

**Your 2012 Medical Benefit Chart
Local PPO Plan
Maine State Employees Health Insurance Program
Effective January 1, 2012**

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Doctor and Hospital Choice</p> <p>You may go to doctors, specialists and hospitals in or out of the network. You do not need a referral. However, some benefits may require authorization.</p>		Higher costs may apply for out-of-network services.
<p>Annual Deductible</p> <ul style="list-style-type: none"> The deductible applies to covered services as noted within each category prior to the copay or coinsurance, if any, being applied. 	<p>\$200</p> <p>Combined in-network and out-of-network</p>	
Inpatient Services		
<p>Inpatient hospital care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Semi-private room (or a private room if medically necessary) Meals including special diets Regular nursing services Costs of special care units (such as intensive or coronary care units) Drugs and medications Lab tests X-rays and other radiology services Necessary surgical and medical supplies Use of appliances, such as wheelchairs Operating and recovery room costs Physical therapy, occupational therapy and speech language therapy Inpatient substance abuse services 	<p>Prior authorization is required for elective, rehabilitation, substance abuse and Medicare-covered transplant admissions.</p> <p>For Medicare-covered hospital stays:</p> <p>\$0 copay per admission Deductible applies.</p> <p>No limit to the number of days covered by the plan each benefit period.</p>	<p>Providers are encouraged to call the plan for a predetermination of coverage for elective inpatient admissions.</p> <p>For Medicare-covered hospital stays:</p> <p>10% coinsurance per admission Deductible applies.</p> <p>No limit to the number of days covered by the plan each benefit period.</p>

A health plan with a Medicare contract.

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<p>Inpatient hospital care (cont)</p> <ul style="list-style-type: none"> • Inpatient dialysis (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. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood – including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If possible, plan should be notified of emergency admissions within one business day of admission.</p> <p>Note: To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>\$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay Deductible applies.</p>	<p>10% coinsurance for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay Deductible applies.</p>
<p>Inpatient mental health care</p> <p>Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital.</p>	<p>For Medicare-covered hospital stays:</p>	<p>For Medicare-covered hospital stays:</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Inpatient mental health care (cont)</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If possible, plan should be notified of emergency admissions within one business day of admission.</p>	<p>Prior authorization is required for mental nervous and mental nervous rehabilitation admissions. Please contact the Behavioral Health Care program associated with your plan.</p> <p>\$0 copay per admission Deductible applies.</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>\$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay Deductible applies.</p>	<p>Providers are encouraged to call the plan for a predetermination of coverage for elective inpatient admissions. Please contact the Behavioral Health Care program associated with your plan.</p> <p>10% coinsurance per admission Deductible applies.</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>10% coinsurance for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay Deductible applies.</p>
<p>Skilled nursing facility (SNF) care</p> <p>Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period.</p> <p>A “benefit period” begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row.</p>	<p>Prior authorization is required for SNF services.</p> <p>For Medicare-covered SNF stays:</p>	<p>Providers are encouraged to call the plan for a predetermination of coverage for SNF services.</p> <p>For Medicare-covered SNF stays:</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Skilled nursing facility (SNF) care (cont)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • 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 and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • 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 services <p>Generally, you will receive your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital <p>No prior hospitalization is required.</p>	<p>\$0 copay per admission Deductible applies.</p>	<p>10% coinsurance per admission Deductible applies.</p>

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<p>Inpatient services covered when the hospital or SNF days are not covered or are no longer covered</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF) stay.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetic and orthotic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back and neck braces; trusses and artificial legs, arms and eyes including adjustments, repairs and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, occupational therapy and speech language therapy 	<p>After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefit chart at the deductible and/or cost share amounts indicated.</p>	
<p>Home health agency care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services. (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week.) • Physical therapy, occupational therapy and speech language therapy • Medical social services • Medical equipment and supplies 	<p>Prior authorization may be required for select services.</p> <p>\$0 copay for Medicare-covered home health visits Deductible applies.</p> <p>DME copay or coinsurance, if any, may apply. Deductible applies.</p>	<p>Prior authorization is requested for select services.</p> <p>10% coinsurance for Medicare-covered home health visits Deductible applies.</p> <p>DME copay or coinsurance, if any, may apply. Deductible applies.</p>

