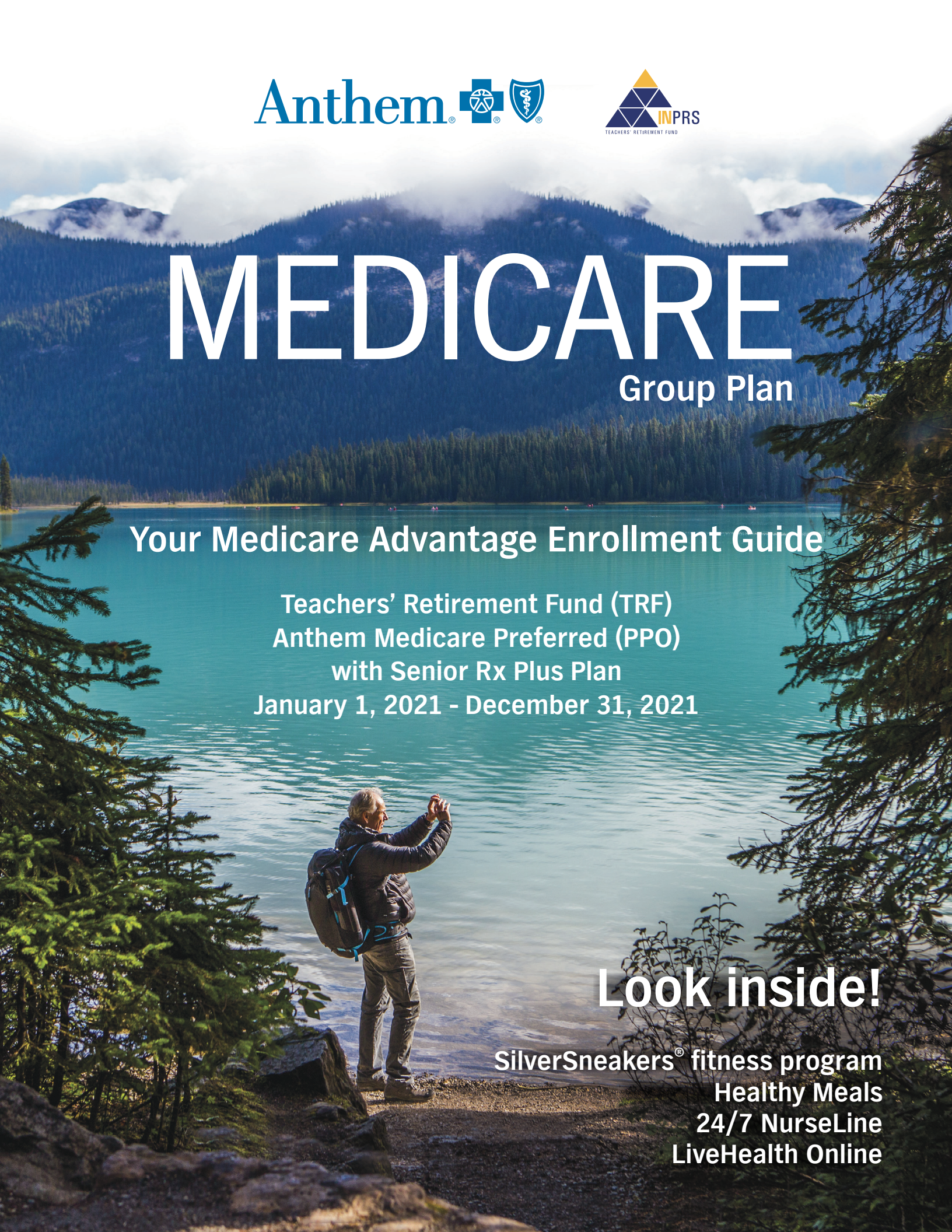


MEDICARE

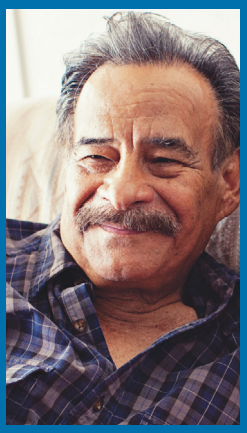
Group Plan

Your Medicare Advantage Enrollment Guide

Teachers' Retirement Fund (TRF)
Anthem Medicare Preferred (PPO)
with Senior Rx Plus Plan
January 1, 2021 - December 31, 2021

Look inside!

SilverSneakers® fitness program
Healthy Meals
24/7 NurseLine
LiveHealth Online



What is inside

This guide is designed to help you understand the benefits, tools and resources you receive with this plan.

Overall plan highlights

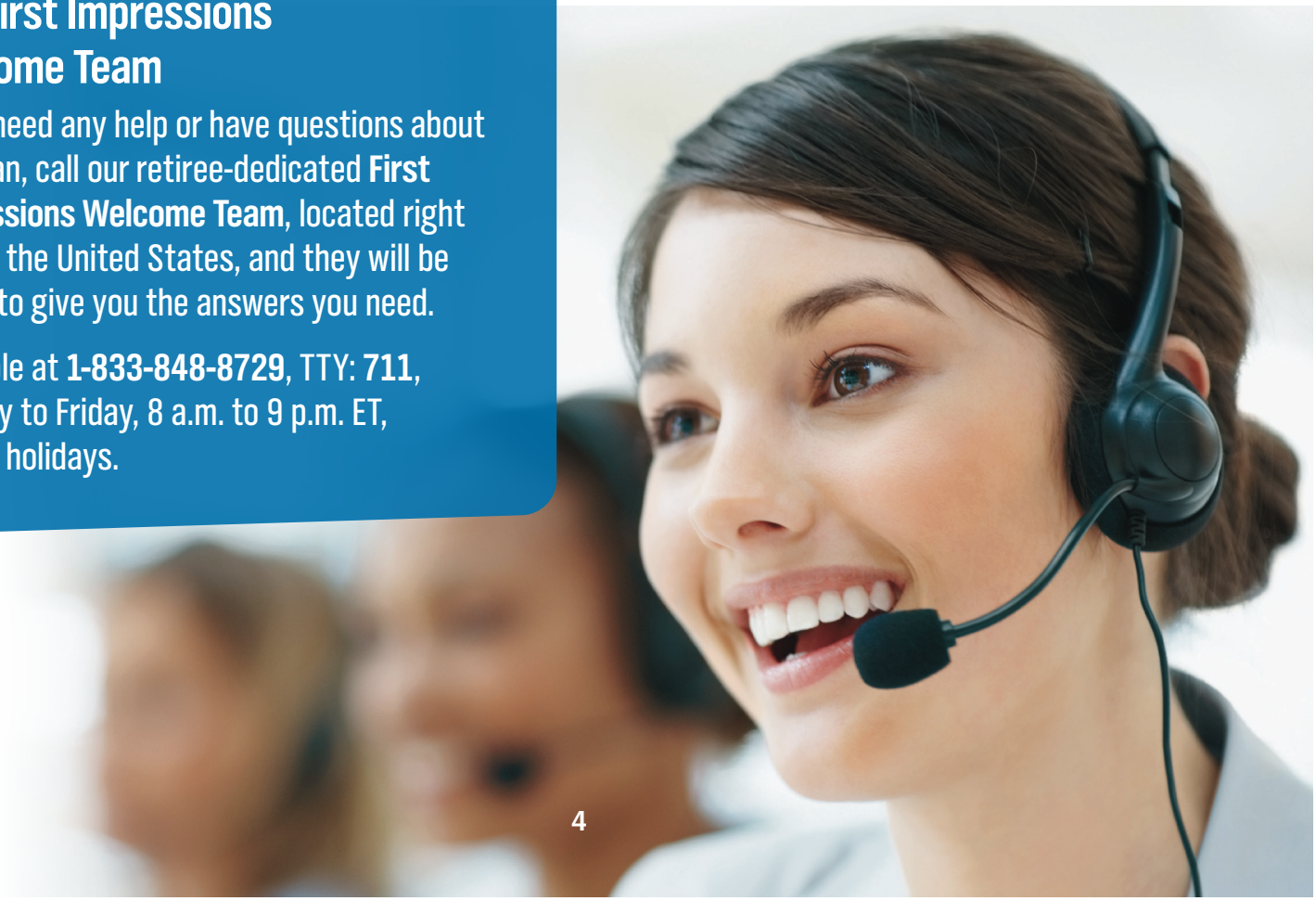
Teachers' Retirement Fund (TRF) offers Anthem Medicare Preferred (PPO) with Senior Rx Plus plans, that includes many health resources and benefits that Original Medicare does not offer, like:

- A $0 copay for an annual wellness visit.
- National Access Plus, which allows you to see any doctor who accepts Medicare and our plan. You're not tied to a provider network and you pay the same copay or coinsurance percentage whether your provider is in-network or out-of-network.
- A $0 copay for Select Generics.
- The freedom to choose providers who accept Medicare and the plan, nationwide. See page 10 for more details.
- A comprehensive nationwide pharmacy network.
- Access to SilverSneakers®, LiveHealth Online, and SpecialOffers from our partners.

The First Impressions Welcome Team

If you need any help or have questions about this plan, call our retiree-dedicated **First Impressions Welcome Team**, located right here in the United States, and they will be happy to give you the answers you need.

Available at **1-833-848-8729**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays.



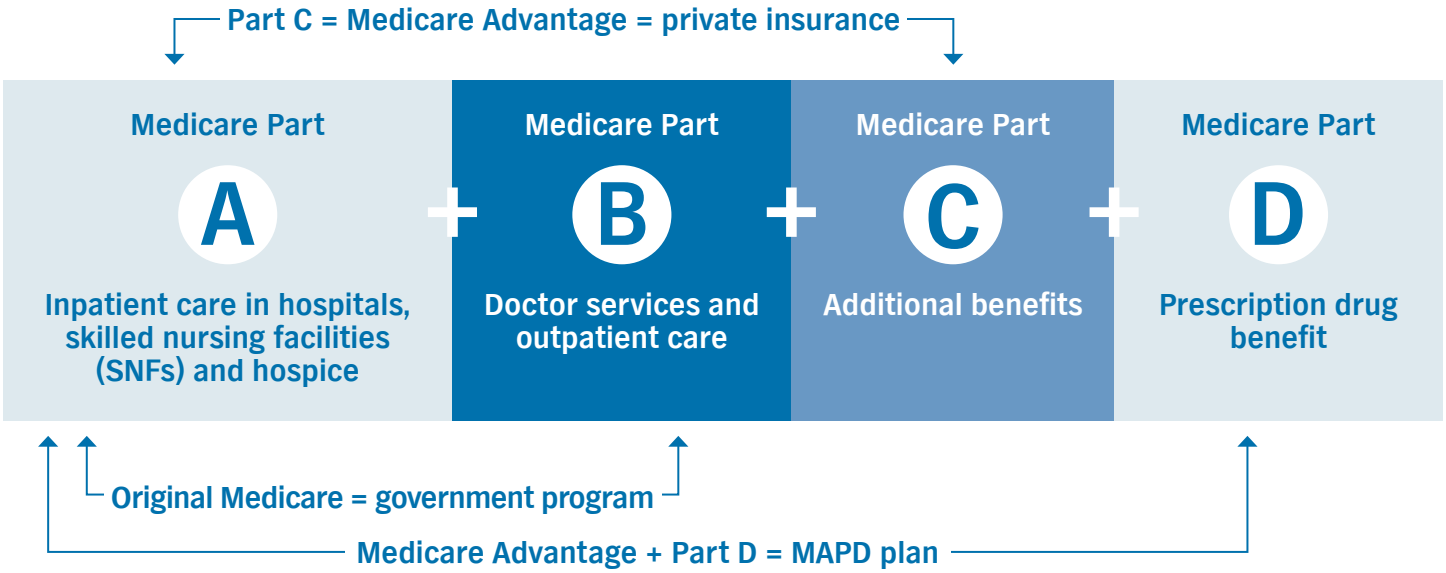
How Medicare works

Medicare is a federal government health insurance program offered to people 65 years of age or older, people under age 65 with certain disabilities and anyone with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease.

The A-B-C-Ds of Medicare

You may have heard about the different parts of Medicare. Here is a quick look at what they mean to your medical coverage:

- **Medicare Parts A + B =** Original Medicare, the government program.
- **Medicare Part C =** Original Medicare + additional benefits. Part C is also called Medicare Advantage (MA).
- **Medicare Part D =** The prescription drug benefit. This plan includes Part D, so the plan name includes MA + Part D or MAPD.



Please visit **www.medicare.gov** to learn more about Medicare and find more ways to maximize your benefits. You can also contact Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users, call **1-877-486-2048**.

How is Medicare Advantage different?

This plan is a Medicare Advantage preferred provider organization (PPO) plan.

Medicare Advantage is a Medicare Part C plan. That means it is a Medicare plan offered by a private insurance company. Anthem Blue Cross and Blue Shield (Anthem) is the private insurance company that manages this plan.

Medicare Advantage offers more than Original Medicare. Original Medicare covers Part A (hospital benefits) and Part B (doctor and outpatient care). Medicare Advantage covers both Parts A and B, and more. See examples in the chart below.

Overview	Original Medicare	MEDICARE ADVANTAGE WITH SENIOR RX PLAN
Annual out-of-pocket maximum (or Max OOP) is the amount members pay each year	There is no maximum amount members will pay annually.	After the Max OOP is met, **the plan pays 100% of covered medical costs** for the rest of the plan year.
Copays and coinsurance	20% coinsurance for common services such as outpatient surgery and health visits	**Copays are used more often** than coinsurance to help make cost share amounts simple and transparent.
Emergency care when traveling outside the U.S.	No coverage when traveling outside the U.S.	**Emergency care is provided** when traveling outside the U.S.
Additional benefits	Not offered	**This plan gives you access to:** • 24/7 NurseLine • SilverSneakers® • LiveHealth Online

Note: Not all medical costs are included or subject to the annual out-of-pocket maximum. For more details and what services are covered by this plan, please see the Benefits Charts included in this guide.

Frequently asked questions

Whom can I call if I have questions about this plan?
Call the **First Impressions Welcome Team** at **1-833-848-8729**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays.

What is a deductible?
When applicable, a deductible is the amount of money you pay for health care services before your plan starts paying. After you reach your deductible, you will still have to pay toward your cost share for services. Certain plans have no deductible and will cover your health care services from the start. Other services will be covered by your plan before you reach the deductible. For more details, please see the Benefits Charts included in this guide.

