Your 2011 Medical Benefit Chart
Local PPO Plan
University of Maine System – Effective January 1, 2011

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Doctor and hospital choice You may go to doctors, specialists and hospitals in or out of the network. You do not need a referral. However some benefits may require authorization.		Higher costs may apply for out-of-network services.
Annual deductible • The deductible applies to covered services as noted within each category prior to the copay, if any, being applied.	$300 Combined in-network and out-of-network	$300 Combined in-network and out-of-network
Inpatient Services		
Inpatient hospital care Covered services include, but are not limited to, the following: • Semi-private room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational and speech language therapy services.	Prior authorization is required. For Medicare-covered hospital stays: 10% coinsurance per admission. Deductible applies. No limit to the number of days covered by the plan each benefit period $0 copay for physician services received	Prior authorization is requested. For Medicare-covered hospital stays: 20% coinsurance per admission. Deductible applies. No limit to the number of days covered by the plan each benefit period 20% coinsurance for physician services received

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Inpatient hospital care (cont) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If possible, plan should be notified of emergency admissions within one (1) business day of admission.	while an inpatient during a Medicare-covered hospital stay. Deductible applies.	while an inpatient during a Medicare-covered hospital stay. Deductible applies.
Inpatient mental health care Includes mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If possible, plan should be notified of emergency admissions within one (1) business day of admission.	For Medicare-covered hospital stays: Prior authorization is required. Please contact the behavioral health care program associated with your plan. 10% coinsurance per admission. Deductible applies. No limit to the number of days covered by the plan each	For Medicare-covered hospital stays: Prior authorization is requested. Please contact the behavioral health care program associated with your plan. 20% coinsurance per admission. Deductible applies. No limit to the number of days covered by the plan each

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Inpatient mental health care (cont)	benefit period $0 copay for physician services received while an inpatient during a Medicare-covered hospital stay. Deductible applies.	benefit period 20% coinsurance for physician services received while an inpatient during a Medicare-covered hospital stay. Deductible applies.
Skilled nursing facility (SNF) care Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A "benefit period" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been inpatient at any hospital or SNF for 60 days in a row. Covered services include, but are not limited to, the following: • Semi-private room (or a private room if medically necessary). • Meals, including special diets. • Regular 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 package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs.	Prior authorization is required. For Medicare-covered SNF stays: 10% coinsurance per admission. Deductible applies.	Prior authorization is requested. For Medicare-covered SNF stays: 20% coinsurance per admission. Deductible applies.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (cont) • Physician services. Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital No prior hospital stay required		
Inpatient services covered when the hospital or SNF days aren't or are no longer covered Covered services include: • Physician services. • Tests (like x-ray or 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 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.	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefit chart at the deductible and/or cost-share amounts indicated.	

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Home health agency care Covered services include: • 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 cannot exceed up to and including eight (8) hours per day or 35 hours per week.) • Physical therapy, occupational therapy and speech therapy. • Medical social services. • Medical equipment and supplies.	Prior authorization may be required for selected services. $0 copay for Medicare-covered home health visits. Deductible applies. DME copay or coinsurance, if any, may apply. Deductible applies.	Prior authorization is requested. 20% coinsurance for Medicare-covered home health visits. Deductible applies. DME copay or coinsurance, if any, may apply. Deductible applies.
Hospice care You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our plan. However, Original Medicare will pay for all of your Part A and Part B services. Your provider will bill Original Medicare for these services while your hospice election is in force. Covered services include: • Drugs for symptom control and pain relief, short-term respite care and other services not otherwise covered by Original Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Original Medicare services are paid for by the Original Medicare Plan, not your Medicare Advantage Plan. You pay a $0 copay for the one time only hospice consultation to a network primary care physician. Deductible does not apply. You pay a 10% coinsurance for the	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Original Medicare services are paid for by the Original Medicare Plan, not your Medicare Advantage Plan. You pay a 20% coinsurance for the one time only hospice consultation to an out-of-network primary care physician. Deductible does