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<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Original Medicare (rather than this plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>Service covered by Original Medicare include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p> <p>You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:</p> <ul style="list-style-type: none"> • You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost-sharing. • Or – you can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost-sharing in our plan and the cost-sharing under Original Medicare. <p>Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.</p>	<p>You must receive care from a Medicare-certified hospice.</p> <p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not this plan.</p> <p>\$20 copay for the one time only hospice consultation. Deductible does not apply.</p>	<p>You must receive care from a Medicare-certified hospice.</p> <p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not this plan.</p> <p>10% coinsurance for the one time only hospice consultation. Deductible does not apply.</p>

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Outpatient services		
<p>Physician services, including doctor’s office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Office visits, including medical and surgical services in a physician’s office • Consultation, diagnosis and treatment by a specialist • Basic diagnostic hearing and balance exams, if your doctor orders it to see if you need medical treatment • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion 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>\$0 copay per visit to a network primary care physician (PCP) for Medicare-covered services Deductible applies.</p> <p>\$20 copay per visit to a network specialist for Medicare-covered services Deductible applies.</p> <p>\$0 copay for Medicare-covered allergy testing Deductible applies.</p> <p>\$0 copay for Medicare-covered allergy injections Deductible applies.</p>	<p>10% coinsurance per visit to an out-of-network primary care physician (PCP) for Medicare-covered services Deductible applies.</p> <p>10% coinsurance per visit to an out-of-network specialist for Medicare-covered services Deductible applies.</p> <p>10% coinsurance for Medicare-covered allergy testing Deductible applies.</p> <p>10% coinsurance for Medicare-covered allergy injections Deductible applies.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation 	<p>Prior authorization may be required for chiropractic services.</p> <p>\$20 copay for each Medicare-covered visit Deductible applies.</p>	<p>Prior authorization may be requested for chiropractic services</p> <p>10% coinsurance for each Medicare-covered visit Deductible applies.</p>

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<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Treatment of injuries and disease of the feet (such as hammer toe or heel spurs) • Medicare-covered routine foot care for member with certain medical conditions affecting the lower limbs. • A foot exam is covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations. 	<p>\$20 copay for each Medicare-covered visit Deductible applies.</p>	<p>10% coinsurance for each Medicare-covered visit Deductible applies.</p>
<p>Outpatient mental health care, including partial hospitalization services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>Prior authorization may be required for outpatient mental health visits after the 12th visit. Prior authorization may be required for partial hospitalization services related to mental health. Please contact the Behavioral Health Care program associated with your plan.</p> <p>\$0 copay for each Medicare-covered professional individual therapy visit Deductible applies.</p> <p>\$0 copay for each Medicare-covered professional group therapy visit Deductible applies.</p>	<p>Prior authorization is requested for outpatient mental health visits after the 12th visit. Prior authorization may be requested for partial hospitalization services related to mental health. Please contact the Behavioral Health Care program associated with your plan.</p> <p>10% coinsurance for each Medicare-covered professional individual therapy visit Deductible applies.</p> <p>10% coinsurance for each Medicare-covered professional group therapy visit Deductible applies.</p>

Covered services	What you must pay for these covered services	
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<p>Outpatient mental health care, including partial hospitalization services (cont)</p>	<p>\$0 copay for each Medicare-covered professional partial hospitalization visit Deductible applies.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies.</p> <p>\$0 copay for each Medicare-covered partial hospitalization facility visit Deductible applies.</p>	<p>10% coinsurance for each Medicare-covered professional partial hospitalization visit Deductible applies.</p> <p>10% coinsurance for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies.</p> <p>10% coinsurance for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies.</p> <p>10% coinsurance for each Medicare-covered partial hospitalization facility visit Deductible applies.</p>