What is a copay?
When applicable, a copay is a fixed dollar amount that you pay for covered services. A copay is often charged to you after your appointment.

What is coinsurance?
When applicable, coinsurance is the percentage of a covered health care cost that you would pay after you meet your deductible, while the plan pays the rest of the covered cost. If you have not yet met your deductible, you pay the full allowed amount.

What is a primary care provider (PCP)?
A primary care provider (PCP) is a general practice doctor who treats basic medical conditions. Primary care doctors do physicals or checkups and give vaccinations. They can help diagnose health problems and either provide care or refer patients to specialists if the condition requires. They are often the first doctor most patients see when they have a health concern.

What is an annual out-of-pocket maximum (or Max OOP)?
One feature of Medicare Advantage is the Max OOP. It is the maximum total amount you may pay every plan year for your covered health care costs, including copays, coinsurance and deductibles. Once you reach the Max OOP, you pay nothing for your covered health care costs until the start of the next plan year. Not all medical costs are included or subject to the annual out-of-pocket maximum. To learn more details and what services are covered by this plan, please see the Benefits Charts included in this guide.

How is inpatient care different from outpatient care?
Inpatient care is medical treatment that is provided when you have been formally admitted to the hospital or other facility with a doctor's order. If you are not admitted with a doctor's order, you may be considered an outpatient, even if you stay in the hospital overnight. Outpatient care is any health care services provided to a patient who is not admitted to a facility. Outpatient care may be provided in a doctor's office, clinic, or hospital outpatient department.

What are preventive care and services?
Preventive care and services help you avoid an illness or injury. Common examples of preventive care are immunizations and an annual wellness visit. Any screening test done in order to catch a disease early is considered a preventive service. Advice or counseling, such as nutrition and exercise guidance, is also an example of preventive care and services.

Medical benefit overview

This plan offers a wealth of benefits designed to help you take advantage of many health resources while keeping expenses down.

Health, access and well-being

- Flu and pneumonia vaccines and most health screenings
- Inpatient hospital care and ambulance services
- Emergency and urgent care
- Skilled nursing facility benefits
- Complex radiology services and radiation therapy
- Diagnostic procedures and testing services received in a doctor's office
- Lab services and outpatient X-rays
- Home health agency care
- Routine hearing exams and hearing aid coverage

Nutrition

- Diabetes services and supplies
- Healthy Meals
- Healthy Pantry

Devices

- Durable medical equipment and related supplies
- Prosthetic devices

Programs and services

- 24/7 NurseLine
- Outpatient surgery and rehabilitation
- SilverSneakers® fitness program
- Medicare Community Resource Support
- Doctors available anytime, anywhere with LiveHealth Online
- Foreign travel emergency and urgently needed services

See the full Benefits Charts starting on page 28 for more details.

No-cost special benefits, services and access to care

Members can choose from a variety of programs and tools to help make choices toward better health in all aspects of life.

Annual health exams and preventive care

The plan offers the following and more with no additional cost, as long as you see a doctor who accepts Medicare and our plan:

- Annual wellness visit
- Preventive care services
- Flu and pneumonia shots
- Tobacco cessation counseling

MyHealth Advantage

This program sends regular reminders via postal mail about needed care, tests or preventive health steps to keep you healthy. It also offers prescription drug cost-cutting tips and access to health specialists who can answer your questions.

These resources are available at no additional cost to you.

House Call program[1]

The House Call program offers a personalized visit in your home or other appropriate health care setting that can lead to a treatment plan tailored to you. The House Call program is available at no additional cost for members who qualify based on their health needs.

24/7 NurseLine[2]

When health issues arise after hours, and the doctor's office is closed, you can still obtain the answers you need — right away. Our 24/7 NurseLine puts you in touch with a registered nurse anytime of the day or night. Call our 24/7 NurseLine at **1-800-700-9184** (TTY: **711**).

1 House Call program is administered by an independent vendor. It is available to members who qualify.

2 The information contained in this program is for general guidelines only. Your doctor will be specific regarding recommendations for your individual circumstances. Recommended treatments may not be covered under your health plan.

More no-cost special benefits, services and access to care

LiveHealth Online*

Using LiveHealth Online, you can visit with a doctor, therapist or psychologist through live video on your smartphone, tablet or computer with a webcam. It's a great way to:

- Access a board-certified doctor in the comfort of your home, 24/7.
- Get help with common conditions like the flu, colds, sinus infections, pink eye, and skin rash – this even includes having prescriptions sent to the pharmacy, if needed.
- Set up a 45-minute counseling session with a licensed therapist or psychologist to find help when you feel depressed, anxious or stressed.

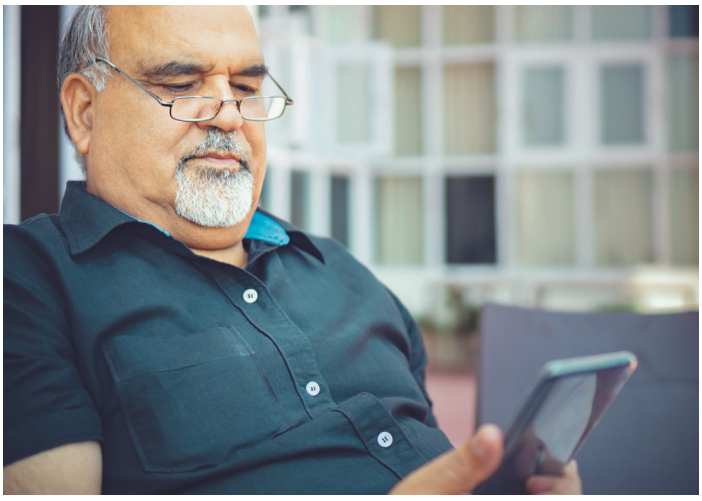
Video visits using LiveHealth Online are $0 with your plan. Sign up today at **livehealthonline.com**. Or use the free LiveHealth Online mobile app.

Healthy Meals

If you are not able to prepare a meal for yourself after being discharged from the hospital, or if you have a body mass index (BMI) of 18.5 or less, or 25 or more, or an A1C level of more than 9.0%, we will provide prepared meals that only need to be reheated, delivered directly to your home. You may receive up to 14 healthy meals per event, up to four events.

Healthy Pantry

Once approved, you receive monthly nutritional counseling sessions via phone and a monthly delivery of nonperishable healthy pantry items.



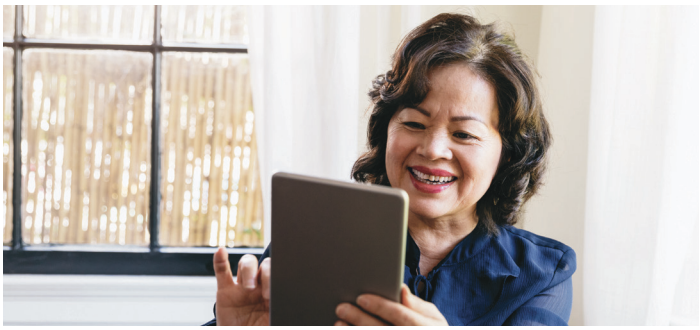
* LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of this plan.

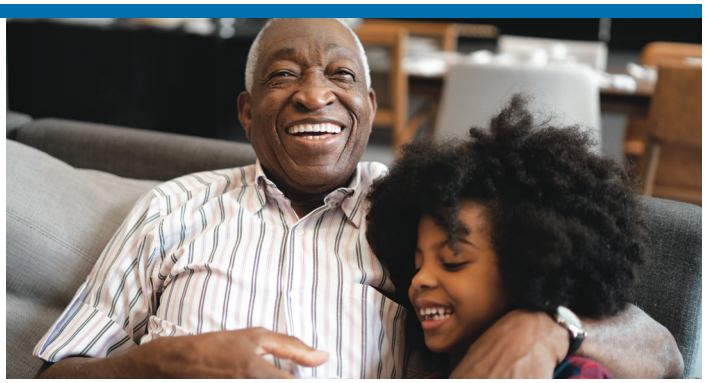
SilverSneakers®[1]

SilverSneakers is a fitness and lifestyle benefit that gives you the opportunity to connect with your community, make friends and stay active. Your membership gives you:

- Memberships to thousands of participating locations with use of basic amenities,[2] plus group exercise classes[3] for all levels at select locations.
- The SilverSneakers GO™ app with adjustable workout programs tailored to individual fitness levels, schedule reminders for favorite activities, the option to find convenient locations, and more.
- SilverSneakers On-Demand™ online videos for at-home workouts, plus health and nutrition tips.

To find a location near you, visit **www.SilverSneakers.com** or call **1-888-423-4632**, TTY: **711**, Monday to Friday, 8 a.m. to 8 p.m. ET.





Care and support with Aspire[4]

Aspire Health is a community-based program that specializes in providing an extra layer of support to patients facing serious illness and their families. This support is provided by a team of doctors, nurse practitioners, nurses, and social workers who work closely with a patient's primary care provider and other providers to coordinate care and improve communication. Aspire's clinical team is available 24/7 to provide extra care and attention, as well as education about illness, the plan of care and medications. Aspire's services are provided through a combination of home-based visits and telehealth support, depending upon location.

1 Always talk with your doctor before starting an exercise program. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2020 Tivity Health, Inc. All rights reserved.

2 Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

3 Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

4 Aspire Health is a separate company providing coordination of care through home-based visits and telehealth services on behalf of this plan.

Your doctor, your choice — nationwide

How National Access Plus works

- **Convenience** — see any doctor, provider or specialist who participates in Medicare and accepts the plan as an out-of-network provider.
- **Your copay or coinsurance remains the same** — whether in or out of this plan's provider network, your cost share doesn't change.
- **Your benefits and coverage won't change**, locally or nationwide, in or out of network, giving you added value.

What if a doctor or other provider says they don't accept this plan?

Doctors who are not in our network may not know they can work with us. Show them your membership card with the National Access Plus icon (appears at the top of this page and on your membership card). It helps ensure payment to your provider for your visit.

If your provider still has questions, have them call the provider phone number listed on the back of your membership card.

See any doctor, provider or specialist who participates in Medicare and accepts the plan.

Stay well and save money with SpecialOffers

With SpecialOffers, you can receive additional discounts on products and services that help promote better health and well-being.

Fitness and healthy living

Fitbit

Fitbit trackers and smartwatches that fit with your lifestyle, budget and goals. Save up to 22% on select Fitbit devices!

The Active&Fit Direct™ program*

- Choose from 10,000+ participating fitness centers nationwide
- $25/month membership (plus $25 enrollment fee and applicable taxes)
- No long-term contracts

Puritan's Pride

10% off vitamins, supplements and minerals

Garmin

20% off select Garmin wellness devices

Jenny Craig®

Free three-month program (food not included), plus $120 in food savings (purchase required) or save 50% off our premium programs (food cost separate)

SelfHelpWorks

Choose one of the online Living programs and save 15% on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep or face an alcohol problem.

The ChooseHealthy® program*

- Discounts on services such as acupuncture, chiropractic care, therapeutic massage and more from a nationwide network of health care providers.
- Discounts on fitness and wellness products such as activity trackers, equipment, and more. Obtain access to online health and wellness classes at no additional cost.

GlobalFit™

Discounts on gym memberships, fitness equipment, coaching, and more

* The ChooseHealthy program is provided by ChooseHealthy, Inc. and the Active&Fit Direct program is provided by American Specialty Health Fitness, Inc. (ASH Fitness). ChooseHealthy, Inc. and ASH Fitness are subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthy and Active&Fit Direct are trademarks of ASH and used with permission herein. The ChooseHealthy program is a discount program; it is not insurance. You can access services from any ChooseHealthy participating provider; referral from a primary care physician is not required. You are responsible for paying the discounted fee directly to the contracted provider.

More SpecialOffers

Vision

1-800 CONTACTS® or Glasses.com™

- $20 off orders of $100 or more for the latest contact lenses or brand-name frames
- Free shipping

Premier LASIK

- Save $800 on LASIK when you choose any featured Premier LASIK Network provider.
- Save 15% with all other in-network providers.

TruVision

- Save up to 40% on LASIK eye surgery at over 1,000+ locations
- Over 6.5 million procedures performed in the network

Family and home offerings

Allergy Control and National Allergy

Save up to 25% on select products. Free shipping on all orders over $59 when shipping ground within the contiguous U.S.

23andMe

- $40 off each Health + Ancestry Service kit
- 20% off one 23andMe kit — learn about your wellness, ancestry and more

Dental

ProClear™ Aligners

Improving your smile shouldn't cost a fortune. Now you can get a beautiful, professional smile in the comfort of your own home — all at a 50% savings. No metal braces; no time consuming dentist visits; no hidden fees. Order now and get a free whitening kit, along with your great-looking smile.

SpecialOffers is a discount program that is not part of your health plan coverage. It is a value-added online service we provide to give our Medicare Advantage members access to discounts offered by different vendors. Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for the products, services or information provided by SpecialOffers vendors. Arrangements and discounts were negotiated between vendors and Anthem for the benefit of our members. The products and services described are not part of our contract with Medicare. They are not subject to the Medicare appeals process. Any disputes about these products or services may be subject to the Anthem grievance process.

Easy plan onboarding

After joining the plan, watch for your welcome guide in the mail and keep it nearby so you can refer to it often.

Once your enrollment in this plan is processed, we will send you:

- Acknowledgment of your enrollment request and your effective start date.
- A letter showing proof of membership — use this until your plan membership card arrives.
- Your plan membership card.
- A simple health survey (within 90 days of enrollment) to help us understand and address your unique needs.

Additionally, you will receive our plan welcome guide. It explains how to:

- Start maximizing your benefits.
- Find doctors, hospitals, urgent care centers, and more providers.
- Access your plan documents online and in print, if needed.
- Contact us with questions.
- Find help when you need it.

Online and mobile resources*

We offer two convenient ways to access your plan information.

1 The Anthem consumer website

After you receive your membership card, register at **www.anthem.com** and follow the menu options to:

- View details of your plan, including claims status and history, and all of your plan documents, like your *Evidence of Coverage (EOC)*.
- Find a doctor, hospital, lab and other health care providers in your plan.
- Request a replacement membership card or print a temporary membership card.
- Use our secure messaging feature to reach us quickly and easily when you need help.
- Provide your email address and let us know your communication preference settings.
- Access our library of articles and videos to learn more about self-care, medicines and various health conditions, tests and treatments.