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Hospice care (cont)	one time only hospice consultation to a network specialist. Deductible does not apply.	not apply. You pay a 20% coinsurance for the one time only hospice consultation to an out-of-network specialist. Deductible does not apply.
Outpatient Services		
Physician services, including doctor's office visits Covered services include: • Office visits, including medical and surgical services in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis and treatment by a specialist. • Hearing and balance exams, if your doctor orders it to see if you need medical treatment. • Telehealth office visits including consultation, diagnosis and treatment by a specialist. • Second opinion by another plan provider prior to surgery. • Physician services rendered in the home. • Outpatient hospital services. • Non-routine dental. 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 doctor. • Allergy testing and allergy injections.	$0 copay per visit to a network primary care physician (PCP) for Medicare-covered services. Deductible applies. 10% coinsurance per visit to a network specialist for Medicare-covered services. Deductible applies. $0 copay for allergy testing or for allergy injections. Deductible applies.	20% coinsurance per visit to an out-of-network primary care physician (PCP) for Medicare-covered services. Deductible applies. 20% coinsurance per visit to an out-of-network specialist for Medicare-covered services. Deductible applies. 20% coinsurance for allergy testing or for allergy injections. Deductible applies.

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Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation.	Prior authorization may be required. 10% coinsurnace for each Medicare-covered visit. Deductible applies.	Prior authorization is requested. 20% coinsurance for each Medicare-covered visit. Deductible applies.
Podiatry services • Treatment of injuries and disease of the feet (such as hammer toe or heal spurs) • Medicare-covered routine foot care for member with certain medical conditions affecting the lower limbs. A foot exam is covered every six (6) months for people with diabetic peripheral neuropathy and loss of protective sensations.	10% coinsurance for each Medicare-covered visit. Deductible applies.	20% coinsurance for each Medicare-covered visit. Deductible applies.
Outpatient mental health care, including partial hospitalization services Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant or other mental health care professional as allowed under applicable state laws. “Partial hospitalization” is a structured program of active treatment 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 may be required after the 12th visit. Please contact the behavioral health care program associated with your plan. $0 copay for each Medicare-covered professional individual therapy visit. Deductible applies. $0 copay for each Medicare-covered professional group therapy visit. Deductible applies.	Prior authorization is requested after the 12th visit. Please contact the behavioral health care program associated with your plan. 20% coinsurance for each Medicare-covered professional individual therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered professional group therapy visit. Deductible applies.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services (cont)	$0 copay for each Medicare-covered professional partial hospitalization visit. Deductible applies. $0 copay for each Medicare-covered outpatient hospital individual therapy visit. Deductible applies. $0 copay for each Medicare-covered outpatient hospital group therapy visit. Deductible applies $0 copay for each Medicare-covered partial hospitalization visit. Deductible applies.	20% coinsurance for each Medicare-covered professional partial hospitalization visit. Deductible applies. 20% coinsurance for each Medicare-covered outpatient hospital individual therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered outpatient hospital group therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered partial hospitalization visit. Deductible applies.
Outpatient substance abuse services	Prior authorization may be required after the 12th visit. Please contact the behavioral health care program associated with your plan.	Prior authorization is requested after the 12th visit. Please contact the behavioral health care program associated with your plan.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Outpatient substance abuse services (cont)	$0 copay for each Medicare-covered professional individual therapy visit. Deductible applies. $0 copay for each Medicare-covered professional group therapy visit. Deductible applies. $0 copay for each Medicare-covered outpatient hospital individual therapy visit. Deductible applies. $0 copay for each Medicare-covered outpatient hospital group therapy visit. Deductible applies.	20% coinsurance for each Medicare-covered professional individual therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered professional group therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered outpatient hospital individual therapy visit. Deductible applies. 20% coinsurance for each Medicare-covered outpatient hospital group therapy visit. Deductible applies.
Outpatient surgery (includes services provided at ambulatory surgical centers) (Facilities where surgical procedures are performed and the patient is released the same day)	Prior authorization is required for UPPP, gastric obesity surgery, Arthroscopy (shoulder/knee) surgery and all medically necessary cosmetic surgery.	Prior authorization is requested for UPPP, gastric obesity surgery, Arthroscopy (shoulder/knee) surgery and all medically necessary cosmetic surgery.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Outpatient surgery (includes services provided at ambulatory surgical centers) (cont)	10% coinsurance for each outpatient hospital facility or ambulatory surgical center visit for surgery. Deductible applies. 10% coinsurance for each Medicare-covered observation room stay. Deductible applies.	$100 copay for each outpatient hospital facility or ambulatory surgical center visit for surgery. Deductible applies. $100 copay for each Medicare-covered observation room stay. Deductible applies.
Outpatient hospital services, non-surgical	10% coinsurance for a visit to a physician in an outpatient hospital setting/clinic for non-surgical services. Deductible applies. 10% coinsurance for each Medicare-covered observation room stay. Deductible applies.	20% coinsurance for a visit to a physician in an outpatient hospital setting/clinic for non-surgical services. Deductible applies. $100 copay for each Medicare-covered observation room stay. Deductible applies.
Ambulance services Covered ambulance services include fixed wing, rotary wing and ground ambulance services to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the	Prior authorization is required for non-emergent air and water transportation from network providers and requested from out-of-network providers. 10% coinsurance for Medicare-covered ambulance services Cost share, if any, is applied per one-way trip for Medicare-covered ambulance services.	

