Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
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 beneficiaries eligible for this preventive screening. (*)
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they 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. • Non-emergency 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.	$250 copayment for each Medicare-covered trip. $250 copayment applies to each one-way trip.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **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" 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 annual wellness visit.
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 Medicare-covered bone mass measurement

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
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 covered screening mammograms.
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 referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**Prior authorization is required.** **In-network: $35 copayment for each Medicare-covered visit.** **Out-of-network: $50 copayment for each Medicare-covered visit through your POS benefit.**
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.	There is no coinsurance, copayment, or deductible for the 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 cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	**What you must pay** when you get these services
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 cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	In-network: $20 copayment for each Medicare-covered chiropractic visit. (*) Out-of-network: $40 copayment for each Medicare-covered chiropractic visit through your POS benefit.
Colorectal cancer screening 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 (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening.

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover non-routine dental care required to treat illness or injury that may be covered as inpatient or outpatient by a Medicare provider.	**Prior authorization is required.** **In-network: $35 copayment for each Medicare-covered dental visit.** **Out-of-network: $50 copayment for each Medicare-covered dental visit through your POS benefit.**
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	There is no coinsurance, copayment, or deductible for an 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 two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
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. • For people with diabetes who have severe diabetic foot	There is no coinsurance, copayment or deductible for the diabetes self-management training benefit. In-network: $0 copayment for Medicare-covered lab services.

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Diabetes self-management training, diabetic services and supplies (continued) disease: One pair per calendar 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). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	Out-of-network: $0 copayment for Medicare-covered lab services through your POS benefit. In-network: $0 copayment for supplies to monitor your blood glucose. Out-of-network: $0 copayment for supplies to monitor your blood glucose through your POS benefit. **Prior authorization is required for the following services:** **In-network: You pay 20% of the cost for Medicare-covered therapeutic custom molded shoes and inserts for custom molded shoes.** **Out-of-network: You pay 30% of the cost for Medicare-covered therapeutic custom molded shoes and inserts for custom molded shoes through your POS benefit.**

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. 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.	**Prior authorization is required.** **In-network: You pay 20% of the cost of Medicare-covered durable medical equipment and related supplies.** **Out-of-network: You pay 30% of the cost of Medicare-covered durable medical equipment and related supplies through your POS benefit.**
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. 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. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Emergency care is covered worldwide.	$65 copayment for each emergency room visit. Your copayment is waived if you are admitted to a hospital within 24-hours for the same condition; you pay $0 copayment for the emergency room visit. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	In-network: $35 copayment for each Medicare-covered diagnostic hearing exam and balance evaluation. (*) Out-of-network: $50 copayment for each Medicare-covered diagnostic hearing exam and balance evaluation through your POS benefit.
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 beneficiaries eligible for Medicare-covered preventive HIV screening.
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 therapy • Medical and social services • Medical equipment and supplies	**Prior Authorization is required.** **In-network: $0 copayment for each Medicare-covered home health visit.** **Out-of-network: You pay 30% of the cost for each Medicare-covered home health visit through your POS benefit.** **In-network: $35 copayment for each Medicare-covered physical therapy, speech therapy and occupational therapy visit. (*)**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Home health agency care (continued)	**Out-of-network: $50 copayment for each Medicare-covered physical therapy, speech therapy and occupational therapy visit through your POS benefit.** **In-network: You pay 20% of the cost for Medicare-covered prosthetics, orthotic devices and durable medical equipment.** **Out-of-network: You pay 30% of the cost for Medicare-covered prosthetics, orthotic devices and durable medical equipment through your POS benefit.**
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 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care 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 our 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,	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Moda Health HMO (HMO-POS).