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<p>Outpatient substance abuse services, including partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>Prior authorization may be required for outpatient substance abuse visits after the 12th visit. Prior authorization may be required for partial hospitalization services related to substance abuse. Please contact the Behavioral Health Care program associated with your plan.</p> <p>\$0 copay for each Medicare-covered professional individual therapy visit Deductible applies.</p> <p>\$0 copay for each Medicare-covered professional group therapy visit Deductible applies.</p> <p>\$0 copay for each Medicare-covered professional partial hospitalization visit Deductible applies.</p>	<p>Prior authorization is requested for outpatient substance abuse visits after the 12th visit. Prior authorization may be requested for partial hospitalization services related to substance abuse. Please contact the Behavioral Health Care program associated with your plan.</p> <p>10% coinsurance for each Medicare-covered professional individual therapy visit Deductible applies.</p> <p>10% coinsurance for each Medicare-covered professional group therapy visit Deductible applies.</p> <p>10% coinsurance for each Medicare-covered professional partial hospitalization visit Deductible applies.</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Outpatient substance abuse services, including partial hospitalization services (cont)</p>	<p>\$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies.</p> <p>\$0 copay for each Medicare-covered partial hospitalization facility visit Deductible applies.</p>	<p>10% coinsurance for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies.</p> <p>10% coinsurance for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies.</p> <p>10% coinsurance for each Medicare-covered partial hospitalization facility visit Deductible applies.</p>
<p>Outpatient surgery including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>(Facilities where surgical procedures are performed and the patient is released the same day.)</p> <p>Note: If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery.</p> <p>Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>Prior authorization is required for select outpatient surgeries to include, but not limited to: uvulopalatopharyngoplasty (UP3), bariatric, arthroplasty, orthopedic, blepharoplasty.</p> <p>\$100 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for</p>	<p>Prior authorization is requested for select outpatient surgeries to include, but not limited to: uvulopalatopharyngoplasty (UP3), bariatric, arthroplasty, orthopedic, blepharoplasty.</p> <p>10% coinsurance for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for</p>

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<p>Outpatient surgery including services provided at hospital outpatient facilities and ambulatory surgical centers (cont)</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>surgery Deductible applies.</p> <p>\$100 copay for each Medicare-covered outpatient observation room visit. Deductible applies.</p>	<p>surgery Deductible applies.</p> <p>10% coinsurance for each Medicare-covered outpatient observation room visit. Deductible applies.</p>
<p>Outpatient hospital services, non-surgical</p> <p>Covered services include medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>\$0 copay for a visit to a network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies.</p> <p>\$20 copay for a visit to a network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies.</p> <p>\$100 copay for each Medicare-covered outpatient observation room visit Deductible applies.</p>	<p>10% coinsurance for a visit to an out-of-network primary care physician in an outpatient hospital setting/clinic Medicare-covered for non-surgical services Deductible applies.</p> <p>10% coinsurance for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies.</p> <p>10% coinsurance for each Medicare-covered outpatient observation room visit Deductible applies.</p>

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<p>Ambulance services</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing and ground ambulance services to the nearest appropriate facility that can provide care only if the services are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health). The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. • Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required. • Ambulance service is not covered for physician office visits. 		<p>Prior authorization for nonemergent air and water transportation is required for network providers and requested for out-of-network providers.</p> <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. Deductible does not apply.</p>
<p>Emergency care</p> <p>Emergency care is care that is needed to evaluate or stabilize an emergency medical condition.</p> <ul style="list-style-type: none"> • 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. • Emergency care copay is waived if the member is admitted to the hospital within 72 hours for the same condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p>		<p>\$65 copay for each Medicare-covered emergency room visit Deductible does not apply.</p>