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Ambulance services (cont) person's health) and that transportation by ambulance is medically required. Ambulance service is not covered for physician office visits.	Deductible does not apply.	
Emergency care • This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. • Emergency care copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	$50 copay for each Medicare-covered emergency room visit. Deductible does not apply.	
Urgently needed care • Urgently needed care is available on a worldwide basis. • If you are outside of the service area for your plan, your plan covers urgently needed care, including urgently required renal dialysis. Your plan also covers urgently needed care if you are within the plan's service area, but it isn't reasonable under the circumstances to obtain medical care from a network provider. Generally, however, if you are in the plan's service area and your health is not in serious danger, you should obtain care from a network provider. • Urgently needed care copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	10% coinsurance for each Medicare-covered urgently needed care visit. Deductible does not apply.	
Outpatient rehabilitation services Physical therapy, occupational therapy, speech and language therapy, cardiac rehabilitation services, intensive cardiac rehabilitation services, pulmonary rehabilitation services and Comprehensive Outpatient Rehabilitation Facility (CORF) services, in outpatient, office or home setting. Cardiac rehabilitation therapy is covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery and/or have stable angina pectoris, have had a heart valve repair/replacement, angioplasty or coronary	Prior authorization may be required for physical therapy, occupational therapy and speech therapy. 10% coinsurance for Medicare-covered physical, speech and occupational	Prior authorization is requested for physical therapy, occupational therapy and speech therapy. 20% coinsurance for Medicare-covered physical, speech and occupational

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Outpatient rehabilitation services (cont)	therapy visits. Deductible applies.	therapy visits. Deductible applies.
stenting or have had a heart or heart-lung transplant or other cardiac conditions as specified through a national coverage determination (NCD).	10% coinsurance for Medicare-covered cardiac and pulmonary rehabilitation visits. Deductible applies.	20% coinsurance for Medicare-covered cardiac and pulmonary rehabilitation visits. Deductible applies.
Durable medical equipment (DME) and related supplies Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer and walker. 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.	Prior authorization is required for power operated vehicles, power wheelchairs and accessories, non-standard wheelchairs and non-standard beds. 10% coinsurance on all Medicare-covered DME. Deductible applies. $0 copay for supplies Deductible applies	Prior authorization is requested for power operated vehicles, power wheelchairs and accessories, non-standard wheelchairs and non-standard beds. 20% coinsurance on all Medicare-covered DME. Deductible applies. 20% coinsurance for supplies Deductible appies
Prosthetic devices and related supplies Devices (other than dental) that replace 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.	Prior authorization is required for prosthetics and orthotics.	Prior authorization is requested for prosthetics and orthotics.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Prosthetic devices and related supplies (cont)	10% coinsurance on all Medicare-covered prosthetics and orthotics. Deductible applies. $0 copay for supplies Deductible applies	20% coinsurance on all Medicare-covered prosthetics and orthotics. Deductible applies 20% coinsurance for supplies Deductible applies.
Diabetes self-monitoring training and supplies For all people who have diabetes (insulin and non-insulin users) • Covered services include: blood glucose monitor, blood glucose test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors. • One (1) pair per year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two (2) additional pairs of inserts, or one (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease. • Self-management training is covered under certain conditions. • For persons at risk of diabetes, fasting plasma glucose tests are covered.	For Medicare-covered: 10% coinsurance for a 30-day supply on each purchase of glucose test strips, urine test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors. Deductible applies except for items purchased at the pharmacy. 10% coinsurance for blood glucose monitor and therapeutic shoes. Deductible applies except for items purchased at the pharmacy.	For Medicare-covered: 20% coinsurance for a 30-day supply on each purchase of glucose test strips, urine test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors. Deductible applies except for items purchased at the pharmacy. 20% coinsurance for blood glucose monitor and therapeutic shoes. Deductible applies except for items purchased at the pharmacy.