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently 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 a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by Moda Health HMO (HMO-POS) but are not covered by Medicare Part A or B: Moda Health HMO (HMO-POS) 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. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these 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 care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are at a distant location, you may choose to go locally or distant as long as the local transplant providers are willing to accept the Original Medicare rate. If Moda Health HMO (HMO-POS) provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. If the transplant facility requires you to be within a certain proximity for pre- and post-surgery care and your residence is not within that proximity, you will be reimbursed up to $120 maximum per night for hotel up to a	**Prior authorization is required.** **In-network:** **Days 1 – 5 $300 copayment each day** **Days 6 and beyond $0 copayment each day** **Out-of-network (through your POS benefit):** **Days 1 – 5 $400 copayment each day** **Days 6 and beyond $0 copayment each day** There is no limit to the number of days covered by the plan each benefit period. A benefit period starts the day you are admitted to the hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins There is no limit to the number of benefit periods you can have. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) maximum of $6,000 for lodging expenses only. Lodging while on a transplant waiting list is not covered. If you drive to the facility you will be reimbursed $0.19 a mile for the mileage measured by driving directions only from your home to the facility and then from the facility back to your home. You will be reimbursed 80% of the total cost of the lowest round trip fare scheduled two weeks in advance of departure for air, bus and train. When traveling by air, bus or train the cab fare will be reimbursed at 80% of the total cost from the arrival location to the hotel and then from the hotel to the departure location. Then the cab fare will be reimbursed at 80% of the total cost for each necessary daily round trip from the hotel to the facility and back. You must submit valid receipts for reimbursement. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services **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 or 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 2 at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Inpatient mental health care Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	**Prior authorization is required.** **In-network:** **Days 1 – 5 $300 copayment each day** **Days 6 - 90** **$0 copayment each day** **Out-of-network (through your POS benefit):** **Days 1 – 5 $400 copayment each day** **Days 6 - 90** **$0 copayment each day** A benefit period starts the day you are admitted to the hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.
Inpatient services covered during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician	In-network: $25 copayment for each primary care provider visit. Out-of-network: $40 copayment for each primary care provider visit through your POS benefit. In-network: $35 copayment for each specialist visit. (*) Out-of-network: $50