2 The Sydney Health mobile app

Want access to your plan information on the go? Sydney Health gives you a simple and connected experience through your iPhone or Android smartphone.

- View your membership card — wherever you are.
- Use your device's GPS to find nearby doctors, hospitals, and urgent care centers.
- Check the status of recent medical claims.
- Use the chat feature to quickly find answers to health questions.
- Set health reminders and wellness goals.
- Store and share health records with My Family Health Record (myFHR), which gives you the ability to share your health information with doctors, family members, and caregivers.

* Website tools are offered to Anthem plan members as extra services. They are not part of the contract and can change or stop.

Prescription drug benefit highlights

This plan covers the brand-name and generic drugs, including high-cost specialty drugs, you may use the most and offers the convenience of mail-order drug coverage, usually at a lower cost.

Our plan offers:

A pharmacy network

Our National Discount Network includes over 66,000 locations, which includes most national chains and many local pharmacies.

A $0 copay for Select Generics

This plan gives you access to commonly prescribed and proven generic drugs — treating conditions like diabetes, hypertension, and high cholesterol — with zero out-of-pocket expenses.

Coverage for most commonly prescribed drugs

This guide includes a list of the most commonly prescribed drugs that are covered by this plan. The complete drug list for this plan, also called the *Formulary*, includes all Medicare Part D eligible drugs covered by this plan. For a complete listing, please call **1-833-848-8729**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays.

Take advantage of our mail-order pharmacy options

Our mail-order pharmacy can offer significant cost savings, plus save you time, by providing up to a 90-day supply of your prescription drugs instead of a one-month supply. The copay for an increased supply through mail order is often lower than what you would pay at a retail pharmacy. Please check the Benefits Charts for the maximum day supply limits in the plan for mail-order drugs.

The top 50 **most commonly used drugs covered by this plan**

Generic drugs are in lowercase italics (for example, *lisinopril*), and brand-name drugs are shown in capital letters (for example, JANUVIA). If you do not see a medication you are using on this list, please call the **First Impressions Welcome Team** and ask them to check the full drug list for you.[1]

atorvastatin calcium	*latanoprost*	*triamterene/hydrochlorothiazide*
amlodipine besylate	SYNTHROID	*trazodone hydrochloride*
lisinopril	*losartan potassium/ hydrochlorothiazide*	*valsartan*
losartan potassium	*furosemide*	LANTUS
levothyroxine sodium tablet	*alendronate sodium*	*azithromycin*
metoprolol succinate	*ezetimibe*	*lovastatin*
simvastatin[2]	XARELTO	
metformin hydrochloride[2]	*lisinopril/hydrochlorothiazide*	
rosuvastatin calcium	SHINGRIX	
tamsulosin hydrochloride	*fluticasone propionate*	
hydrochlorothiazide	*meloxicam*	
gabapentin	JANUVIA	
metoprolol tartrate	*donepezil hydrochloride*	
pantoprazole sodium	*potassium chloride*[2]	
pravastatin sodium	*tramadol hydrochloride*	
ELIQUIS[2]	*glimepiride*	
carvedilol[2]	*duloxetine hydrochloride*	
montelukast sodium	*sertraline hydrochloride*	
clopidogrel	*allopurinol*	
omeprazole	*diclofenac sodium tablet*	
escitalopram oxalate	*atenolol*	
finasteride	*estradiol transdermal*	

Access a full list of covered drugs

Our **First Impressions Welcome Team** can check the full drug list for you. Give them a call at **1-833-848-8729**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays.

1 This list is current as of May 2020 but is not a complete list of drugs covered by our plan.

2 Not all dosages are covered at the generic cost share.

$0 copay for Select Generics[1]

TYPE OF DRUG	NAME OF DRUG	
Cardiovascular	Atenolol tablet	Irbesartan tablet
	Atenolol/chlorthalidone tablet	Irbesartan/hydrochlorothiazide tablet
	Benazepril hcl tablet	Lisinopril tablet
	Benazepril hcl/hydrochlorothiazide tablet	Lisinopril/hydrochlorothiazide tablet
	Bisoprolol/hydrochlorothiazide tablet	Losartan potassium tablet
	Carvedilol tablet	Losartan potassium/ hydrochlorothiazide tablet
	Chlorthalidone tablet	Metoprolol tartrate tablet
	Enalapril maleate tablet	Ramipril tablet
	Enalapril/hydrochlorothiazide tablet	Valsartan tablet
	Furosemide tablet	Valsartan/hydrochlorothiazide tablet
	Hydrochlorothiazide capsule/tablet	
Cholesterol	Atorvastatin tablet	Rosuvastatin tablet
	Lovastatin tablet	Simvastatin tablet[2]
	Pravastatin sodium tablet	
Diabetes	Glimepiride tablet	Glipizide/metformin hcl tablet
	Glipizide ER tablet	Metformin hcl ER tablet[2]
	Glipizide tablet	Metformin hcl tablet
Osteoporosis	Alendronate sodium tablet	

1 This list is current as of May 2020 but is not a complete list of drugs covered by our plan.

2 Not all dosages are covered at the Select Generics cost share.

How does Medicare Part D work?

This plan includes medical and prescription drug coverage. Your prescription drug coverage is called Medicare Part D. Part D is designed to help make your drugs more affordable. With your Part D coverage, you and your doctor are able to choose from a list of covered drugs, also called a formulary. These drugs are separated into tiers, which have different copay and coinsurance amounts.

How do drug tiers work?

Your plan's drug list is grouped into levels, or tiers. The drugs on the lowest tier are generally less expensive and the drugs on the highest tier are generally more expensive.

The table below can help you identify what type of drugs are covered on each tier.

How do I estimate my out-of-pocket prescription drug costs?

Call the **First Impressions Welcome Team** and ask them if your prescription drugs are covered. They can also estimate your out-of-pocket costs for your prescriptions.

What if my prescription drugs are not covered by this plan?

If the drug you take is not on our drug list, then you have three options:

1. Ask your doctor to switch you to a different drug that is covered.
2. Request an exception.
3. Request a temporary supply and discuss other drug options with your doctor.

TYPE OF MED.	DESCRIPTION OF MED.	TIER COVERAGE	COST COMPARISON
Generic medications	Same active ingredients and effects as the brand-name drug, but not the brand name	Tier 1	Least expensive drugs. Usually less than brand-name drugs.
		Tier 1 and Tier 2, if generic medications are split into two tiers based on price	
Preferred brand-name medications	Brand-name drugs that are proven to be safe and effective. This plan has preferred pricing for many drugs on this tier.	Tier 2, if the plan has one generic tier	More than generic drugs but less than non-preferred brand-name drugs
		Tier 3, if the plan has two generic tiers	
Non-preferred brand-name medications	Brand-name drugs with higher costs to this plan. Most of these drugs have a generic drug on a lower tier.	Tier 3, if the plan has one generic tier	More than preferred brand-name drugs
		Tier 4, if the plan has two generic tiers	
Specialty medications	Drugs that cost more than $670 for a 30-day supply and may need special handling	Tier 4, if the plan has one generic tier	These are the most expensive drugs.
		Tier 5, if the plan has two generic tiers	

How to qualify and enroll

How you qualify for this plan

To qualify for an Anthem Medicare Preferred (PPO) with Senior Rx Plus plan, you must meet all of these conditions:

- You are a United States (U.S.) citizen or are lawfully present in the U.S.
- You live in the plan's service area.
- You are now entitled to Medicare Part A and enrolled in Part B.
- You keep paying your Medicare Part B premiums, unless they are paid by Medicaid or through another third party.
- You qualify for coverage under your or your spouse's group-sponsored health plan.

For more information on enrollment, call the **First Impressions Welcome Team** at **1-833-848-8729**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays. You can also visit **www.medicare.gov** to learn more about when you can sign up for a plan.

How to enroll

When you are ready to enroll, complete and mail in the enrollment election form included in this guide. For more information on the Anthem Medicare Preferred (PPO) with Senior Rx Plus plans, please see the Benefits Charts starting on page 28.

What you need to complete the enrollment election form

- Your Medicare Number (the number on your red, white and blue Medicare card). Fill out the requested information as it appears on your Medicare card. If required, also attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board and send it along with your completed enrollment election form.
- Your permanent address and phone number.
- You must complete all items on pages marked required. The items on the page marked optional are not required to join the plan. Complete and sign the enrollment election form that starts on the next page, and mail it to the address listed on it.

Anthem

Anthem Blue Cross and Blue Shield Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required (unless marked optional)		
Group sponsor name: **Teachers' Retirement Fund (TRF)**		Group #: **IN000GRS**
Anthem Medicare Preferred (PPO) with Senior Rx Plus plan you will join **(check ONE box only)**: ☐ **Plan 5P - $192.36/per month** ☐ **Plan 10P - $65.21/per month** ☐ **Plan 0P - $236.03/per month**		Requested effective date of coverage: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) Generally the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed.
FIRST name:	LAST name:	Middle initial:
Birthdate: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ M ☐ F	Phone number: ( ) ☐ Cell ☐ Other
Permanent residence street address (Do not enter a P.O. Box):		
City:	State:	ZIP code:
Mailing address, if different from your permanent address (P.O. Box allowed): Street address: City: State: ZIP code:		
Email address:_____ Your email address will be used for communications only from Anthem Blue Cross and Blue Shield. We will not share your email address.		
Your Medicare information:		
Medicare Number:		

Please read and answer these important questions
1. Are you the retiree? ☐ Yes ☐ No If "yes," retirement date (month/date/year): _____ If "no," name of retiree:_____ Retiree Medicare ID #:_____
2. Do you have other medical insurance? ☐ Yes ☐ No If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____ What are the effective dates of coverage? _____
3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No If "yes," please provide the following information: Name of institution:_____ Address (number and street) and phone number of institution:_____ _____
4. Will you have other prescription drug coverage (like VA or TRICARE) in addition to this plan? ☐ Yes ☐ No Name of other coverage: Member number for this coverage: Group number for this coverage: _____ _____ _____
This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team at **1-833-848-8729**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays, for additional information or questions you may have.

All fields in this section are optional
Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No
List your primary care physician (PCP), clinic, or health center:

IMPORTANT: Read and sign below:

- I must keep Medicare Part A and Part B to stay in the plan I have selected.
- **Release of information:** By joining this Medicare Advantage Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Anthem Blue Cross and Blue Shield will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations.
- The information on this enrollment election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Anthem Medicare Preferred (PPO) with Senior Rx Plus coverage begins, I must get all of my medical and prescription drug benefits from Anthem Blue Cross and Blue Shield. Benefits and services authorized by Anthem Blue Cross and Blue Shield and contained in my Anthem Medicare Preferred (PPO) with Senior Rx Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Anthem Blue Cross and Blue Shield will pay for benefits or services.**
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this enrollment election form means that I have read and understand the contents of this enrollment election form. If signed by an authorized representative (as described above), this signature certifies that:
    1) This person is authorized under state law to complete this enrollment election form, and
    2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you are the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Anthem

Please check one of the boxes below to indicate premium payment method for your Anthem Medicare Preferred (PPO) with Senior Rx Plus plan:

☐ Deduct premium from pension fund

☐ Bill me directly (This is the default if no selection is made)

If you are the spouse and would like to select the pension deduction as your payment method, please have retiree sign below to authorize.

REQUIRED INFORMATION IF PENSION DEDUCTION IS SELECTED ABOVE:

TRF/Pension Identification Number (PID)* _____

Retiree signature_____ Today's date_____

* If you are unable to locate your PID, or your PID was not provided, please contact Indiana Public Retirement System (INPRS) at **1-844-464-6777**.

Note: If Pension deduction is selected and not available, Direct Billing will apply and an invoice including any retroactive premiums due will be sent to the address on file.

INTERNAL ANTHEM USE ONLY:
PID must be entered to EEID with enrollment processing for billing processes.

HIPAA authorization

If you would like to authorize an individual to have the ability to speak with us and/or obtain protected health information (PHI) on your account, please complete the HIPAA (Health Insurance Portability and Accountability Act) Member Authorization Form on the next page, and **sign and return it with this enrollment election form**. This form is valid for one year from the signature date.

- If you don't complete the HIPAA form at this time, a future request for this form can be made by contacting Member Services at the telephone number on the back of your membership card.
- If you wish to continue having the authorized representative on your account, a new form is required annually.
- If you have a durable health care power of attorney document, it can also be returned with the HIPAA form.

Please return this enrollment election form to:

Anthem Blue Cross and Blue Shield

P.O. Box 110

Fond du Lac, WI 54936-0110

Please refer to the Anthem Blue Cross and Blue Shield *Evidence of Coverage* for a complete listing of all plan benefits, conditions, limitations and exclusions of coverage.

Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team number listed in this document to request interpreter services.

512528INSENABS_ISTRF

Instructions for completing the *Pre-member/member authorization form*

If you have any questions, please call the First Impressions Welcome Team.

Please read the following for help completing page one of the form.

Part A: pre-member/member information

This section applies to the pre-member/member who is asking for the release of their information to another person or company.

1. Print your last name, first name and middle initial.
2. Write your date of birth in this format: MM/DD/YYYY. (If you were born on October 5, 1960, you would write 10/05/1960.)
3. Write your full street address, city, state and ZIP code.
4. Write your daytime phone number (including area code).
5. Write your cell/mobile phone number (including area code).
6. Write your identification number (issued when enrolled as a member). You will find this number on your membership card.
7. Write your group number. You will find this number on the enrollment election form. If your enrollment election form does not have a group number, leave this blank.