Covered Services	**What you must pay for these covered services**	
Important Information	In-Network	Out-of-Network
Diabetes self-monitoring training and supplies (cont)	10% coinsurance for self-management training. Deductible applies. 10% coinsurance fasting plasma glucose tests covered up to twice a year. Deductible applies.	20% coinsurance for self-management training. Deductible applies. 20% coinsurance for fasting plasma glucose tests covered up to twice a year. Deductible applies.
Medical nutrition therapy For people with diabetes, renal (kidney) disease (but not on dialysis) and after a transplant when referred by your doctor.	10% coinsurance for each Medicare-covered visit. Deductible applies.	20% coinsurance for each Medicare-covered visit. Deductible applies.
Kidney disease education services Education to teach kidney care and help members make informed decisions about their care. For people with stage IV chronic kidney disease when referred by their doctor. We cover up to six (6) sessions of kidney disease education services per lifetime.	$0 copay for each Medicare-covered session Deductible applies.	20% coinsurance for each Medicare-covered session. Deductible applies.
Outpatient diagnostic tests, therapeutic services and supplies Covered services include: • X-rays. • Complex diagnostic tests and x-rays. • Radiation/chemotherapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.	Prior authorization may be required for complex imaging, as well as limited diagnostic and therapeutic radiology services including but not limited to injectable/infusible medications, radiation therapy, PET, echocardiograms, CT, SPECT and MRI scans. $10 copay	Prior authorization is requested for complex imaging, as well as limited diagnostic and therapeutic radiology services including but not limited to injectable/infusible medications, radiation therapy, PET, echocardiograms, CT, SPECT and MRI scans. 20% coinsurance

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Outpatient diagnostic tests, therapeutic services and supplies (cont) Certain diagnostic tests and x-rays are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs) and nuclear medicine studies, which includes PET scans.	for each Medicare-covered x-ray visit. Deductible applies. $10 copay for each Medicare-covered complex diagnostic radiology visit. Deductible applies. $10 copay for each Medicare-covered radiation therapy & chemotherapy treatment. Deductible applies. $0 copay for supplies. Deductible applies. $0 copay for each Medicare-covered clinical/diagnostic lab test. Deductible applies. $0 copay per pint of blood. Deductible does not apply.	for each Medicare-covered x-ray visit. Deductible applies. 20% coinsurance for each Medicare-covered complex diagnostic radiology visit. Deductible applies. 20% coinsurance for each Medicare-covered radiation therapy & chemotherapy treatment. Deductible applies. 20% coinsurance for supplies. Deductible applies. 20% coinsurance for each Medicare-covered clinical/ diagnostic lab test. Deductible applies. $0 copay per pint of blood. Deductible does not apply.
Vision care Covered services include: • Outpatient physician services for eye care. • 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 Medicare-covered services: 10% coinsurance for visits to a network primary care physician for exams to diagnose	For Medicare-covered services: 20% coinsurance for visits to an out-of-network primary care physician for exams to diagnose

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Vision care (cont) • Eye exams: An eye exam to check for diabetic retinopathy once every 12 months. • One (1) pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	and treat diseases of the eye 10% coinsurance for visits to a network specialist for exams to diagnose and treat diseases of the eye. Deductible applies. 10% coinsurance for glaucoma screening Deductible does not apply. 10% coinsurance for glasses/ contacts following cataract surgery. Deductible applies.	and treat diseases of the eye 20% coinsurance for visits to an out-of-network specialist for exams to diagnose and treat diseases of the eye. Deductible applies. 20% coinsurance for glaucoma screening Deductible does not apply. 20% coinsurance for glasses/ contacts following cataract surgery. Deductible applies.
Preventive Care and Screening Tests		
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	$0 copay for Medicare-covered screening. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be	20% coinsurance Medicare-covered screening. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Abdominal aortic aneurysm screening (cont)	applied for office services received from a network specialist.	20% coinsurance will be applied for office services received from an out-of-network specialist.
Bone mass measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every two (2) years 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.	$0 copay for Medicare-covered bone mass measurement. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	20% coinsurance for Medicare-covered bone mass measurement. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. For people at high risk of colorectal cancer, the following are covered:	$0 copay for Medicare-covered screenings. Deductible does not apply. If an office visit, other than a routine physical exam, is	20% coinsurance for Medicare-covered screenings. Deductible does not apply. If an office visit, other than a routine physical exam, is

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Colorectal screening (cont) • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, the following is covered: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy. In the event the procedure goes beyond a screening exam and involves biopsy or removal of any growth during the procedure, the procedure will be considered outpatient surgery, and the outpatient surgery member copayment will apply.	billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
HIV screening For people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test • Covered once every 12 months for persons without a pregnancy diagnosis • Covered up to three (3) times during a pregnancy	$0 copay for Medicare-covered screening. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	20% coinsurance for Medicare-covered screening. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.