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Inpatient services covered during a non-covered inpatient stay (continued) materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics 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, speech therapy, and occupational therapy	copayment for each specialist visit through your POS benefit. In-network: $0 copayment for Medicare-covered lab services. Out-of-network: $0 copayment for Medicare-covered lab services through your POS benefit. In-network: You pay 20% of the cost for X-rays. Out-of-network: You pay 30% of the cost for X-rays through your POS benefit. **Prior Authorization is required for the following services**: **In-network: You pay 20% of the cost for diagnostic radiology and therapeutic radiology services.** **Out-of-network: You pay 30% of the cost for diagnostic radiology and therapeutic radiology services through your POS benefit.** **In-network: You pay 20% of the cost for Medicare-covered prosthetics, orthotic devices and durable medical equipment.**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Inpatient services covered during a non-covered inpatient stay (continued)	**Out-of-network: You pay 30% of the cost for Medicare-covered prosthetics, orthotic devices and durable medical equipment through your POS benefit.** **In-network: $35 copayment for each Medicare-covered physical therapy, speech therapy and occupational therapy visit. (*)** **Out-of-network: $50 copayment for each Medicare-covered physical therapy, speech therapy and occupational therapy visit through your POS benefit.** **In-network: $35 copayment for each Medicare-covered cardiac and pulmonary rehabilitation visit.** **Out-of-network: $50 copayment for each Medicare-covered cardiac and pulmonary rehabilitation visit through your POS benefit.**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
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 3 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 2 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 the next calendar year.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.
Medicare Part B prescription 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 that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were 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 dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	**Prior authorization is required.** **In-network: You pay 20% of the cost for Medicare Part B covered drugs and chemotherapy drugs.** **Out-of-network: You pay 30% of the cost for Medicare Part B covered drugs and chemotherapy drugs through your POS benefit.**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs (continued) Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	
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 preventive obesity screening and therapy.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests	In-network: $0 copayment for Medicare-covered lab services, diagnostic procedures and tests. Out-of-network: $0 copayment for Medicare-covered lab services, diagnostic procedures and tests through your POS benefit. In-network: You pay 20% of the cost for X-rays. Out-of-network: You pay 30% of the cost for X-rays through your POS benefit. **Prior Authorization is required for all of the following services:** **In-network: You pay 20% of the cost for diagnostic radiology, MRI/CT/CAT/**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued)	**SPECT/PET, Nuclear Cardiology and radiation therapy.** **Out-of-network: You pay 30% of the cost for diagnostic radiology, MRI/CT/CAT/ SPECT/PET, Nuclear Cardiology and radiation therapy through your POS benefit.**
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself **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 http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-	In-network: $0 copayment for Medicare-covered lab services, diagnostic procedures and tests. Out-of-network: $0 copayment for Medicare-covered lab services, diagnostic procedures and tests through your POS benefit. In-network: You pay 20% of the cost for X-rays. Out-of-network: You pay 30% of the cost for X-rays through your POS benefit. $65 copayment for each emergency room visit. **Prior Authorization is required for all of the following services:** **In-network: $35 copayment per day for Medicare-covered partial hospitalization.**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services (continued) 877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**Out-of-network: $50 copayment per day for Medicare-covered partial hospitalization through your POS benefit.** **In-network: You pay 20% of the cost for diagnostic radiology, MRI/CT/CAT/ SPECT/PET, Nuclear Cardiology and radiation therapy.** **Out-of-network: You pay 30% of the cost for diagnostic radiology, MRI/CT/CAT/ SPECT/PET, Nuclear Cardiology and radiation therapy through your POS benefit.** **In-network: You pay 20% of the cost for Medicare Part B drugs and biologicals.** **Out-of-network: You pay 30% of the cost for Medicare Part B drugs and biologicals through your POS benefit.** **In-network: You pay 10% of the cost for each Medicare-covered outpatient procedure in an Ambulatory Surgical Center (ASC).** **Out-of-network: You pay 20% of the cost for each**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services (continued)	**Medicare-covered outpatient procedure in an Ambulatory Surgical Center (ASC) through your POS benefit.** **In-network: You pay 20% of the cost for each Medicare-covered outpatient procedure in a hospital.** **Out-of-network: You pay 30% of the cost for each Medicare-covered outpatient procedure in a hospital through your POS benefit.**
Outpatient mental health care 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.	In-network: $25 copayment for each Medicare-covered group and individual therapy visit. Out-of-network: $40 copayment for each Medicare-covered group and individual therapy visit through your POS benefit.

Services that are covered for you	**What you must pay** when you get these services
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).	**Prior Authorization is required.** **In-network: $35 copayment for each Medicare-covered visit. (*)** **Out-of-network: $50 copayment for each Medicare-covered visit through your POS benefit.**
Outpatient substance abuse services Medicare-covered alcohol and substance abuse assessment and intervention/treatment for those with substance use disorders in a provider office or outpatient facility.	In-network: $25 copayment for each Medicare-covered group and individual therapy visit. Out-of-network: $40 copayment for each Medicare-covered group and individual therapy visit through your POS benefit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, 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."	**Prior authorization is required.** **In-network: You pay 10% of the cost for each Medicare-covered outpatient procedure in an Ambulatory Surgical Center (ASC).** **Out-of-network: You pay 20% of the cost for each Medicare-covered outpatient procedure in an Ambulatory Surgical**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers (continued)	**Center (ASC) through your POS benefit.** **In-network: You pay 20% of the cost for each Medicare-covered outpatient procedure in a hospital.** **Out-of-network: You pay 30% of the cost for each Medicare-covered outpatient procedure in a hospital through your POS benefit.**
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**Prior Authorization is required.** **In-network: $35 copayment per day for Medicare-covered partial hospitalization.** **Out-of-network: $50 copayment per day for Medicare-covered partial hospitalization through your POS benefit.**
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location	In-network: $25 copayment for each primary care provider visit. Out-of-network: $40 copayment for each primary care provider visit through your POS benefit.