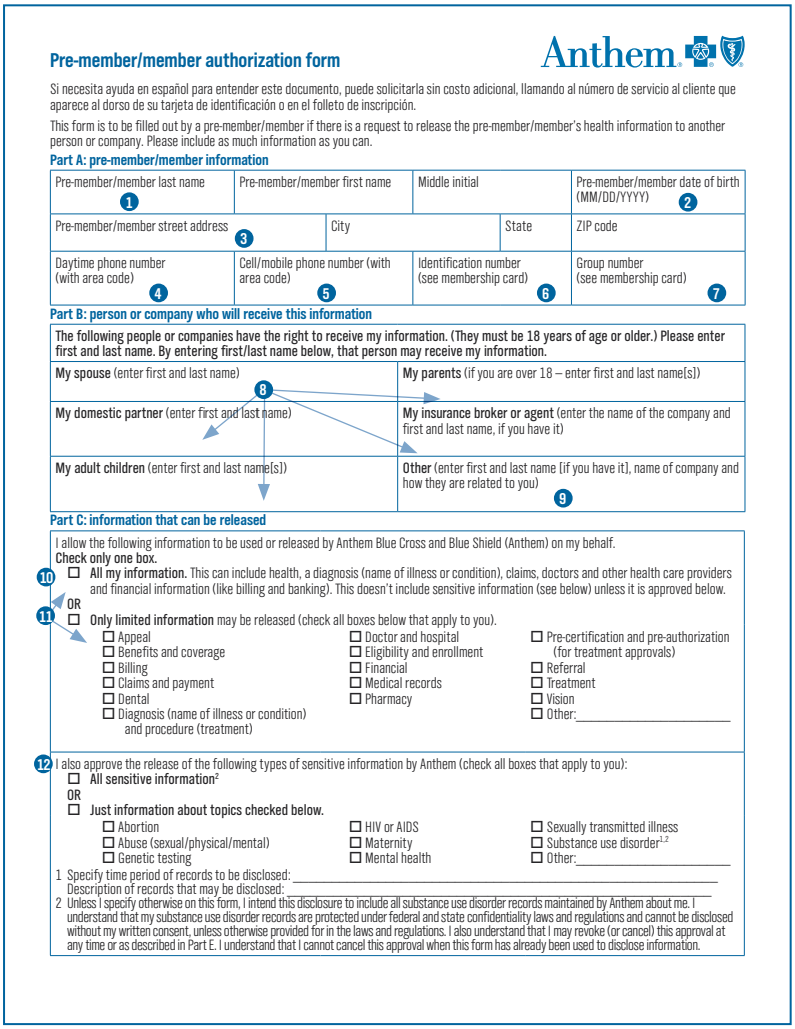
Part B: person or company who will receive this information

8. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son," as it will not be accepted. You need to be specific.
9. If you check "Other," give the first and last name (if available), the name of the company (if applicable) and how they relate to you.

Part C: information that can be released

This section tells us what information you would like us to release: all or just some.

10. For all of your information, check the first box.
11. For limited information, check the second box and the boxes that apply to you.
12. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.



Pre-member/member authorization form

Anthem

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a pre-member/member if there is a request to release the pre-member/member's health information to another person or company. Please include as much information as you can.

Part A: pre-member/member information

Pre-member/member last name (1)	Pre-member/member first name	Middle initial	Pre-member/member date of birth (MM/DD/YYYY) (2)
Pre-member/member street address (3)	City	State	ZIP code
Daytime phone number (with area code) (4)	Cell/mobile phone number (with area code) (5)	Identification number (see membership card) (6)	Group number (see membership card) (7)

Part B: person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older.) Please enter first and last name. By entering first/last name below, that person may receive my information.

My spouse (enter first and last name) (8)	**My parents** (if you are over 18 – enter first and last name[s])
My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	**Other** (enter first and last name [if you have it], name of company and how they are related to you) (9)

Part C: information that can be released

I allow the following information to be used or released by Anthem Blue Cross and Blue Shield (Anthem) on my behalf.
Check only one box.

(10) ☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

(11) ☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Dental
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pharmacy
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Vision
- ☐ Other:_____

(12) I also approve the release of the following types of sensitive information by Anthem (check all boxes that apply to you):

☐ **All sensitive information**[2]

OR

☐ **Just information about topics checked below.**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Substance use disorder[1,2]
- ☐ Other:_____

1 Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent, unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Please read the following for help completing page two of the form.

Part D: purpose of this approval

This section tells us the reason you've asked for the release of your information.

1. Check the first box to let us know to give out this information as shown on this form.
2. Check the second box for a specific reason. An example might be to settle a life insurance claim.

Part E: date your approval expires

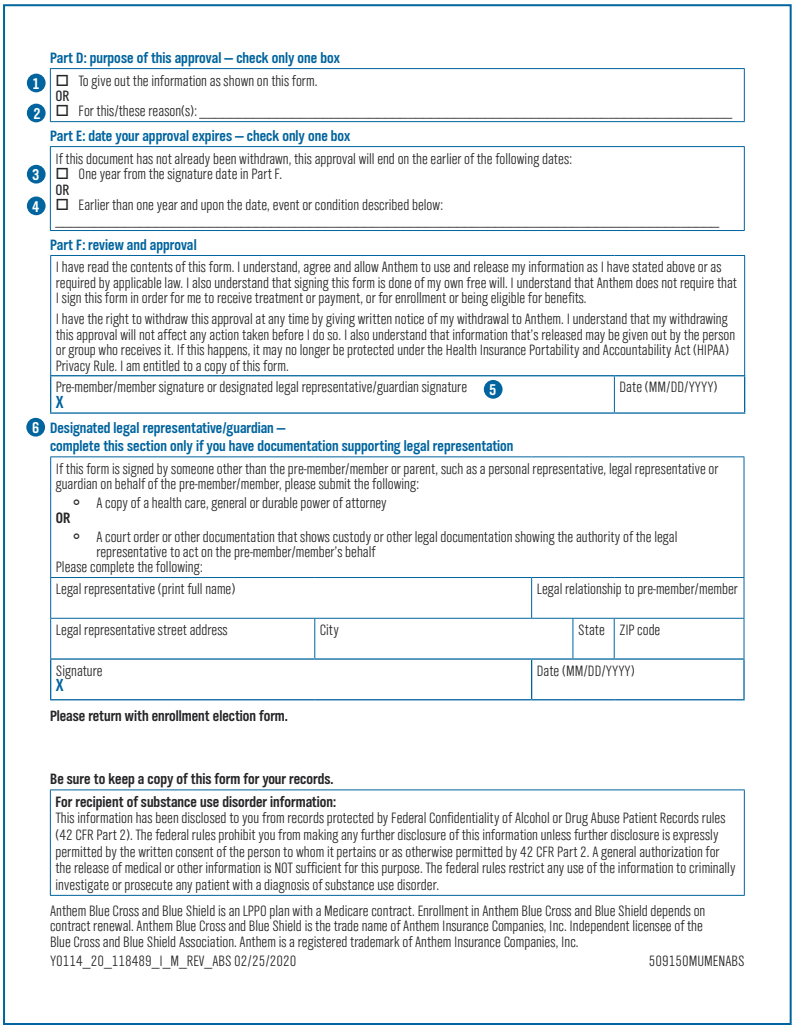
You have two choices of when you would like this approval to end.

3. Check the first box for the approval to end after one year, which is standard.
4. Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

Part F: review and approval

5. **Sign your name and put the date on the form.** Your name and signature ***must*** match the information in Part A.
6. **If you are signing this form on behalf of another person, or if you have power of attorney for health care or are a legal guardian/conservator, you must do the following:**
   - You must complete the designated legal representative/guardian section.
   - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



Part D: purpose of this approval – check only one box

1 ☐ To give out the information as shown on this form.
OR
2 ☐ For this/these reason(s): _____

Part E: date your approval expires – check only one box

If this document has not already been withdrawn, this approval will end on the earlier of the following dates:
3 ☐ One year from the signature date in Part F.
OR
4 ☐ Earlier than one year and upon the date, event or condition described below:
_____

Part F: review and approval

I have read the contents of this form. I understand, agree and allow Anthem to use and release my information as I have stated above or as required by applicable law. I also understand that signing this form is done of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I am entitled to a copy of this form.

Pre-member/member signature or designated legal representative/guardian signature 5 X	Date (MM/DD/YYYY)

6 **Designated legal representative/guardian – complete this section only if you have documentation supporting legal representation**

If this form is signed by someone other than the pre-member/member or parent, such as a personal representative, legal representative or guardian on behalf of the pre-member/member, please submit the following:
- A copy of a health care, general or durable power of attorney

OR
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the pre-member/member's behalf

Please complete the following:

Legal representative (print full name)			Legal relationship to pre-member/member
Legal representative street address	City	State	ZIP code
Signature X			Date (MM/DD/YYYY)

Please return with enrollment election form.

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information:
This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.

Examples of legal documents:

- **Health care, general or durable power of attorney.** This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal guardianship.** This is when the court appoints someone to care for another person.
- **Conservatorship.** This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for themselves.
- **Executor of estate.** This type of document would be used when the person who is being represented has died.

Pre-member/member authorization form

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a pre-member/member if there is a request to release the pre-member/member's health information to another person or company. Please include as much information as you can.

Part A: pre-member/member information

Pre-member/member last name	Pre-member/member first name	Middle initial	Pre-member/member date of birth (MM/DD/YYYY)
Pre-member/member street address	City	State	ZIP code
Daytime phone number (with area code)	Cell/mobile phone number (with area code)	Identification number (see membership card)	Group number (see membership card)

Part B: person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older.) Please enter first and last name. By entering first/last name below, that person may receive my information.

My spouse (enter first and last name)	**My parents** (if you are over 18 – enter first and last name[s])
My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	**Other** (enter first and last name [if you have it], name of company and how they are related to you)

Part C: information that can be released

I allow the following information to be used or released by Anthem Blue Cross and Blue Shield (Anthem) on my behalf.

Check only one box.

☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Dental
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pharmacy
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Vision
- ☐ Other:_____

I also approve the release of the following types of sensitive information by Anthem (check all boxes that apply to you):

☐ **All sensitive information**[2]

OR

☐ **Just information about topics checked below.**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Substance use disorder[1,2]
- ☐ Other:_____

1 Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent, unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Part D: purpose of this approval – check only one box

☐ To give out the information as shown on this form.
OR
☐ For this/these reason(s): _____

Part E: date your approval expires – check only one box

If this document has not already been withdrawn, this approval will end on the earlier of the following dates:
☐ One year from the signature date in Part F.
OR
☐ Earlier than one year and upon the date, event or condition described below:

_____

Part F: review and approval

I have read the contents of this form. I understand, agree and allow Anthem to use and release my information as I have stated above or as required by applicable law. I also understand that signing this form is done of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I am entitled to a copy of this form.

Pre-member/member signature or designated legal representative/guardian signature **X**	Date (MM/DD/YYYY)

Designated legal representative/guardian – complete this section only if you have documentation supporting legal representation

If this form is signed by someone other than the pre-member/member or parent, such as a personal representative, legal representative or guardian on behalf of the pre-member/member, please submit the following:

- A copy of a health care, general or durable power of attorney

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the pre-member/member's behalf

Please complete the following:

Legal representative (print full name)		Legal relationship to pre-member/member	
Legal representative street address	City	State	ZIP code

Signature **X**	Date (MM/DD/YYYY)

Please return with enrollment election form.

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information:
This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.

Complete Benefits Charts

The Benefits Charts give you details about the many medical and prescription drug benefits this plan offers, including:

- What we cover.
- Copay amounts, if any.
- Coinsurance amounts, if any.
- Out-of-pocket costs, if any.

Need help?

We're always happy to go over your Benefits Charts with you! The **First Impressions Welcome Team** is available at **1-833-848-8729**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays.

Look for the apple

It shows a preventive service. **We cover preventive services at no cost** if you see a doctor who accepts Medicare and the plan.

Be in the know!

The Medical and Prescription Drug Benefits Charts start on the next page.

5P plan Benefits Charts

The following pages show the medical and prescription drug benefits charts for the 5P plan. There is a monthly premium of $192.36 for the 5P plan.

Your 2021 Medical Benefits Chart
PPO Plan 5P Low

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.		
Prior authorization* Benefit categories that include services that require prior authorization are marked with an asterisk (*). Additional information can be found on the last page of the medical benefits chart.		
Annual deductible • The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	$0 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	For Medicare-covered hospital stays: $100 copay per admission The inpatient hospital out-of-pocket maximum is $300 per year combined with inpatient mental health care and combined in-network and out-of-network.	For Medicare-covered hospital stays: $100 copay per admission The inpatient hospital out-of-pocket maximum is $300 per year combined with inpatient mental health care and combined in-network and out-of-network.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • 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 • 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.	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	No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Physician services In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	For Medicare-covered hospital stays: $100 copay per admission The inpatient mental health care out-of-pocket maximum is $300 per year combined with inpatient hospital care and combined in-network and out-of-network. 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	For Medicare-covered hospital stays: $100 copay per admission The inpatient mental health care out-of-pocket maximum is $300 per year combined with inpatient hospital care and combined in-network and out-of-network. No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care*	For Medicare-covered SNF stays:	For Medicare-covered SNF stays:
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.	$10 copay per day for days 1-100 per benefit period	$10 copay per day for days 1-100 per benefit period
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	No prior hospital stay required.	No prior hospital stay required.
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)		

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	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefits chart at the cost share amounts indicated.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home health agency care*	$0 copay for Medicare-covered home health visits	$0 copay for Medicare-covered home health visits
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	Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	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. $20 copay for the one time only hospice consultation	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. $20 copay for the one time only hospice consultation

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Hospice care (con't) For services that are covered by this plan but are not covered by Medicare Part A or B: This plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. If you have Part D prescription drug coverage, some drugs may be covered under your Part D benefit. Drugs are never covered by both hospice and your Part D plan at the same time. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient services		
Physician services, including doctor's office visits*	$5 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services	$5 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services
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	$20 copay per visit to an in-network specialist for Medicare-covered services	$20 copay per visit to an out-of-network specialist for Medicare-covered services
• Basic diagnostic hearing and balance exams, if your doctor orders it to see if you need medical treatment, when furnished by a physician, audiologist, or other qualified provider		
• Telehealth services for some physician or mental health services can be found in the section of this benefit chart titled, Video doctor visits. You have the option of getting these services through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, you must use a network provider who has an agreement with us to provide telehealth services.	$5 copay per visit to an in-network retail health clinic for Medicare-covered services	$5 copay per visit to an out-of-network retail health clinic for Medicare-covered services
• Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare	$0 copay for Medicare-covered allergy testing	$0 copay for Medicare-covered allergy testing
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home	$0 copay for Medicare-covered allergy injections	$0 copay for Medicare-covered allergy injections
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke	See antigen cost share in Part B drug section.	See antigen cost share in Part B drug section.
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network

Physician services, including doctor's office visits (con't)
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if:
  ○ You're not a new patient **and**
  ○ The evaluation isn't related to an office visit in the past 7 days **and**
  ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient
• 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		