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Medicare Part B Immunizations Covered services include: • Pneumonia vaccine. • Flu shots, including H1N1, once a year in the fall or winter. • If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine. • Other vaccines if you are at risk. If Part D prescription drug coverage is included with your medical plan, we also cover some vaccines under our outpatient prescription drug benefit.	$0 copay for Medicare-covered immunizations. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	$0 copay for Medicare-covered immunizations. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Mammography screening You can get this service on your own, without a referral from your provider. • One (1) baseline exam between the ages of 35 and 39 • One (1) screening every 12 months for women age 40 and older	Prior authorization is required for CT scans, MRIs and PET scans of the breast for non-emergent services. $0 copay for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to	Prior authorization is requested for CT scans, MRIs and PET scans of the breast for non-emergent services. 20% coinsurance for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Mammography screening (cont)	the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Pap test, pelvic exam and clinical breast exam Covered services include: For all women, Pap tests, pelvic exams and clinical breast exams 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 (1) Pap test every 12 months.	$0 copay for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10% coinsurance will be applied for office services received from a network specialist.	20% coinsurance for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
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.	$0 copay for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a $10% coinsurance will be applied for office services received from a network specialist.	20% coinsurance for Medicare-covered screening exams. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) every five (5) years	$0 copay for Medicare-covered tests. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a $0 copay will be applied for office services received from a network primary care physician, or a 10%	20% coinsurance for Medicare-covered tests. Deductible does not apply. If an office visit, other than a routine physical exam, is billed in addition to the preventive service, a 20% coinsurance will be applied for office services received from an out-of-network primary

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Cardiovascular disease testing (cont)	coinsurance will be applied for office services received from a network specialist.	care physician, or a 20% coinsurance will be applied for office services received from an out-of-network specialist.
Other Services		
Physical exams Routine physical exams (limited to one (1) exam per year) are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury and are not required by a third party (i.e., insurance companies, business establishments, governmental agencies). Includes measurement of height, weight, body mass index, blood pressure, visual acuity screen and other routine measurements; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Routine labs and x-rays ordered in conjunction with the physical exam are covered under "Outpatient diagnostic tests and therapeutic services and supplies" unless otherwise specified in this benefit chart.	$0 copay for services rendered by a network primary care physician (PCP) $0 copay for services rendered by a network physician specialist Deductible does not apply.	20% coinsurance for services rendered by an out-of-network primary care physician (PCP) 20% coinsurance for services rendered by an out-of-network physician specialist Deductible does not apply.
Personalized prevention plan services (Annual Wellness Visit) Available to members in the first 12 months that they have Medicare Part B or 12 months after the member has the one-time initial preventative physical exam (Welcome to Medicare Physical Exam)	$0 copay for services rendered by a network primary care physician (PCP) $0 copay for services rendered by a network physician specialist Deductible does not apply.	$0 copay for services rendered by an out-of-network primary care physician (PCP) $0 copay for services rendered by an out-of-network physician specialist Deductible does not apply.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Renal Dialysis (Kidney) Covered services include: • Outpatient or physician office (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). • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and others for the person helping you with your home dialysis treatments) • Home dialysis equipment and supplies.	Prior notice is requested for all members initiating dialysis treatment. For Medicare-covered services: $0 copay for outpatient or, physician office visits. Deductible does not apply. $0 copay for home dialysis or home support services. Deductible does not apply. Inpatient hospital coinsurance applies to inpatient dialysis. $0 copay for self-dialysis training. Deductible does not apply. $0 copay for home dialysis equipment and supplies. Deductible applies.	Prior notice is requested for all members initiating dialysis treatment. For Medicare-covered services: $0 copay for outpatient or, physician office visits. Deductible does not apply. $0 copay for home dialysis or home support services. Deductible does not apply. Inpatient hospital coinsurance applies to inpatient dialysis. 20% coinsurance for self-dialysis training. Deductible does not apply. 20% coinsurance for home dialysis equipment and supplies. Deductible applies.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Prescription drugs covered under your medical plan (Part B) "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. Drugs that usually are not self-administered by the patient and are injected while receiving physician services. Your Medicare Advantage plan also covers some drugs that are "usually not self-administered" even if you inject them at home. • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by your Medicare Advantage plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare • 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, Erythropoietin (Epogen®) or Epoetin Alfa and Darboetin Alfa (Aranesp®) • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home If Part D prescription drug coverage is included with your medical plan, please refer to your prescription drug Evidence of Coverage for information on your Part D prescription drug benefits.	Prior authorization may be required for certain injectables/ infusibles. 10% coinsurance up to a $100 out of pocket for Medicare Part B covered drugs. Deductible does not apply. 10% coinsurance up to a $100 out of pocket for Medicare Part B covered chemotherapy drugs. Deductible does not apply.	Prior authorization is requested for certain injectables/ infusibles. 10% coinsurance up to a $100 out of pocket for Medicare Part B covered drugs. Deductible does not apply. 10% coinsurance up to a $100 out of pocket for Medicare Part B covered chemotherapy drugs. Deductible does not apply.