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<p>Urgently needed care</p> <ul style="list-style-type: none"> Urgently needed care is available on a world-wide basis. Urgently needed care copay is waived if the member is admitted to the hospital within 72 hours for the same condition. <p>If you are outside of the service area for your plan, your plan covers urgently needed care, including urgently required renal dialysis. Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. Generally, however, if you are in the plan's service area and your health is not in serious danger, you should obtain care from a network provider.</p>	<p>\$20 copay for each Medicare-covered urgently needed care visit Deductible does not apply.</p>	
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>Prior authorization may be required for physical therapy, occupational therapy and speech language therapy visits.</p> <p>\$20 copay for Medicare-covered physical therapy, occupational therapy and speech language therapy visits Deductible applies.</p>	<p>Prior authorization is requested for physical therapy, occupational therapy and speech language therapy visits.</p> <p>10% coinsurance for Medicare-covered physical therapy, occupational therapy and speech language therapy visits Deductible applies.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions. The plan covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>\$20 copay for Medicare-covered cardiac rehabilitation therapy visits Deductible applies.</p>	<p>10% coinsurance for Medicare-covered cardiac rehabilitation therapy visits Deductible applies.</p>

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<p>Cardiac rehabilitation services (cont)</p> <p>Cardiac rehabilitation therapy is covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery and/or have stable angina pectoris, have had a heart valve repair/replacement, angioplasty or coronary stenting or have had a heart or heart-lung transplant or other cardiac conditions as specified through a national coverage determination (NCD).</p>		
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.</p>	<p>\$20 copay for Medicare-covered pulmonary rehabilitation therapy visits Deductible applies.</p>	<p>10% coinsurance for Medicare-covered pulmonary rehabilitation therapy visits Deductible applies.</p>
<p>Durable medical equipment (DME) and related supplies</p> <p>Covered items include: 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>Prior authorization is required for power operated vehicles, power wheelchairs and accessories, non-standard wheelchairs and non-standard beds.</p> <p>\$0 copay on all Medicare-covered DME Deductible applies.</p>	<p>Prior authorization is requested for power operated vehicles, power wheelchairs and accessories, non-standard wheelchairs and non-standard beds.</p> <p>10% coinsurance on all Medicare-covered DME Deductible applies.</p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace a body part or function. These include, but not limited to, colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery, see “Vision Care” later in this section for more detail.</p>	<p>Prior authorization may be required for prosthetics and orthotics.</p> <p>\$0 copay on all Medicare-covered prosthetics and orthotics Deductible applies.</p>	<p>Prior authorization is requested for prosthetics and orthotics.</p> <p>10% coinsurance on all Medicare-covered prosthetics and orthotics Deductible applies.</p>