Chiropractic services • We cover only manual manipulation of the spine to correct subluxation.	$20 copay for each Medicare-covered visit	$20 copay for each Medicare-covered visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain* Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • Not associated with surgery; and • Not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	$5 copay for each Medicare-covered visit	$5 copay for each Medicare-covered visit
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	$20 copay for each Medicare-covered visit	$20 copay for each Medicare-covered visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services*	$20 copay for each Medicare-covered professional individual therapy visit	$20 copay for each Medicare-covered professional individual therapy visit
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	$20 copay for each Medicare-covered professional group therapy visit	$20 copay for each Medicare-covered professional group therapy visit
"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.	$20 copay for each Medicare-covered professional partial hospitalization visit	$20 copay for each Medicare-covered professional partial hospitalization visit
	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit
	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit
	$0 copay for each Medicare-covered partial hospitalization facility visit	$0 copay for each Medicare-covered partial hospitalization facility visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient substance abuse services, including partial hospitalization services*	$20 copay for each Medicare-covered professional individual therapy visit	$20 copay for each Medicare-covered professional individual therapy visit
"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.	$20 copay for each Medicare-covered professional group therapy visit	$20 copay for each Medicare-covered professional group therapy visit
	$20 copay for each Medicare-covered professional partial hospitalization visit	$20 copay for each Medicare-covered professional partial hospitalization visit
	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit
	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit
	$0 copay for each Medicare-covered partial hospitalization facility visit	$0 copay for each Medicare-covered partial hospitalization facility visit

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 www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	$50 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $50 copay for each Medicare-covered outpatient observation room visit	$50 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $50 copay for each Medicare-covered outpatient observation room visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient hospital observation, non-surgical* Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **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 www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	$5 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $20 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $50 copay for each Medicare-covered outpatient observation room visit	$5 copay for a visit to an out-of-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $20 copay for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $50 copay for each Medicare-covered outpatient observation room visit
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. $50 copay per one-way trip for Medicare-covered ambulance services	

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.	$50 copay for each Medicare-covered emergency room visit	

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.	$20 copay for each Medicare-covered urgently needed care visit	
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).	$20 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits	$20 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits
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.	$20 copay for Medicare-covered cardiac rehabilitation therapy visits	$20 copay for Medicare-covered cardiac rehabilitation therapy visits

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	$20 copay for Medicare-covered pulmonary rehabilitation therapy visits	$20 copay for Medicare-covered pulmonary rehabilitation therapy visits
Supervised exercise therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$20 copay for Medicare-covered supervised exercise therapy visits	$20 copay for Medicare-covered supervised exercise therapy visits

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, continuous blood glucose monitors, 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. Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. Coverage is limited to 2 sensors per month and one receiver every 2 years. This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids (HA). For new prescriptions, we will not cover other brands unless your provider tells us it is medically necessary. The review of medical necessity for use of HA and any non-preferred brands is part of the plan's prior authorization process.	10% coinsurance for Medicare-covered DME See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.	10% coinsurance for Medicare-covered DME See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.
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.	10% coinsurance for Medicare-covered prosthetics and orthotics	10% coinsurance for Medicare-covered prosthetics and orthotics

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefits • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier • Durable medical equipment – pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items	$0 copay for Medicare-covered professional services provided by a Medicare-certified home health agency or home infusion supplier 10% coinsurance for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)	$0 copay for Medicare-covered professional services provided by a Medicare-certified home health agency or home infusion supplier 10% coinsurance for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Diabetes self-management training, diabetic services, and supplies*	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	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
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 year • Up to 200 blood glucose test strips and lancets for a 30-day supply • One pair per year of therapeutic custom molded shoes (including inserts provided with such shoes) and two additional pairs of inserts or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Diabetes self-management training is covered under certain conditions	10% coinsurance for Medicare-covered blood glucose monitor 10% coinsurance for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training	10% coinsurance for Medicare-covered blood glucose monitor 10% coinsurance for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies*	$20 copay for each Medicare-covered X-ray visit and/or simple diagnostic test	$20 copay for each Medicare-covered X-ray visit and/or simple diagnostic test
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.	$50 copay for Medicare-covered complex diagnostic test and/or radiology visit $20 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease 10% coinsurance for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood	$50 copay for Medicare-covered complex diagnostic test and/or radiology visit $20 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease 10% coinsurance for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Opioid treatment program services* Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	$20 copay per visit for Medicare-covered opioid treatment program services	$20 copay per visit for Medicare-covered opioid treatment program services

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Vision care (non-routine) 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.)	$5 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $20 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening $5 copay for glasses/contacts following Medicare-covered cataract surgery	$5 copay for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $20 copay for visits to an out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening $5 copay for glasses/contacts following Medicare-covered cataract surgery

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.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.

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 at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy Colorectal services: • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.
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.	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.

Covered services	What you must pay for these covered services	
	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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Medicare Part B immunizations Covered services include: • Pneumonia vaccine • Flu shots, including H1N1, once each flu season in the fall and winter, with additional flu shots if medically necessary • 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 pneumonia, influenza, Hepatitis B, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.
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.	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
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.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.
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 healthy.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.
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.	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
"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.	There is no coinsurance, copayment, or deductible for the Medicare-covered "Welcome to Medicare" preventive visit.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.
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/or referrals.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.
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.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
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.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.

Covered services	What you must pay for these covered services	
	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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Covered services	What you must pay for these covered services	
	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.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Smoking and tobacco use cessation (counseling to quit smoking) 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Other services		
Services to treat outpatient kidney disease 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 $5 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $5 copay for Medicare-covered self-dialysis training 10% coinsurance for Medicare-covered home dialysis equipment and supplies 10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies	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 $5 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $5 copay for Medicare-covered self-dialysis training 10% coinsurance for Medicare-covered home dialysis equipment and supplies 10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies

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)*	20% coinsurance for Medicare-covered Part B drugs	20% coinsurance for Medicare-covered 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 We also cover some vaccines under our Part B prescription drug benefit.	20% coinsurance for Medicare-covered Part B drug administration 20% coinsurance for Medicare-covered Part B chemotherapy drugs 20% coinsurance for Medicare-covered Part B chemotherapy drug administration	20% coinsurance for Medicare-covered Part B drug administration 20% coinsurance for Medicare-covered Part B chemotherapy drugs 20% coinsurance for Medicare-covered Part B chemotherapy drug administration

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) (con't) Some of Part B covered drugs listed above may be subject to step therapy. You may log into your secure member portal to find the list of Part B drugs that may be subject to step therapy. This list is located with your Plan Documents under your Benefits section. **If you have Part D prescription drug coverage, please refer to your *Evidence of Coverage* for information on your Part D prescription drug benefits.**		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Additional supplemental benefits, services, and discounts		
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. The hearing aid benefit does not provide coverage for amplifiers, internet purchases, assistive listening devices (ALDs) or accessories. We have partnered with Hearing Care Solutions to bring you these discounts and services. For additional benefit information and to locate a Hearing Care Solutions participating provider, please contact Member Services. Hearing benefit management administered by Hearing Care Solutions, an independent company.	Must use a Hearing Care Solutions participating provider. $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Members receive a free battery supply during the first 3 years with a 64-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 any remaining cost.	$0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Members receive a free battery supply during the first 3 years with a 64-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 any 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 1 every calendar year. The routine vision exam is limited to a $70 maximum benefit every calendar year combined in-network and out-of-network. • Eyewear Eyewear is limited to a $100 maximum benefit* every 2 calendar years combined in-network and out-of-network. Covered eyewear includes prescription glasses, lenses, frames and contacts. This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. This information is intended to be a brief outline of coverage. For additional benefit information, including exclusions and limitations or to locate a participating Blue View Vision provider, please contact Member Services. You will be directed to the dedicated Blue View Vision Member Services line. If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. In-network benefits and discounts will not apply. * Any remaining unused eyewear benefit amount must be used in the same calendar year of the first eyewear purchase. Unused amounts cannot carry over to the following calendar year or benefit period.	Must use a Blue View Vision provider. $0 copay for routine vision exams $0 copay for eyewear After the plan pays benefits for routine vision exams and eyewear you are responsible for any remaining cost.	$0 copay for routine vision exams $0 copay for eyewear After the plan pays benefits for routine vision exams and eyewear you are responsible for any remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	$5 copay for each visit to an in-network primary care physician for routine foot care $20 copay for each visit to an in-network specialist for routine foot care After the plan pays benefits for routine foot care, you are responsible for any remaining cost.	$5 copay for each visit to an out-of-network primary care physician for routine foot care $20 copay for each visit to an out-of-network specialist for routine foot care After the plan pays benefits for routine foot care, you are responsible for any 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	$0 copay for an annual physical exam

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 and psychiatrists 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 Membership 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 Membership 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 talk with a therapist[2] or make an appointment and talk with a psychiatrist[3] from the privacy of your home. Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this Plan. 1. Prescription is prescribed based on physician recommendations and state regulations (rules). 2. Appointments are typically scheduled within 14 days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. 3. Appointments are typically scheduled within 14 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.	$0 copay for video doctor visits using LiveHealth Online	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Health and wellness education programs **SilverSneakers®** Membership SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GO™. 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. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. 1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2020 Tivity Health, Inc. All rights reserved.	$0 copay for the SilverSneakers fitness benefit	

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 the nurse helpline is included in our plan. All other nurse access programs are excluded.	$0 copay for nurse helpline	
Foreign travel emergency and urgently needed services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than 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.	$50 copay for emergency care $20 copay for urgently needed services $100 copay per admission for emergency inpatient care	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Community Resource Support Need help with a specific issue? Although your plan benefits are designed to cover what Medicare would cover, as well as some additional supplemental benefits as described in this benefits chart, you might need additional help. As a member, your plan provides the support of a community resource outreach team to help bridge the gap between your medical benefits and the resources available to you in your community. The Medicare Community Resource Support team will assist you by providing information and education about community-based services and support programs in your area. If you need assistance or have questions about this benefit, call Member Services at the number listed on the back of your Membership Card.	$0 copay for Medicare Community Resource Support	
Healthy Meals* • Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total). • A qualifying event includes when you are in a hospital or a skilled nursing facility and are discharged home or when you have a Body Mass Index (BMI) of 18.5 or under, you have a BMI of 25 or higher or an A1C level more than 9.0 as determined by your provider. For fastest qualification, your provider or case manager is best suited to request this on your behalf. Alternatively, you can contact Member Services and a representative will initiate the process to validate your eligibility. In order for us to provide your meals benefit, we, or a third party acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements.	$0 copay for Healthy Meals	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Healthy Pantry*	$0 copay for Healthy Pantry	
Special Supplemental Benefits for the Chronically Ill Maintaining a healthy diet to support a chronic medical condition can help you maintain or improve your overall health. As a Special Supplemental Benefit for the Chronically Ill, you must: • Meet the CMS mandated criteria. This criteria can be found in the Chapter “Medical benefits (what is covered and what you pay)" in your Evidence of Coverage. • Provide supporting documentation from your physician identifying you, as having a condition that can be made worse by not having or would benefit from having nutritional counseling and help with obtaining appropriate pantry items. We can help you obtain this information. We are unable to initiate your benefit without speaking to you. By requesting this benefit you are expressly authorizing us to contact you by telephone. Upon approval you are eligible for: • Monthly nutritional counseling sessions via phone. • A monthly delivery of non-perishable pantry items sent directly to your home. Your monthly box of staples will consist of a variety of non-perishable foods that can vary each month. • Your nutritional consultations will help you utilize these items and provide you with information on how to supplement them with additional food resources. You can contact Member Services on the back of your Membership Card to begin the process to validate your eligibility.		

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 benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of the routine hearing services, routine vision 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.	$3,400 Combined in-network and out-of-network	

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the Benefits Chart.

Your 2021 Prescription Drug Benefits Chart
Basic 10/30/60/200 (Generic Gap) (with Senior Rx Plus)

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

Formulary	Basic
Deductible	$250
Supplemental Gap Coverage	Tier 1 Generics

Covered Services	What you pay
Part D Initial Coverage	
Below is your payment responsibility from the time you meet your deductible, until the amount paid by you and your retiree drug plan for covered Part D prescriptions reaches your Initial Coverage Limit of $4,130.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay Deductible waived on Select Generics
• Generics	$10 copay
• Preferred Brands	$30 copay
• Non-Preferred Drugs	$60 copay
• Specialty Drugs	$200 copay
Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.	
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay Deductible waived on Select Generics
• Generics	$20 copay
• Preferred Brands	$60 copay
• Non-Preferred Drugs	$120 copay
• Specialty Drugs	$200 copay

Covered Services	What you pay
Part D Gap Coverage	
Your payment responsibility changes once you reach your Initial Coverage Limit of $4,130. Below is your payment responsibility during the period after you meet your Initial Coverage Limit and until you meet your True Out of Pocket limit.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Generics	$10 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
• Specialty Drugs	25% coinsurance
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay
• Generics	$20 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
• Specialty Drugs	25% coinsurance
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $6,550.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Generic Drugs	5% coinsurance with a minimum copay of $3.70 and a maximum copay of $10
• Brand-Name Drugs	5% coinsurance with a minimum copay of $9.20 and a maximum copay of $30

- **Coverage Gap Discount Program:** If you are not receiving help to pay your share of drug cost through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2021, once the cost paid by you and your retiree drug plan reaches $4,130 the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount. The Coverage Gap Discount applies until the cost paid by you and the Discount reaches $6,550. Drug manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. **Please note:** Your retiree drug plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to drugs listed as "Extra Covered Drugs" in your benefits.

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever, and Hepatitis A are covered under Medicare drug coverage. Hepatitis B is covered under drug coverage unless you fall into a high risk category, then it is covered under medical coverage. Other common vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to pay its share of the cost. Please see your Evidence of Coverage for complete details on what you pay for vaccines.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits and the Coverage Gap Discount. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

10P plan Benefits Charts

The following pages show the medical and prescription drug benefits charts for the 10P plan. There is a monthly premium of $65.21 for the 10P plan.