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Additional Benefits		
Routine foot care Up to four (4) covered visits per year. Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails and other hygienic and preventive maintenance care.	$0 copay for each routine foot care visit to network primary care physicians (PCP) 10% coinsurance for each routine foot care visit to network physician specialists Deductible applies.	$50 copay for each routine foot care visit to out-of-network primary care physicians (PCP) $50 copay for each routine foot care visit to out-of-network physician specialists Deductible applies.
Hearing services Benefits include: • Routine hearing exams. Routine hearing exam is limited to one (1) per year.	10% coinsurance for routine hearing exams. Deductible does not apply.	20% coinsurance for routine hearing exams. Deductible does not apply.
Routine vision care • Routine vision exams Routine vision exams are limited to a $50 benefit maximum per year. Routine vision exam is limited to one (1) per year.	10% coinsurance for routine vision exams. Deductible does not apply.	20% coinsurance for routine vision exams. Deductible does not apply.
Acupuncture The services of a physician for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 24 visits during a calendar year. Chinese herbs and supplements are excluded	$0 copay per visit up to 24 visits per calendar year	Not covered

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Health and Wellness		
SilverSneakers® You can enroll in this fitness program provided by SilverSneakers®, an independent company. A fitness plan designed especially for Medicare-eligible individuals, SilverSneakers® includes: • A complimentary basic membership in a participating fitness center in your area. You can use all the services available to fitness center members with a basic membership, such as steam and sauna rooms, exercise equipment and SilverSneakers® classes custom-designed for all levels of fitness. • Opportunities to join in fitness promotions and health education seminars. There is not a separate charge for this program, as long as you only use services available with basic fitness center memberships. After you enroll in this Medicare Advantage plan, you will receive a brochure that shows the participating fitness centers in your area and describes how to enroll in SilverSneakers®. Contact Customer Service for more information on this program, or visit www.SilverSneakers.com.	$0 copay for the SilverSneakers® fitness benefit. Deductible does not apply.	
Smoking cessation (counseling to quit smoking) Up to eight (8) face-to-face visits in a 12 month period if you are diagnosed with an illness caused or complicated by tobacco use; or, you take a medication that is affected by tobacco. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.	$0 copay for each Medicare-covered visit. Deductible does not apply.	20% coinsurance for each Medicare-covered visit. Deductible does not apply.
Foreign travel emergency and urgently needed care Emergency or urgently needed care services while traveling outside the United States during a temporary absence of less than six (6) months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. • Emergency outpatient care	$50 copay for emergency care. Deductible does not apply. 10% coinsurance for urgent care. Deductible does not apply.	

Covered Services	What you must pay for these covered services	
Important Information	In-Network	Out-of-Network
Foreign travel emergency and urgently needed care (cont) • Urgently needed care • 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.	10% coinsurance per admission for emergency inpatient care. Deductible does not apply.	
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 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 coinsurance, copayments and deductibles listed in this benefit chart are accrued toward the medical plan out of pocket maximum with the exception of routine vision, routine hearing, routine foot care, and any foreign travel emergency and urgently needed care cost-sharing amounts. Part D prescription drug deductibles and copays do not apply to the medical plan out of pocket maximum.	$1,100	