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<p>Diabetes self-monitoring training, supplies and services</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"> • Blood glucose monitor, blood glucose test strips, urine test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors • One pair per year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or insert. • Diabetes self-management training is covered under certain conditions. 	<p>For Medicare-covered:</p> <p>\$0 copay for a 30-day supply on each Medicare-covered purchase of glucose test strips, urine test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors Deductible applies except for the items purchased at a pharmacy.</p> <p>\$0 copay for blood glucose monitor Deductible applies except for the items purchased at a pharmacy.</p> <p>\$0 copay for Medicare-covered therapeutic shoes Deductible applies.</p> <p>\$0 copay for Medicare-covered self-management training Deductible does not apply.</p>	<p>For Medicare-covered:</p> <p>10% coinsurance for a 30-day supply on each Medicare-covered purchase of glucose test strips, urine test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors Deductible applies except for the items purchased at a pharmacy.</p> <p>10% coinsurance for blood glucose monitor Deductible applies except for the items purchased at a pharmacy.</p> <p>10% coinsurance for Medicare-covered therapeutic shoes Deductible applies.</p> <p>10% coinsurance for Medicare-covered self-management training Deductible does not apply.</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Complex diagnostic tests and X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • 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 and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests <p>Certain diagnostic tests and X-rays 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.</p>	<p>Prior authorization may be required for complex imaging, as well as limited diagnostic and therapeutic radiology services including but not limited to injectable/infusible medications, radiation therapy, PET, CT SPECT, MRI scans and echocardiograms.</p> <p>\$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test Deductible applies.</p> <p>\$0 copay for Medicare-covered complex diagnostic test and/or radiology visit Deductible applies.</p> <p>\$0 copay for each Medicare-covered radiation therapy treatment Deductible applies.</p> <p>\$0 copay for Medicare-covered supplies Deductible applies.</p>	<p>Prior authorization is requested for complex imaging, as well as limited diagnostic and therapeutic radiology services including but not limited to injectable/infusible medications, radiation therapy, PET, CT SPECT, MRI scans and echocardiograms.</p> <p>10% coinsurance for each Medicare-covered X-ray visit and/or simple diagnostic test Deductible applies.</p> <p>10% coinsurance for Medicare-covered complex diagnostic test and/or radiology visit Deductible applies.</p> <p>10% coinsurance for each Medicare-covered radiation therapy treatment Deductible applies.</p> <p>10% coinsurance for Medicare-covered supplies Deductible applies.</p>