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Second opinion prior to surgery • 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)	In-network: $35 copayment for each specialist visit. (*) Out-of-network: $50 copayment for each specialist visit through your POS benefit. **Prior authorization is required.** **In-network: $35 copayment for each Medicare-covered dental visit.** **Out-of-network: $50 copayment for each Medicare-covered dental visit through your POS benefit.** **In-network: You pay 10% of the cost for each Medicare-covered outpatient procedure in an Ambulatory Surgical Center (ASC).** **Out-of-network: You pay 20% of the cost for each Medicare-covered outpatient procedure in an Ambulatory Surgical Center (ASC) through your POS benefit.** **In-network: You pay 20% of the cost for each Medicare-covered outpatient procedure in a hospital.**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued)	**Out-of-network: You pay 30% of the cost for each Medicare-covered outpatient procedure in a hospital through your POS benefit.**
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs	In-network: $35 copayment for each Medicare-covered podiatry visit. (*) Out-of-network: $50 copayment for each Medicare-covered podiatry visit through your POS benefit.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of 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.	**Prior Authorization is required.** **In-network: You pay 20% of the cost for Medicare-covered prosthetic devices and related supplies** **Out-of-network: You pay 30% of the cost for Medicare-covered prosthetic devices and related supplies through your POS benefit.**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
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 the chronic respiratory disease.	**Prior authorization is required.** **In-network: $35 copayment for each Medicare-covered visit.** **Out-of-network: $50 copayment for each Medicare-covered visit through your POS benefit.**
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 4 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.

Services that are covered for you	**What you must pay** when you get these services
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.
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 to prevent STIs preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Services to treat kidney disease and conditions Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • 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) 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, "Medicare Part B prescription drugs."	In-network: $0 copayment for kidney disease education services Out-of-network: $0 copayment for kidney disease education services through your POS benefit. **Prior Authorization is required for the following services:** **In-network:** **Days 1 – 5 $300 copayment each day** **Days 6 and beyond $0 copayment each day** **Out-of-network (through your POS benefit):** **Days 1 – 5 $400 copayment each day** **Days 6 and beyond $0 copayment each day** **In-network: You pay 20% of the cost for renal dialysis.** **Out-of-network: You pay 20% of the cost for renal dialysis through your POS benefit.** **In-network: You pay 20% of the cost for home dialysis equipment and supplies.**

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Services to treat kidney disease and conditions (continued)	**Out-of-network: You pay 20% of the cost for home dialysis equipment and supplies through your POS benefit.**
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	**Prior Authorization is required.** **In-network:** **Days 1 – 20 $0 copayment each day** **Days 21 – 100 $100 copayment each day** **Out-of-network (through your POS benefit):** **Days 1 – 20 $0 copayment each day** **Days 21 – 100 $100 copayment each day** No prior hospital stay required. A benefit period starts the day you are admitted to the hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.

Services that are covered for you	**What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four 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 two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when 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. Urgently needed services are covered worldwide.	$35 copayment for each urgent care visit Your copayment is waived if you are admitted to the hospital within 24-hours for the same condition; you pay $0 copayment for the urgent care visit
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • For people with diabetes, screening for diabetic retinopathy	In-network: $0 copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye Out-of-network: $0 copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye through the POS benefit.

(*) PCP referral is required for this covered service

Services that are covered for you	**What you must pay** when you get these services
Vision care (continued) 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.) • Routine eye exam, limited to once every two calendar years	In-network: $0 copayment for one pair of eyeglasses or contact lenses after cataract surgery Out-of-network: $0 copayment for one pair of eyeglasses or contact lenses after cataract surgery through your POS benefit. In-network: $35 copayment for one non-Medicare covered routine eye exam, including eye refractions, every two calendar years. Out-of-network: $35 copayment for one non-Medicare covered routine eye exam, including eye refractions, every two calendar years through your POS benefit.
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, 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 "Welcome to Medicare" preventive visit.