Your 2021 Medical Benefits Chart
PPO Plan 10P
Indiana State Teachers' Retirement Fund

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.		
Prior authorization* Benefit categories that include services that require prior authorization are marked with an asterisk (*). Additional information can be found on the last page of the medical benefits chart.		
Annual deductible • The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	$0 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	For Medicare-covered hospital stays: $275 copay per day for days 1-7, per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: $275 copay per day for days 1-7, per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • 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 • 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.		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) Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines. • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Physician services In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	For Medicare-covered hospital stays: $235 copay per day for days 1-6, per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: $235 copay per day for days 1-6, per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care*	For Medicare-covered SNF stays:	For Medicare-covered SNF stays:
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)	$0 copay for days 1-20; $172 copay per day for days 21-100 per benefit period No prior hospital stay required.	$0 copay for days 1-20; $172 copay per day for days 21-100 per benefit period 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	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefits chart at the cost share amounts indicated.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home health agency care*	$0 copay for Medicare-covered home health visits	$0 copay for Medicare-covered home health visits
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	Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	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.	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. $40 copay for the one time only hospice consultation	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. $40 copay for the one time only hospice consultation

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Hospice care (con't) • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services. <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*	$10 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services	$10 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services

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
• Telehealth services for some physician or mental health services can be found in the section of this benefit chart titled, Video doctor visits. You have the option of getting these services through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, you must use a network provider who has an agreement with us to provide telehealth services.
• Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:
  ○ You're not a new patient **and**
  ○ The check-in isn't related to an office visit in the past 7 days **and**
  ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
	$40 copay per visit to an in-network specialist for Medicare-covered services
	
	$10 copay per visit to an in-network retail health clinic for Medicare-covered services
	
	$0 copay for Medicare-covered allergy testing
	
	$0 copay for Medicare-covered allergy injections
	
	See antigen cost share in Part B drug section.
		$40 copay per visit to an out-of-network specialist for Medicare-covered services
		
		$10 copay per visit to an out-of-network retail health clinic for Medicare-covered services
		
		$0 copay for Medicare-covered allergy testing
		
		$0 copay for Medicare-covered allergy injections
		
		See antigen cost share in Part B drug section.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network

Physician services, including doctor's office visits (con't)
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if:
  ○ You're not a new patient **and**
  ○ The evaluation isn't related to an office visit in the past 7 days **and**
  ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient
• 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		

Chiropractic services • We cover only manual manipulation of the spine to correct subluxation.	$20 copay for each Medicare-covered visit	$20 copay for each Medicare-covered visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain* Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • Not associated with surgery; and • Not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	$10 copay for each Medicare-covered visit	$10 copay for each Medicare-covered visit
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	$40 copay for each Medicare-covered visit	$40 copay for each Medicare-covered visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services*	$40 copay for each Medicare-covered professional individual therapy visit	$40 copay for each Medicare-covered professional individual therapy visit
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	$40 copay for each Medicare-covered professional group therapy visit	$40 copay for each Medicare-covered professional group therapy visit
"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.	$40 copay for each Medicare-covered professional partial hospitalization visit	$40 copay for each Medicare-covered professional partial hospitalization visit
	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit
	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit
	$0 copay for each Medicare-covered partial hospitalization facility visit	$0 copay for each Medicare-covered partial hospitalization facility visit

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.	$40 copay for each Medicare-covered professional individual therapy visit $40 copay for each Medicare-covered professional group therapy visit $40 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit	$40 copay for each Medicare-covered professional individual therapy visit $40 copay for each Medicare-covered professional group therapy visit $40 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit

Covered services	What you must pay for these covered services	
	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 www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	$225 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $225 copay for each Medicare-covered outpatient observation room visit	$225 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $225 copay for each Medicare-covered outpatient observation room visit

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient hospital observation, non-surgical* Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **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 www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$10 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $40 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $225 copay for each Medicare-covered outpatient observation room visit	$10 copay for a visit to an out-of-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $40 copay for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $225 copay for each Medicare-covered outpatient observation room visit

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. $265 copay per one-way trip for Medicare-covered ambulance services	

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.	$90 copay for each Medicare-covered emergency room visit	

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.	$35 copay for each Medicare-covered urgently needed care visit	
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).	$40 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits	$40 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits
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.	$35 copay for Medicare-covered cardiac rehabilitation therapy visits	$35 copay for Medicare-covered cardiac rehabilitation therapy visits

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	$30 copay for Medicare-covered pulmonary rehabilitation therapy visits	$30 copay for Medicare-covered pulmonary rehabilitation therapy visits
Supervised exercise therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$30 copay for Medicare-covered supervised exercise therapy visits	$30 copay for Medicare-covered supervised exercise therapy visits

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, continuous blood glucose monitors, 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. Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. Coverage is limited to 2 sensors per month and one receiver every 2 years. This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids (HA). For new prescriptions, we will not cover other brands unless your provider tells us it is medically necessary. The review of medical necessity for use of HA and any non-preferred brands is part of the plan's prior authorization process.	20% coinsurance for Medicare-covered DME See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.	20% coinsurance for Medicare-covered DME See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.
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.	20% coinsurance for Medicare-covered prosthetics and orthotics	20% coinsurance for Medicare-covered prosthetics and orthotics

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home infusion therapy*	$0 copay for Medicare-covered professional services provided by a Medicare-certified home health agency or home infusion supplier	$0 copay for Medicare-covered professional services provided by a Medicare-certified home health agency or home infusion supplier
Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefits • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier • Durable medical equipment – pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items	20% coinsurance for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)	20% coinsurance for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)

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 year • Up to 200 blood glucose test strips and lancets 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	20% 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 20% coinsurance for Medicare-covered blood glucose monitor 20% coinsurance for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training	20% 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 20% coinsurance for Medicare-covered blood glucose monitor 20% coinsurance for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies*	$40 copay for each Medicare-covered X-ray visit and/or simple diagnostic test	$40 copay for each Medicare-covered X-ray visit and/or simple diagnostic test
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.	$125 copay for Medicare-covered complex diagnostic test and/or radiology visit 20% coinsurance for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease 20% coinsurance for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood	$125 copay for Medicare-covered complex diagnostic test and/or radiology visit 20% coinsurance for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease 20% coinsurance for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Opioid treatment program services* Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	$40 copay per visit for Medicare-covered opioid treatment program services	$40 copay per visit for Medicare-covered opioid treatment program services

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Vision care (non-routine) Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic-Americans who are age 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	$10 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $40 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening $0 copay for glasses/contacts following Medicare-covered cataract surgery	$10 copay for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $40 copay for visits to an out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening $0 copay for glasses/contacts following Medicare-covered cataract surgery

Covered services	What you must pay for these covered services	
	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.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.

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 at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy Colorectal services: • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.
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.	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.

Covered services	What you must pay for these covered services	
	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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Medicare Part B immunizations Covered services include: • Pneumonia vaccine • Flu shots, including H1N1, once each flu season in the fall and winter, with additional flu shots if medically necessary • 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 pneumonia, influenza, Hepatitis B, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.

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.	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.
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.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
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.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.
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 healthy.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.
"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.	There is no coinsurance, copayment, or deductible for the Medicare-covered "Welcome to Medicare" preventive visit.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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/or referrals.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.
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.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.
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.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.
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.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
🍎 **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.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Other services		
Services to treat outpatient kidney disease 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 20% coinsurance for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $10 copay for Medicare-covered self-dialysis training 20% coinsurance for Medicare-covered home dialysis equipment and supplies 20% coinsurance for Medicare-covered outpatient dialysis equipment and supplies	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 20% coinsurance for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $10 copay for Medicare-covered self-dialysis training 20% coinsurance for Medicare-covered home dialysis equipment and supplies 20% coinsurance for Medicare-covered outpatient dialysis equipment and supplies

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)*	20% coinsurance for Medicare-covered Part B drugs	20%coinsurance for Medicare-covered 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 We also cover some vaccines under our Part B prescription drug benefit.	20% coinsurance for Medicare-covered Part B drug administration 20% coinsurance for Medicare-covered Part B chemotherapy drugs 20% coinsurance for Medicare-covered Part B chemotherapy drug administration	20% coinsurance for Medicare-covered Part B drug administration 20% coinsurance for Medicare-covered Part B chemotherapy drugs 20% coinsurance for Medicare-covered Part B chemotherapy drug administration

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) (con't) Some of Part B covered drugs listed above may be subject to step therapy. You may log into your secure member portal to find the list of Part B drugs that may be subject to step therapy. This list is located with your Plan Documents under your Benefits section. **If you have Part D prescription drug coverage, please refer to your *Evidence of Coverage* for information on your Part D prescription drug benefits.**		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Additional supplemental benefits, services, and discounts		
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. The hearing aid benefit does not provide coverage for amplifiers, internet purchases, assistive listening devices (ALDs) or accessories. We have partnered with Hearing Care Solutions to bring you these discounts and services. For additional benefit information and to locate a Hearing Care Solutions participating provider, please contact Member Services. Hearing benefit management administered by Hearing Care Solutions, an independent company.	Must use a Hearing Care Solutions participating provider. $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Members receive a free battery supply during the first 3 years with a 64-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 any remaining cost.	$0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Members receive a free battery supply during the first 3 years with a 64-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 any 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 1 every calendar year. The routine vision exam is limited to a $70 maximum benefit every calendar year combined in-network and out-of-network. • Eyewear Eyewear is limited to a $100 maximum benefit* every 2 calendar years combined in-network and out-of-network. Covered eyewear includes prescription glasses, lenses, frames and contacts. This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. This information is intended to be a brief outline of coverage. For additional benefit information, including exclusions and limitations or to locate a participating Blue View Vision provider, please contact Member Services. You will be directed to the dedicated Blue View Vision Member Services line. If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. In-network benefits and discounts will not apply. * Any remaining unused eyewear benefit amount must be used in the same calendar year of the first eyewear purchase. Unused amounts cannot carry over to the following calendar year or benefit period.	Must use a Blue View Vision provider. $0 copay for routine vision exams $0 copay for eyewear After the plan pays benefits for routine vision exams and eyewear you are responsible for any remaining cost	$0 copay for routine vision exams $0 copay for eyewear After the plan pays benefits for routine vision exams and eyewear you are responsible for any remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	$10 copay for each visit to an in-network primary care physician for routine foot care $40 copay for each visit to an in-network specialist for routine foot care After the plan pays benefits for routine foot care, you are responsible for any remaining cost.	$10 copay for each visit to an out-of-network primary care physician for routine foot care $40 copay for each visit to an out-of-network specialist for routine foot care After the plan pays benefits for routine foot care, you are responsible for any 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	$0 copay for an annual physical exam

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 and psychiatrists 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 Membership 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 Membership 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 talk with a therapist[2] or make an appointment and talk with a psychiatrist[3] from the privacy of your home.	$0 copay for video doctor visits using LiveHealth Online	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Video doctor visits (con't) Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this Plan. 1. Prescription is prescribed based on physician recommendations and state regulations (rules). 2. Appointments are typically scheduled within 14 days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. 3. Appointments are typically scheduled within 14 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Health and wellness education programs **SilverSneakers®** Membership SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GOTM. 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. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. 1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc.	$0 copay for the SilverSneakers fitness benefit	

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 the nurse helpline is included in our plan. All other nurse access programs are excluded.	$0 copay for nurse helpline	
Foreign travel emergency and urgently needed services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than 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.	$90 copay for emergency care $35 copay for urgently needed services $275 copay per admission for emergency inpatient care	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Community Resource Support Need help with a specific issue? Although your plan benefits are designed to cover what Medicare would cover, as well as some additional supplemental benefits as described in this benefits chart, you might need additional help. As a member, your plan provides the support of a community resource outreach team to help bridge the gap between your medical benefits and the resources available to you in your community. The Medicare Community Resource Support team will assist you by providing information and education about community-based services and support programs in your area. If you need assistance or have questions about this benefit, call Member Services at the number listed on the back of your Membership Card.	$0 copay for Medicare Community Resource Support	
Healthy Meals* • Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total). • A qualifying event includes when you are in a hospital or a skilled nursing facility and are discharged home or when you have a Body Mass Index (BMI) of 18.5 or under, you have a BMI of 25 or higher or an A1C level more than 9.0 as determined by your provider. For fastest qualification, your provider or case manager is best suited to request this on your behalf. Alternatively, you can contact Member Services and a representative will initiate the process to validate your eligibility. In order for us to provide your meals benefit, we, or a third party acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements.	$0 copay for Healthy Meals	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Healthy Pantry*	$0 copay for Healthy Pantry	
Special Supplemental Benefits for the Chronically Ill Maintaining a healthy diet to support a chronic medical condition can help you maintain or improve your overall health. As a Special Supplemental Benefit for the Chronically Ill, you must: • Meet the CMS mandated criteria. This criteria can be found in the Chapter “Medical benefits (what is covered and what you pay)" in your Evidence of Coverage. • Provide supporting documentation from your physician identifying you, as having a condition that can be made worse by not having or would benefit from having nutritional counseling and help with obtaining appropriate pantry items. We can help you obtain this information. We are unable to initiate your benefit without speaking to you. By requesting this benefit you are expressly authorizing us to contact you by telephone. Upon approval you are eligible for: • Monthly nutritional counseling sessions via phone. • A monthly delivery of non-perishable pantry items sent directly to your home. Your monthly box of staples will consist of a variety of non-perishable foods that can vary each month. • Your nutritional consultations will help you utilize these items and provide you with information on how to supplement them with additional food resources. You can contact Member Services on the back of your Membership Card to begin the process to validate your eligibility.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Routine dental services • Routine dental services Routine dental services are limited to a $75 maximum benefit per year combined in-network and out-of-network. For additional benefit information and to locate a Liberty participating provider, please contact customer service. You will be directed to the dedicated customer service line. Dental benefit management administered by Liberty Dental, an independent company.	To receive benefits, you must use a Liberty participating provider. $0 copay for routine dental services After the plan pays benefits for routine dental services, you are responsible for the remaining cost.	$0 copay for routine dental services After the plan pays benefits for routine dental services, you are responsible for the remaining cost.
Medicare-approved clinical research studies A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.	After Original Medicare has paid its share of the Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's cost-sharing for like services. Any remaining plan cost-sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Annual out-of-pocket maximum All copays, coinsurance, and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of the routine hearing services, routine vision services, routine dental 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.	$6,000 Combined in-network and out-of-network	

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the Benefits Chart.