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

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Vision care (cont)</p>	<p>\$0 copay for Medicare-covered glaucoma screening Deductible does not apply.</p> <p>\$0 copay for glasses/contacts following Medicare-covered cataract surgery Deductible applies.</p>	<p>10% coinsurance for Medicare-covered glaucoma screening Deductible does not apply.</p> <p>10% coinsurance for glasses/contacts following Medicare-covered cataract surgery Deductible applies.</p>
<p>Preventive services and screening tests</p> <p>Note: For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received. In addition, if an office visit is billed for the existing medical condition or an additional non-preventive service received, the applicable network primary care physician or network specialist copay will apply.</p>		
<p>Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.</p>	<p>\$0 copay for Medicare-covered screening Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered screening Deductible does not apply.</p>
<p>Bone mass measurements</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>\$0 copay for Medicare-covered bone mass measurement Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered bone mass measurement Deductible does not apply.</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Colorectal screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, the following is covered:</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, the following is covered:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy 	<p>\$0 copay for Medicare-covered screenings Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered screenings Deductible does not apply.</p>
<p>HIV Screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, covered services include:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, covered services include:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>\$0 copay for Medicare-covered screenings Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered screenings Deductible does not apply.</p>
<p>Medicare Part B Immunizations</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, including H1N1, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>If Part D prescription drug coverage is included with your medical plan, we also cover some vaccines under our outpatient prescription drug benefit.</p>	<p>\$0 copay for Medicare-covered immunizations Deductible does not apply.</p>	<p>\$0 copay for Medicare-covered immunizations Deductible does not apply.</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline exam between the ages of 35 and 39 • One screening every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	<p>\$0 copay for Medicare-covered screening exams Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered screening exams Deductible does not apply.</p>
<p>Cervical and vaginal cancer screening</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, one Pap test every 12 months. 	<p>\$0 copay for Medicare-covered screening exams Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered screening exams Deductible does not apply.</p>
<p>Prostate cancer screening exams</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>\$0 copay for Medicare-covered screening exams Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered screening exams Deductible does not apply.</p>
<p>Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years.</p>	<p>\$0 copay for Medicare-covered tests Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered tests Deductible does not apply.</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>“Welcome to Medicare” physical exam</p> <p>The plan covers a one-time “Welcome to Medicare” physical exam, which 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: You must have the physical exam 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” physical exam.</p>	<p>\$0 copay for Medicare-covered exam Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered exam Deductible does not apply.</p>
<p>Annual Wellness Visit</p> <p>If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” exam. However, you don’t need to have had a “Welcome to Medicare” exam to be covered for annual wellness visits after you’ve had Part B for 12 months.</p>	<p>\$0 copay for Medicare-covered visits Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered visits Deductible does not apply.</p>
<p>Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>\$0 copay for Medicare-covered diabetes screening including fasting plasma glucose tests Deductible does not apply.</p>	<p>10% coinsurance for Medicare-covered diabetes screening including fasting plasma glucose tests Deductible does not apply.</p>
<p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor.</p>	<p>\$0 copay for each Medicare-covered visit Deductible does not apply.</p>	<p>10% coinsurance for each Medicare-covered visit Deductible does not apply.</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Medical nutrition therapy (cont)</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>Smoking and tobacco use cessation (counseling to quit smoking)</p> <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: we cover two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>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 two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.</p>	<p>\$0 copay for each Medicare-covered visit Deductible does not apply.</p>	<p>10% coinsurance for each Medicare-covered visit Deductible does not apply.</p>
Other Services		
<p>Services to treat outpatient kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. 	<p>No prior authorization is required; however notice is requested for all members initiating dialysis treatment.</p>	<p>No prior authorization is required; however notice is requested for all members initiating dialysis treatment.</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Services to treat outpatient kidney disease and conditions (cont)</p> <ul style="list-style-type: none"> • Outpatient dialysis treatment 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 others for the person helping you with your home dialysis treatments) • Home dialysis equipment and supplies 	<p>\$0 copay for each Medicare-covered kidney education session Deductible applies.</p> <p>\$0 copay for Medicare-covered outpatient or physician office dialysis Deductible does not apply.</p> <p>\$0 copay for Medicare-covered home dialysis or home support services Deductible does not apply.</p> <p>\$0 copay for Medicare-covered self-dialysis training Deductible does not apply.</p> <p>\$0 copay for Medicare-covered home dialysis equipment and supplies Deductible applies.</p>	<p>10% coinsurance for each Medicare-covered kidney education session Deductible applies.</p> <p>\$0 copay for Medicare-covered outpatient or physician office dialysis Deductible does not apply.</p> <p>10% coinsurance for Medicare-covered home dialysis or home support services Deductible does not apply.</p> <p>10% coinsurance for Medicare-covered self-dialysis training Deductible does not apply.</p> <p>10% coinsurance for Medicare-covered home dialysis equipment and supplies Deductible applies.</p>
<p>Medicare Part B prescription drugs, covered under your medical plan (Part B drugs)</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan.</p>	<p>Prior authorization may be required for certain injectable/infusible drugs.</p>	<p>Prior authorization is requested for certain injectable/infusible drugs.</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Medicare Part B prescription drugs, covered under your medical plan (Part B drugs) (cont)</p> <p>Covered drugs include:</p> <ul style="list-style-type: none"> • “Drugs” includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by your Medicare Advantage Plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoiesis-stimulating agents (such as Erythropoietin (Epogen®), Procrit® or Epoetin Alfa and Darboetin Alfa (Aranesp®)) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>If Part D prescription drug coverage is included with your medical plan, please refer to your Evidence of Coverage for information on your Part D prescription drug benefits.</p>	<p>\$0 copay for Medicare-covered Part B drugs Deductible does not apply.</p> <p>\$0 copay for Medicare-covered Part B drug administration Deductible does not apply.</p> <p>\$0 copay for Medicare-covered Part B chemotherapy drugs Deductible does not apply.</p> <p>\$0 copay for Medicare-covered Part B chemotherapy drug administration Deductible does not apply.</p>	<p>\$0 copay for Medicare-covered Part B drugs Deductible does not apply.</p> <p>\$0 copay for Medicare-covered Part B drug administration Deductible does not apply.</p> <p>\$0 copay for Medicare-covered Part B chemotherapy drugs Deductible does not apply.</p> <p>\$0 copay for Medicare-covered Part B chemotherapy drug administration Deductible does not apply.</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Additional Benefits		
<p>Hearing services</p> <ul style="list-style-type: none"> Routine hearing exams. <p>Routine hearing exam is limited to one per year combined in-network and out-of-network.</p>	<p>\$0 copay for routine hearing exams Deductible does not apply.</p> <p>After plan paid benefits for hearing exams you are responsible for the remaining cost.</p>	<p>10% coinsurance for routine hearing exams Deductible does not apply.</p> <p>After plan paid benefits for hearing exams you are responsible for the remaining cost.</p>
<p>Routine vision care</p> <ul style="list-style-type: none"> Routine vision exams <p>Routine vision exam is limited to one per year combined in-network and out-of-network.</p>	<p>\$0 copay for routine vision exams Deductible does not apply.</p> <p>After plan paid benefits for routine vision exams, you are responsible for the remaining cost.</p>	<p>10% coinsurance for routine vision exams Deductible does not apply.</p> <p>After plan paid benefits for routine vision exams, you are responsible for the remaining cost.</p>
<p>Routine foot care</p> <p>Up to four covered visits per year. Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails and other hygienic and preventive maintenance care.</p>	<p>\$0 copay for each visit to a network primary care physician for routine foot care Deductible applies.</p> <p>\$20 copay for each visit to a network specialist for routine foot care Deductible applies.</p> <p>After plan paid benefits for routine foot exams you are responsible for the</p>	<p>10% coinsurance for each visit to an out-of-network primary care physician for routine foot care Deductible applies.</p> <p>10% coinsurance for each visit to an out-of-network specialist for routine foot care Deductible applies.</p> <p>After plan paid benefits for routine</p>

