered home dialysis equipment and supplies Deductible applies. 10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies Deductible applies.	10% coinsurance for Medicare-covered home dialysis equipment and supplies Deductible applies. 10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Part B prescription drugs covered under your medical plan (Part B drugs) 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.**	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. 20% coinsurance for Medicare-covered Part B drugs Deductible does not apply. 20% coinsurance for Medicare-covered Part B drug administration Deductible does not apply. 20% coinsurance for Medicare-covered Part B chemotherapy drugs Deductible does not apply. 20% coinsurance for Medicare-covered Part B chemotherapy drug administration Deductible does not apply.	You or your provider are encouraged to get prior approval from the plan before you get certain injectable/infusible drugs. Claims received without approval are subject to review and may include a medical necessity evaluation. Call the plan to learn which drugs apply. 20% coinsurance for Medicare-covered Part B drugs Deductible does not apply. 20% coinsurance for Medicare-covered Part B drug administration Deductible does not apply. 20% coinsurance for Medicare-covered Part B chemotherapy drugs Deductible does not apply. 20% coinsurance for Medicare-covered Part B chemotherapy drug administration Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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 combined in-network and out-of-network. • 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 combined in-network and out-of-network. Includes digital hearing aid technology and inner ear, outer ear, and over the ear models. Fitting adjustment after hearing aid is received, if necessary. To receive in-network benefits for routine hearing services in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin members must use a HearUSA participating provider. To receive in-network benefits in all other states, members must use a Blue Medicare Advantage (PPO) in-network provider for routine hearing services. For additional benefit information and to locate a HearUSA or Blue Medicare Advantage (PPO) in-network participating provider, please contact customer service. Hearing benefit management administered by HearUSA, an independent company.	$0 copay for routine hearing exams Deductible does not apply. $0 copay for hearing aid fitting evaluations Deductible does not apply. $0 copay for hearing aids Deductible does not apply. 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.	$0 copay for routine hearing exams Deductible does not apply. $0 copay for hearing aid fitting evaluations Deductible does not apply. $0 copay for hearing aids Deductible does not apply. 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	
	In-Network	Out-of-Network
Routine vision services • Routine vision exams Routine vision exams are limited to a $50 maximum benefit per year combined in-network and out-of-network. Routine vision exams are limited to 1 per year combined in-network and out-of-network.	$0 copay for routine vision exams Deductible applies. After the plan pays benefits for routine vision exams, you are responsible for the remaining cost.	$0 copay for routine vision exams Deductible applies. After the plan pays benefits for routine vision exams, you are responsible for the remaining cost.
Routine foot care • Up to four covered visits per year combined in-network and out-of-network 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.	$15 copay for each visit to an in-network primary care physician for routine foot care Deductible applies. $30 copay for each visit to an in-network specialist for routine foot care Deductible applies. After the plan pays benefits for routine foot care, you are responsible for the remaining cost.	$15 copay for each visit to an out-of-network primary care physician for routine foot care Deductible applies. $30 copay for each visit to an out-of-network specialist for routine foot care Deductible applies. 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 Deductible does not apply.	$0 copay for an annual physical exam Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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. A maximum allowance of $49 for each visit with a board-certified doctor. A maximum allowance of $80 for each visit with a therapist and $95 for each visit with a psychologist.	$0 copay for video doctor visits using LiveHealth Online Deductible does not apply. After the plan pays benefits for LiveHealth Online services, you are responsible for the remaining cost.	$0 copay for video doctor visits. Deductible does not apply. After the plan pays benefits for video doctor visits, you are responsible for the remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Video Doctor Visits (con't) LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this 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.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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 Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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 Deductible does not apply.	
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 six 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 (60 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.	$75 copay for emergency care Deductible does not apply. $30 copay for urgently needed services Deductible does not apply. $500 copay per admission for emergency inpatient care Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	
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 the routine hearing services and the foreign travel emergency and urgently needed care copay or coinsurance amounts. Part D Prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.	$5,000	