Your 2021 Prescription Drug Benefits Chart
Basic 4/12/42/95/33% (Generic Gap) (with Senior Rx Plus)
Indiana State Teachers' Retirement Fund

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

Formulary	Basic
Deductible	None
Supplemental Gap Coverage	Tier 1 and 2 Generics

Covered Services	What you pay
Part D Initial Coverage	
Below is your payment responsibility until the amount paid by you and your retiree drug plan for covered Part D prescriptions reaches your Initial Coverage Limit of $4,130.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Preferred Generics	$4 copay
• Generics	$12 copay
• Preferred Brands	$42 copay
• Non-Preferred Drugs	$95 copay
• Specialty Drugs	33% coinsurance
Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.	
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay
• Preferred Generics	$0 copay
• Generics	$24 copay
• Preferred Brands	$84 copay
• Non-Preferred Drugs	$190 copay
• Specialty Drugs	33% coinsurance

Covered Services	What you pay
Part D Gap Coverage	
Your payment responsibility changes once you reach your Initial Coverage Limit of $4,130. Below is your payment responsibility during the period after you meet your Initial Coverage Limit and until you meet your True Out of Pocket limit.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Preferred Generics	$4 copay
• Generics	$12 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
• Specialty Drugs	25% coinsurance
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay
• Preferred Generics	$0 copay
• Generics	$24 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
• Specialty Drugs	25% coinsurance
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $6,550.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Generic Drugs	$3.70 copay or 5% coinsurance whichever is greater
• Brand-Name Drugs	$9.20 copay or 5% coinsurance whichever is greater

- **Coverage Gap Discount Program:** If you are not receiving help to pay your share of drug cost through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2021, once the cost paid by you and your retiree drug plan reaches $4,130 the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount. The Coverage Gap Discount applies until the cost paid by you and the Discount reaches $6,550. Drug manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. **Please note:** Your retiree drug plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to drugs listed as "Extra Covered Drugs" in your benefits.

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever, and Hepatitis A are covered under Medicare drug coverage. Hepatitis B is covered under drug coverage unless you fall into a high risk category, then it is covered under medical coverage. Other common vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to pay its share of the cost. Please see your Evidence of Coverage for complete details on what you pay for vaccines.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits and the Coverage Gap Discount. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

OP plan Benefits Charts

The following pages show the medical and prescription drug benefits charts for the OP plan. There is a monthly premium of $236.03 for the OP plan (Anthem Medicare Comprehensive Plan).

Your 2021 Medical Benefits Chart
PPO Plan 0P
Indiana State Teachers' Retirement Fund

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.		
Prior authorization* Benefit categories that include services that require prior authorization are marked with an asterisk (*). Additional information can be found on the last page of the medical benefits chart.		
Annual deductible • The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	$200 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	For Medicare-covered hospital stays: $0 copay per admission Deductible applies. 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: $0 copay per admission Deductible applies. 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.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • 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 • 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.		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) Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines. • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Physician services In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	For Medicare-covered hospital stays: $0 copay per admission Deductible applies. 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: $0 copay per admission Deductible applies. 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.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care*	For Medicare-covered SNF stays:	For Medicare-covered SNF stays:
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.	$0 copay for days 1-100 per benefit period Deductible applies.	$0 copay for days 1-100 per benefit period Deductible applies.
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	No prior hospital stay required.	No prior hospital stay required.
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)		

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	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefits 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	$0 copay for Medicare-covered home health visits Deductible applies. Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	$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.	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. $0 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. $0 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) • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services. <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*	$0 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services Deductible applies.	$0 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services Deductible applies.
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	$0 copay per visit to an in-network specialist for Medicare-covered services Deductible applies.	$0 copay per visit to an out-of-network specialist for Medicare-covered services Deductible applies.
• Telehealth services for some physician or mental health services can be found in the section of this benefit chart titled, Video doctor visits. You have the option of getting these services through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, you must use a network provider who has an agreement with us to provide telehealth services.	$0 copay per visit to an in-network retail health clinic for Medicare-covered services Deductible applies.	$0 copay per visit to an out-of-network retail health clinic for Medicare-covered services Deductible applies.
• Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare	$0 copay for Medicare-covered allergy testing Deductible applies.	$0 copay for Medicare-covered allergy testing Deductible applies.
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home	$0 copay for Medicare-covered allergy injections Deductible applies.	$0 copay for Medicare-covered allergy injections Deductible applies.
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	See antigen cost share in Part B drug section.	See antigen cost share in Part B drug section.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network

Physician services, including doctor's office visits (con't)
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if:
  ○ You're not a new patient **and**
  ○ The evaluation isn't related to an office visit in the past 7 days **and**
  ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient
• 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		

Chiropractic services • We cover only manual manipulation of the spine to correct subluxation.	$0 copay for each Medicare-covered visit Deductible applies.	$0 copay for each Medicare-covered visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain* Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • Not associated with surgery; and • Not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	$0 copay for each Medicare-covered visit Deductible applies.	$0 copay for each Medicare-covered visit Deductible applies.
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	$0 copay for each Medicare-covered visit Deductible applies.	$0 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*	$40 copay for each Medicare-covered professional individual therapy visit Deductible applies.	$40 copay for each Medicare-covered professional individual therapy visit Deductible applies.
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	$40 copay for each Medicare-covered professional group therapy visit Deductible applies.	$40 copay for each Medicare-covered professional group therapy visit Deductible applies.
"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.	$55 copay for each Medicare-covered professional partial hospitalization visit Deductible applies.	$55 copay for each Medicare-covered professional partial hospitalization 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 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 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 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.	$40 copay for each Medicare-covered professional individual therapy visit Deductible applies. $40 copay for each Medicare-covered professional group therapy visit Deductible applies. $55 copay for each Medicare-covered professional partial hospitalization 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.	$40 copay for each Medicare-covered professional individual therapy visit Deductible applies. $40 copay for each Medicare-covered professional group therapy visit Deductible applies. $55 copay for each Medicare-covered professional partial hospitalization 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 www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery Deductible applies. $0 copay for each Medicare-covered outpatient observation room visit Deductible applies.	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery Deductible applies. $0 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 observation, non-surgical*	$0 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.	$0 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.
Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **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 www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$0 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies. $0 copay for each Medicare-covered outpatient observation room visit Deductible applies.	$0 copay for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies. $0 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. $0 copay per one-way trip for Medicare-covered ambulance services Deductible does not apply.	

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.	$0 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.	$0 copay for each Medicare-covered urgently needed care visit Deductible does not apply.	
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).	$0 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits Deductible applies.	$0 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits Deductible applies.
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.	$0 copay for Medicare-covered cardiac rehabilitation therapy visits Deductible applies.	$0 copay for Medicare-covered cardiac rehabilitation therapy visits Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	$0 copay for Medicare-covered pulmonary rehabilitation therapy visits Deductible applies.	$0 copay for Medicare-covered pulmonary rehabilitation therapy visits Deductible applies.
Supervised exercise therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copay for Medicare-covered supervised exercise therapy visits Deductible applies.	$0 copay for Medicare-covered supervised exercise 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, continuous blood glucose monitors, 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. Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. Coverage is limited to 2 sensors per month and one receiver every 2 years. This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids (HA). For new prescriptions, we will not cover other brands unless your provider tells us it is medically necessary. The review of medical necessity for use of HA and any non-preferred brands is part of the plan's prior authorization process.	$0 copay for Medicare-covered DME Deductible applies. See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.	$0 copay for Medicare-covered DME Deductible applies. See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.
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.	$0 copay for Medicare-covered prosthetics and orthotics Deductible applies.	$0 copay for Medicare-covered prosthetics and orthotics Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefits • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier • Durable medical equipment – pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items	$0 copay for Medicare-covered professional services provided by a Medicare-certified home health agency or home infusion supplier Deductible applies. $0 copay for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s) Deductible applies.	$0 copay for Medicare-covered professional services provided by a Medicare-certified home health agency or home infusion supplier Deductible applies. $0 copay for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s) 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 year • Up to 200 blood glucose test strips and lancets 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	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors Deductible applies except for items purchased at a pharmacy. $0 copay for Medicare-covered blood glucose monitor Deductible applies except for items purchased at a pharmacy. $0 copay for Medicare-covered therapeutic shoes and inserts Deductible applies. $0 copay for Medicare-covered diabetes self-management training Deductible does not apply.	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors Deductible applies except for items purchased at a pharmacy. $0 copay for Medicare-covered blood glucose monitor Deductible applies except for items purchased at a pharmacy. $0 copay 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*	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test Deductible applies.	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test Deductible applies.
Covered services include, but are not limited to: • X-rays • Complex diagnostic tests and radiology services • Radiation (radium and isotope) therapy, including technician materials and supplies • Testing to confirm chronic obstructive pulmonary disease (COPD) • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint • Other outpatient diagnostic tests Certain diagnostic tests and radiology services are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans.	$0 copay for Medicare-covered complex diagnostic test and/or radiology visit Deductible applies. $0 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. $0 copay 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.	$0 copay for Medicare-covered complex diagnostic test and/or radiology visit Deductible applies. $0 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. $0 copay 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
Opioid treatment program services* Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	$0 copay per visit for Medicare-covered opioid treatment program services Deductible applies.	$0 copay per visit for Medicare-covered opioid treatment program services Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Vision care (non-routine) 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.)	$0 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye Deductible applies. $0 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. $0 copay for glasses/contacts following Medicare-covered cataract surgery Deductible applies.	$0 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. $0 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. $0 copay 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 at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy Colorectal services: • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services. 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 each flu season in the fall and winter, with additional flu shots if medically necessary • 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 pneumonia, influenza, Hepatitis B, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules. 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.
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 healthy.	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.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.
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.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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/or 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.
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.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.
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.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.
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.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
🍎 **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 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. $0 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. $0 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. $0 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. $0 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 (con't)	$0 copay for Medicare-covered home dialysis equipment and supplies Deductible applies. $0 copay for Medicare-covered outpatient dialysis equipment and supplies Deductible applies.	$0 copay for Medicare-covered home dialysis equipment and supplies Deductible applies. $0 copay 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)*	$0 copay for Medicare-covered Part B drugs Deductible does not apply.	$0 copay for Medicare-covered Part B drugs Deductible does not apply.
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 We also cover some vaccines under our Part B prescription drug benefit.	$0 copay for Medicare-covered Part B drug administration Deductible does not apply. $0 copay for Medicare-covered Part B chemotherapy drugs Deductible does not apply. $0 copay for Medicare-covered Part B chemotherapy drug administration Deductible does not apply.	$0 copay for Medicare-covered Part B drug administration Deductible does not apply. $0 copay for Medicare-covered Part B chemotherapy drugs Deductible does not apply. $0 copay 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
Medicare Part B prescription drugs covered under your medical plan (Part B drugs) (con't) Some of Part B covered drugs listed above may be subject to step therapy. You may log into your secure member portal to find the list of Part B drugs that may be subject to step therapy. This list is located with your Plan Documents under your Benefits section. **If you have Part D prescription drug coverage, please refer to your *Evidence of Coverage* for information on your Part D prescription drug benefits.**		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Additional supplemental benefits, services, and discounts		
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. The hearing aid benefit does not provide coverage for amplifiers, internet purchases, assistive listening devices (ALDs) or accessories. We have partnered with Hearing Care Solutions to bring you these discounts and services. For additional benefit information and to locate a Hearing Care Solutions participating provider, please contact Member Services. Hearing benefit management administered by Hearing Care Solutions, an independent company.	Must use a Hearing Care Solutions participating provider. $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 64-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 any 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 64-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 any remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network

Routine vision services
• A routine comprehensive eye exam, once every 12 months
• Eyewear (excludes Medicare-covered eyewear following cataract surgery)
  • Eyeglass Frames: One pair of eyeglass frames, once every 24 months
  • Eyeglass Lenses (in lieu of contact lenses): One pair of standard plastic prescription lenses, once every 12 months
  • Standard single vision lenses
  • Standard bifocal lenses
  • Standard trifocal lenses
  • Contact Lenses (in lieu of eyeglass lenses): Once every 12 months
Contact lens allowance will only be applied towards the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.
  • Elective conventional lenses (non-disposable)
OR
  • Elective disposable lenses
OR
  • Non-elective contact lenses
 	
This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network.
	$0 copay for routine comprehensive eye exams
	Deductible does not apply.
	
	$130 allowance towards the purchase of frames
	Deductible does not apply.
	
	$0 copay for eyeglass lenses
	Deductible does not apply.
	
	$130 allowance towards the purchase of elective contact lenses
	Deductible does not apply.
	Non-elective contact lenses - covered in full
	Deductible does not apply.
		Up to $70 reimbursement for routine comprehensive eye exams
		Deductible does not apply.
		
		Up to $130 reimbursement towards the purchase of frames
		Deductible does not apply.
		
		Up to $32 reimbursement on Single vision lenses
		
		Up to $48 reimbursement on Bifocal lenses
		
		Up to $85 reimbursement on Trifocal lenses
		Deductible does not apply.
		