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Routine foot care (cont)</p>	<p>remaining cost.</p>	<p>foot exams you are responsible for the remaining cost.</p>
<p>SilverSneakers®</p> <p>You can enroll in this fitness program provided by SilverSneakers, an independent company. A fitness plan designed especially for Medicare-eligible individuals. SilverSneakers includes:</p> <ul style="list-style-type: none"> • A complimentary basic membership in a participating fitness center in your area. You can use all the services available to fitness center members with a basic membership, such as steam and sauna rooms, exercise equipment and SilverSneakers classes custom-designed for all levels of fitness • Opportunities to join in fitness promotions and health education seminars <p>There is not a separate charge for this program, as long as you only use services available with basic fitness center memberships.</p> <p>After you enroll in this Medicare Advantage plan, you will receive a brochure that shows the participating fitness centers in your area and describes how to enroll in SilverSneakers.</p> <p>Contact Customer Service for more information on this program, or visit www.SilverSneakers.com.</p>	<p>\$0 copay for the SilverSneakers fitness benefit Deductible does not apply.</p>	
<p>Foreign travel emergency and urgently needed care</p> <p>Emergency or urgently needed care services while traveling outside the United States during a temporary absence of less than six months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition.</p>	<p>\$65 copay for emergency care Deductible does not apply.</p> <p>\$20 copay for urgently needed care Deductible does not apply.</p> <p>\$0 copay per admission for emergency inpatient care</p>	

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
<p>Foreign travel emergency and urgently needed care (cont)</p> <ul style="list-style-type: none"> • Emergency outpatient care • Urgently needed care • Inpatient care (60 days per lifetime) <p>This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States.</p>	Deductible does not apply.	
<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 vision, routine hearing 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.</p>	\$3,400	

Covered services	What you must pay for these covered services	
ADDITIONAL SERVICES Not Covered by Medicare	In Network	Out of Network
Annual Deductible	\$100	
Lifetime Maximum	Not Applicable	
<p>Chiropractic Services</p> <p>Benefits are provided for ancillary treatment such as massage therapy, heat and electro-stimulation in conjunction with an active course of treatment. Benefits are not provided for maintenance therapy for chronic conditions.</p>	20% coinsurance Deductible applies.	20% coinsurance Deductible applies.
<p>Acupuncture</p> <p>The services of a licensed acupuncturist or Doctor of Chinese Medicine for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion.</p> <p>Chinese herbs and supplements excluded.</p>	20% coinsurance Deductible applies.	20% coinsurance Deductible applies.
<p>Temporomandibular Joint Syndrome (TMJ)</p> <p>Coverage is provided for the treatment of a specific organic condition of or physical trauma to the temporomandibular joint (jaw hinge). Coverage is limited to surgery or injections of the temporomandibular joint, physical therapy, or other medical treatments</p> <p><i>Benefits are not provided for any temporomandibular joint syndrome services not listed as covered in the Covered Services section. Coverage is not provided for any procedure or device that alters the vertical relationship of the teeth or the relation of the mandible to the maxilla. Dental services related to TMJ are not covered.</i></p>	20% coinsurance Deductible applies.	20% coinsurance Deductible applies.
<p>Stockings</p> <p>Benefits are provided for stockings such as Linton, Jobst and Sigvaris stockings only when provided for post-surgical use or when prescribed for circulatory diseases.</p>	20% coinsurance Deductible applies.	20% coinsurance Deductible applies.

Covered services	What you must pay for these covered services	
<p>Wigs/Hairpieces</p> <p>Only covered for certain diseases, injuries, congenital or developmental anomalies, or previous therapeutic processes, resulting in temporary or permanent hair loss. Must be ordered by a physician.</p> <p>Only covered for certain diseases, injuries, congenital or developmental anomalies, or previous therapeutic processes, resulting in temporary or permanent hair loss. Must be ordered by a physician. Limit two per calendar year.</p> <p>Traumatic or surgical scalp avulsion, burns, alopecia areata or totalis. Medical conditions documented by tests and other diagnostic measures resulting in permanent or temporary hair loss. Conditions or injuries being actively treated with an accepted and covered treatment that have resulted in temporary hair loss.</p> <p>Note: If covered, wigs/hairpieces are considered to be a prosthetic and would be subject to any product-specific calendar year limits for prosthetics.</p> <p>The following is a list of exclusions for wigs or hairpieces due to:</p> <ul style="list-style-type: none"> • Aging. • Male pattern baldness or premature old age. • Medical conditions which cannot be documented by test and other diagnostic measures resulting in hair loss. • The cleaning and maintenance of hairpieces. 	<p>20% coinsurance Deductible applies.</p>	<p>20% coinsurance Deductible applies.</p>
<p>Dental Services</p> <p>Dental Services Benefits are provided only for the following teeth and jaw services:</p> <ul style="list-style-type: none"> • Setting a jaw fracture; • Removing a tumor or cyst (but not a root cyst); • Removing impacted or unerupted teeth in a non-hospital or non-rural health center setting; • Repairing or replacing dental prostheses damaged by an accidental bodily injury; 	<p>20% coinsurance Deductible applies.</p>	<p>20% coinsurance Deductible applies.</p>

Covered services**What you must pay for these covered services****Dental Services (cont)**

- Treating accidental bodily injury to natural teeth;
- Emergency stabilization treatment for accidental injury to natural teeth if initiated and completed within 72 hours of the injury or accident;
- Biopsy and excision of a lesion;
- Gingivectomy or gingoplasty (per quadrant per tooth);
- Gingival flap procedure (including root planning per quadrant);
- Osseous surgery (including flap entry and closure per quadrant);
- Osseous surgery or graft; single site or multiple sites (including flap entry, closure, and donor sites);
- Pedicle soft tissue graft;
- Free soft tissue graft (including donor site);
- Apically repositioned flap procedure;
- Excision of partially or completely unerupted teeth;
- Excision of a tooth root without the extraction of the entire tooth;
- Suturing of dental surgical incision;
- Cancer-related dental services; and
- Other incision or excision of the gums or tissues of the mouth.
- Some of the services listed above may also be covered under your dental plan.