		Up to $130 reimbursement towards the purchase of elective contact lenses
		Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Routine vision services (con't) This information is intended to be a brief outline of coverage. For additional benefit information, including exclusions and limitations or to locate a participating Blue View Vision provider, please contact customer service. You will be directed to the dedicated Blue View Vision customer service line. If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt and file a claim for reimbursement up to your maximum out-of-network allowance.	After the plan pays benefits for routine comprehensive eye exams and eyewear, you are responsible for the remaining cost.	Up to $210 reimbursement towards the purchase of non-elective contact lenses Deductible does not apply. After the plan pays benefits for routine comprehensive eye exams and eyewear, 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.	$0 copay for each visit to an in-network primary care physician for routine foot care Deductible applies. $0 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 any remaining cost.	$0 copay for each visit to an out-of-network primary care physician for routine foot care Deductible applies. $0 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 any remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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 and psychiatrists 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 Membership 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 Membership 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 talk with a therapist[2] or make an appointment and talk with a psychiatrist[3] from the privacy of your home.	$0 copay for video doctor visits using LiveHealth Online Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Video doctor visits (con't) Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this Plan. 1. Prescription is prescribed based on physician recommendations and state regulations (rules). 2. Appointments are typically scheduled within 14 days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. 3. Appointments are typically scheduled within 14 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Health and wellness education programs **SilverSneakers®** Membership SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GO™. 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. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. 1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2020 Tivity Health, Inc. All rights reserved.	$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 the 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.	$0 copay for emergency care Deductible does not apply. $0 copay for urgently needed services Deductible does not apply. $0 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 Community Resource Support Need help with a specific issue? Although your plan benefits are designed to cover what Medicare would cover, as well as some additional supplemental benefits as described in this benefits chart, you might need additional help. As a member, your plan provides the support of a community resource outreach team to help bridge the gap between your medical benefits and the resources available to you in your community. The Medicare Community Resource Support team will assist you by providing information and education about community-based services and support programs in your area. If you need assistance or have questions about this benefit, call Member Services at the number listed on the back of your Membership Card.	$0 copay for Medicare Community Resource Support Deductible does not apply.	
Healthy Meals* • Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total). • A qualifying event includes when you are in a hospital or a skilled nursing facility and are discharged home or when you have a Body Mass Index (BMI) of 18.5 or under, you have a BMI of 25 or higher or an A1C level more than 9.0 as determined by your provider. For fastest qualification, your provider or case manager is best suited to request this on your behalf. Alternatively, you can contact Member Services and a representative will initiate the process to validate your eligibility. In order for us to provide your meals benefit, we, or a third party acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements.	$0 copay for Healthy Meals Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Healthy Pantry*	$0 copay for Healthy Pantry Deductible does not apply.	
Special Supplemental Benefits for the Chronically Ill		
Maintaining a healthy diet to support a chronic medical condition can help you maintain or improve your overall health. As a Special Supplemental Benefit for the Chronically Ill, you must: • Meet the CMS mandated criteria. This criteria can be found in the Chapter “Medical benefits (what is covered and what you pay)" in your Evidence of Coverage. • Provide supporting documentation from your physician identifying you, as having a condition that can be made worse by not having or would benefit from having nutritional counseling and help with obtaining appropriate pantry items. We can help you obtain this information. We are unable to initiate your benefit without speaking to you. By requesting this benefit you are expressly authorizing us to contact you by telephone. Upon approval you are eligible for: • Monthly nutritional counseling sessions via phone. • A monthly delivery of non-perishable pantry items sent directly to your home. Your monthly box of staples will consist of a variety of non-perishable foods that can vary each month. • Your nutritional consultations will help you utilize these items and provide you with information on how to supplement them with additional food resources. You can contact Member Services on the back of your Membership Card to begin the process to validate your eligibility.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Private Duty Nursing Private duty nursing is skilled nursing care provided to a recipient by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) in the home or in a hospital setting. Skilled care is defined as medically necessary services, when prescribed by a physician, that can only be rendered under State law or regulation by licensed health professionals such as a medical doctor, physician's assistant, physical therapist, occupational therapist, speech therapist, certified clinical social worker, certified nurse midwife, licensed practical nurse or registered nurse. Services are limited to the time such services are deemed medically necessary. Private duty nursing is limited to a $5,000 maximum benefit per lifetime combined in-network and out-of-network	20% coinsurance for private duty nursing Deductible applies. After the plan pays benefits for private duty nursing, you are responsible for the remaining cost.	20% coinsurance for private duty nursing Deductible applies. After the plan pays benefits for private duty nursing, you are responsible for the remaining cost.
Medicare-approved clinical research studies A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.	After Original Medicare has paid its share of the Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's cost-sharing for like services. Any remaining plan cost-sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Annual out-of-pocket maximum All copays, coinsurance, and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of the routine hearing services and routine vision services. Part D Prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.	$500 Combined in-network and out-of-network	

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the Benefits Chart.

Your 2021 Prescription Drug Benefits Chart
Basic 5/10/45/40%/33% (Generic Gap) (with Senior Rx Plus)
Indiana State Teachers' Retirement Fund

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

Formulary	Basic
Deductible	$150
Supplemental Gap Coverage	Tier 1 and Tier 2 Generics

Covered Services	What you pay
Part D Initial Coverage	
Below is your payment responsibility until the amount paid by you and your retiree drug plan for covered Part D prescriptions reaches your Initial Coverage Limit of $4,130.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics • Preferred Generics	$0 copay Deductible waived on Select Generics $5 copay
• Generics	$10 copay
• Preferred Brands	$45 copay
• Non-Preferred Drugs	40% coinsurance to a maximum of $250
• Specialty Drugs	33% coinsurance to a maximum of $250
Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.	
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics • Preferred Generics	$0 copay Deductible waived on Select Generics $5 copay
• Generics	$10 copay
• Preferred Brands	$90 copay
• Non-Preferred Drugs	40% coinsurance to a maximum of $500
• Specialty Drugs	33% coinsurance to a maximum of $250

Covered Services	What you pay
Part D Gap Coverage	
Your payment responsibility changes once you reach your Initial Coverage Limit of $4,130. Below is your payment responsibility during the period after you meet your Initial Coverage Limit and until you meet your True Out of Pocket limit.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Preferred Generics	$5 copay
• Generics	$10 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
• Specialty Drugs	25% coinsurance
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay
• Preferred Generics	$5 copay
• Generics	$10 copay
• Preferred Brands	25% coinsurance
• Non-Preferred Drugs	25% coinsurance
• Specialty Drugs	25% coinsurance
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $6,550.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Generic Drugs	$3.70 copay or 5% coinsurance whichever is greater
• Brand-Name Drugs	$9.20 copay or 5% coinsurance whichever is greater

- **Coverage Gap Discount Program:** If you are not receiving help to pay your share of drug cost through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2021, once the cost paid by you and your retiree drug plan reaches $4,130 the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount. The Coverage Gap Discount applies until the cost paid by you and the Discount reaches $6,550. Drug manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. **Please note:** Your retiree drug plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to drugs listed as "Extra Covered Drugs" in your benefits.

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever, and Hepatitis A are covered under Medicare drug coverage. Hepatitis B is covered under drug coverage unless you fall into a high risk category, then it is covered under medical coverage. Other common vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to pay its share of the cost. Please see your Evidence of Coverage for complete details on what you pay for vaccines.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits and the Coverage Gap Discount. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

Required information for 2021

Your rights, protections and Medicare options

As a Medicare beneficiary, you have many rights and options put in place to protect you as a consumer.

You have choices. As a Medicare beneficiary, you can choose between:

- The Original (Fee-for-Service) Medicare plan.
- A Medicare health plan like the one offered in this guide.

You may have other options, too

The important thing to remember is that the choice is yours, keeping in mind that you may be able to join or leave a plan only at certain times. Please note that if you do not take your retiree benefits, it may affect other retiree benefits your group sponsor offers. No matter what you decide, you may still be eligible for the Original Medicare program.

Geographic service areas covered by this plan

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, D.C., and all United States territories.

Your Medicare protections

The plan must offer Medicare benefits to you for a full calendar year at a time, although benefits and cost sharing may change from year to year. The plan provider can decide each year whether to keep offering Medicare Advantage plans, or whether or not to continue offering plans in specific geographic areas like yours.

Also, Medicare may decide to end our contract. But rest assured, even if this happens or if your plan is discontinued, you will not lose coverage.

If for some reason this plan is discontinued, we will send you a letter at least 90 days before your coverage ends explaining your options for Medicare coverage in your area.

For more information on the options and rights you have as a Medicare Advantage member with this plan, please contact our **First Impressions Welcome Team** and ask for a copy of the *Evidence of Coverage (EOC)*.

Extra Help from Medicare

You may be able to find help to pay for your prescription drugs and other Medicare costs. If you qualify for Medicare's Extra Help and are enrolled in a Part D plan like this one, Medicare can pay up to 100% of your prescribed drugs. This can help offset your drug plan's monthly premium, plus coinsurance and copays for covered prescription drugs.

Extra Help can also close any drug coverage gaps and stop late enrollment penalties (LEPs). For more information, visit **www.medicare.gov** or **www.ssa.gov**, or call:

- **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.
- **The Social Security Administration** at **1-800-772-1213**, Monday – Friday, 7 a.m. to 7 p.m. ET. TTY users should call **1-800-325-0778**.
- **Your state Medicaid office.**

Required information for 2021

Information about Medicare

To help you make more informed health care decisions, we are providing this important information about Medicare to use as a resource. If you have any questions, please contact our **First Impressions Welcome Team**.

Pay your Medicare Part B premiums

Once you enroll in this plan, you must still pay your Medicare Part B premiums. If you don't, Medicare will terminate your coverage and then you may have to pay a late enrollment penalty if you decide to re-enroll.

Enrolling in other plans

If you decide to enroll in other plans, you will be disenrolled from your current plan.

Notifying your group sponsor

To ensure a smooth enrollment, make sure your group sponsor has your most up-to-date information and that it matches your Social Security information.

What to know about a drug list

A drug list is a list of drugs covered by the plan. We choose our list to provide good prescription coverage and a good value to you, as well.

Your full Benefits Charts will tell you if you have an open or closed drug list plan. Open plans cover almost all Medicare Part D eligible drugs, while closed plans cover most.

When new drugs come to market, we conduct a clinical and cost review and may add them to the drug list. To keep plans affordable, every year we may also remove drugs or change the cost you pay for them the following year. But don't worry; we'll notify you first and send you a new drug list when we make these changes.

Important: Check to see if your drug is on the drug list before you go to the pharmacy.

If the drug you take is not on our drug list, you will have to pay the full price of the drug. If that's the case, or if your drug comes with additional requirements or limits, you may be able to receive a temporary supply. Contact your doctor and ask if you can switch to a different drug listed on our drug list.

About IRMAA and your income level

If your modified adjusted gross income on your IRS tax return from two years ago is above a certain limit, you must pay an income-related monthly adjustment amount (IRMAA) in addition to your monthly plan premium.

The Social Security Administration will contact you if you have to pay an IRMAA, which you must pay to them, not us.

High-income surcharges

If you must pay a high-income surcharge on your Medicare Part B or Part D premium to the Social Security Administration, please be sure to do so to avoid a mandatory disenrollment.

Required information for 2021

Information about Medicare

Our plan has free language interpreter services available to answer questions from non-English speaking members. Please call the **First Impressions Welcome Team** at the number listed in this guide to request interpreter services.

Out-of-network/non-contracted providers are under no obligation to treat Anthem Blue Cross and Blue Shield members, except in emergency situations. Please call our **First Impressions Welcome Team** at **1-833-848-8729**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays, for more information.

This information is not a complete description of benefits. Contact the plan for more information. Every year, Medicare evaluates plans based on a 5-star rating system.

This guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Benefits Charts and *Evidence of Coverage (EOC)*, which are received upon enrollment. In the event of a conflict between the Benefits Charts/*EOC* and this guide, the terms of the Benefits Charts and *EOC* will prevail.

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Required information for 2021

It is important we treat you fairly

That is why we follow Federal civil rights laws in our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language is not English, we offer free language assistance services through interpreters. Interested in these services? Call the **First Impressions Welcome Team** for help (TTY: **711**).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling **1-800-368-1019** (TTY: **1-800-537-7697**) or online at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Find help in your language

Separate from our language assistance program, we make documents available in alternate formats. If you need a copy of this document in an alternate format, please call the **First Impressions Welcome Team**.

English: You have the right to get this information and help in your language for free. Call the **First Impressions Welcome Team** for help. (TTY: **711**)

Spanish: Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY: **711**)

Arabic:
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY: **711**).

Armenian: Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY: **711**)

Chinese: 您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。 (TTY: **711**)

Farsi:
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید (TTY: **711**).

French: Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY: **711**)

Haitian: Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY: **711**)

Italian: Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY: **711**)

Japanese: この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY: **711**)

Korean: 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY: **711**)

Polish: Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY: **711**)

Portuguese-Europe: Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY: **711**)

Russian: Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY: **711**)

Tagalog: May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng **First Impressions Welcome Team** na nasa inyong Membership Card para sa tulong. (TTY: **711**)

Vietnamese: Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY: **711**)

Anthem Blue Cross and Blue Shield – H4036

2021 Medicare Star Ratings

Every year, Medicare evaluates plans based on a 5-star rating system. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Ratings that focus on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2021, Anthem Blue Cross and Blue Shield received the following Overall Star Rating from Medicare:

★★★★
4 Stars

We received the following Summary Star Ratings for Anthem Blue Cross and Blue Shield's health/drug plan services:

Health Plan Services: ★★★★
4 Stars

Drug Plan Services: ★★★½
3.5 Stars

The number of stars shows how well our plan performs.

★★★★★	5 stars – excellent
★★★★	4 stars – above average
★★★	3 stars – average
★★	2 stars – below average
★	1 star – poor

Learn more about our plan and how we are different from other plans at **www.medicare.gov**.

You may also contact us Monday to Friday, 8 a.m. to 9 p.m. ET, at **1-833-848-8729** (toll-free) or **711** (TTY).

Current members please call **1-833-848-8730** (toll-free) or **711** (TTY).

Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

Anthem Blue Cross and Blue Shield is an LPPO plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal.

Important Information Regarding Your Medicare Advantage with Part D Prescription Drug Plan

- I understand that the effective date of coverage is when I can begin using the plan services, and the Medicare Advantage plan will send me written notification of the effective date of my enrollment in the plan. I understand that this Medicare Advantage plan is offered under a contract with the Centers for Medicare & Medicaid Services (CMS) and CMS' review of its benefits. I understand that my coverage will come into effect only if this enrollment is approved by the plan and CMS.
- I understand that I need to keep my Medicare Parts A & B. I must maintain my Medicare Part B insurance by continuing to pay the Part B premium, if applicable.
- I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by CMS from any other Medicare Advantage plan or Medicare Part D Prescription Drug plan of which I am currently a member. **I can only be in one Medicare Advantage plan at a time.** It is my responsibility to inform you of any other prescription drug coverage that I have or may get in the future.
- I understand that enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year if an enrollment period is available, or under certain special circumstances. I may disenroll from this Medicare Advantage plan by sending a written request to Anthem.
- I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
- I will read the Evidence of Coverage document for this Medicare Advantage plan to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.
- This Medicare Advantage plan serves a specific service area, which includes all 50 states, Washington, D.C., American Samoa, Guam, Northern Mariana Islands, US Virgin Islands, and Puerto Rico. If I move out of the area the plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
- I understand that as a member of this plan, I have the right to ask about the plan's decision about payments or coverage for services I receive. I also have the right to appeal plan decisions about payment or services if I disagree.
- **Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations.
- I also acknowledge that this Medicare Advantage plan will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. I understand that if false enrollment information is provided, I will be disenrolled from this Medicare Advantage plan.