Medicare PLUS Blue Group PPO℠

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Medical Benefits Chart

Your medical benefits and costs as a member of the Hope College Medicare Plus Blue Group PPO plan

This document is a part of your 2012 Evidence of Coverage. It is an important legal document. This plan is effective January 1, 2012 - December 31, 2012.

See Chapter 3 of the *Evidence of Coverage* for more information on the plan benefits.

The Medical Benefits Chart on the following pages lists the services Medicare Plus Blue Group PPO covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from Medicare Plus Blue Group PPO.
  - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk in the Medical Benefits Chart.
  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you will pay the coinsurance percentage multiplied by the total provider rate in the provider's contract,
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you will pay the coinsurance percentage times the Medicare allowable,
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you will pay the coinsurance percentage multiplied by the Original Medicare Limiting charge.

For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

Type of maximum	In-network:*	Out-of-network:*
Deductible	$200	$400
Part A and Part B benefit out-of-pocket maximum, except those noted separately below	$1000	$2000
Durable Medical Equipment (DME) and Prosthetic and Orthotic devices (P&O) annual deductible	$0	$0
Durable Medical Equipment (DME) and Prosthetic and Orthotic devices (P&O) annual out-of-pocket maximum	None	$6000

Note: All in-network Part A and Part B cost share applies to the in-network out of pocket (OOP) maximum. The in-network OOP maximum is mutually exclusive from the out-of-network OOP maximum amount. All Part A and Part B out-of-network cost share applies to the out-of-network out of pocket (OOP) maximum. The out-of-network OOP maximum is mutually exclusive from the in-network OOP maximum amount.

* Exceptions: There is no limit on cost-sharing for certain services. For members who have elected the hospice benefit, any Medicare cost-sharing amounts resulting from Medicare's payment of services that are not related to the terminal condition do not contribute to in- or out-of-network out-of-pocket maximums.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Inpatient Care	
Inpatient hospital care* Covered services include: • 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 • Physician Services • 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. If Medicare Plus Blue Group PPO provides transplant services at a distant location (farther away than the normal community patterns of care) 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. Coverage for reasonable travel arrangements is only available for covered transplants when the required transplant is not available locally and the plan sends you to a transplant center outside the normal community patterns of care for the transplant. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need *Inpatient substance abuse health services rendered by plan providers will require prior certification. Your plan	**In-network:** For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. All other services are covered at 100% of the approved amount. You have unlimited days of inpatient care coverage. Medicare-approved clinical lab services and preventive services are covered at 100% of the approved amount. **Out-of-network:** For facility evaluation and management services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. All other services are covered at 100% of the approved amount. You have unlimited days of inpatient care coverage. Medicare-approved clinical lab services and preventive services are covered at 100% of the approved amount.

Services that are covered for you	**What you must pay** when you get these services
provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior certification. **Note:** To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient mental health care* Covered services include mental health care services that require a hospital stay. *Inpatient mental health/behavioral health services rendered by plan providers will require prior certification. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior certification.	**In-network:** For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. Services are covered at 100% of the approved amount. You have unlimited days of inpatient coverage. **Out-of-network:** For facility evaluation and management services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. Services are covered at 100% of the approved amount. You have unlimited days of inpatient coverage.
Skilled nursing facility (SNF) care*	**In-network:**

Services that are covered for you	**What you must pay** when you get these services
(For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Covered services include: • Semiprivate 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 packed red cells begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician services 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. *Skilled nursing facility care rendered by plan providers will require prior certification. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior certification.	For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. All other services are covered at 100% of the approved amount. Plan covers up to 100 days for each benefit period. **Out-of-network:** For facility evaluation and management services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. All other services are covered at 100% of the approved amount. Plan covers up to 100 days for each benefit period.
Inpatient services covered during a non-covered inpatient stay	As described above, the plan covers unlimited days for inpatient hospital care and

Services that are covered for you	**What you must pay** when you get these services
Once you have reached these coverage limits, the plan will no longer cover your stay in the hospital or SNF. However, we will cover certain types of services that you receive while you are still in the hospital or the SNF. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF) stay. Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • 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	up to 100 days per benefit period for skilled nursing facility care. Medicare-approved clinical lab services are covered at 100% of the approved amount. **In-network:** For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. All other services are covered at 100% of the approved amount. **Out-of-network:** For facility evaluation and management services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. All other services are covered at 100% of the approved amount.
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 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	**In-network and out-of-network:** Services are covered at 100% of the approved amount.

Services that are covered for you	**What you must pay** when you get these services
Hospice care You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider. Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options: • You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing • --or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare. **Note:** If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services. Original Medicare covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	When you enroll in a Medicare-certified hospice program, your hospice services are paid for by Original Medicare, not Medicare Plus Blue Group PPO.
Outpatient Services	
Physician services, including doctor's office visits Covered services include: • Medically-necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your	**In-network:** For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. After the first 12 months of Part B coverage,

Services that are covered for you	**What you must pay** when you get these services
PCP or specialist, 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 network provider 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) • One routine physical exam per year.	for an annual routine physical exam, you pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. For office visits, you pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. For surgical services performed in an office, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For all other services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For facility evaluation and management services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. After the first 12 months of Part B coverage, for an annual routine physical exam, you pay a copayment of $40. Not subject to a deductible. These services apply to the out-of-network annual out-of-pocket maximum. For office visits, you pay a copayment of $40. Not subject to a deductible. These services apply to the out-of-network annual out-of-pocket maximum. For surgical services performed in an office, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-

Services that are covered for you	**What you must pay** when you get these services
	of-network annual out-of-pocket maximum. For all other services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum.
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: • Services in an emergency department or outpatient clinic, including same-day surgery • Laboratory 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. *Outpatient mental health/substance abuse services rendered by plan providers may require prior certification. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior certification You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. You pay a $50 copayment for Medicare-covered emergency room visits (waived if admitted within 3 days). Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. You pay a $50 copayment for Medicare-covered emergency room visits (waived if admitted within 3 days). Not subject to the deductible. These services apply to the out-of network annual out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services
Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation • Evaluation and management services • Spine X-rays and chiropractic radiology services • Chiropractic physical therapy visits	**In-network:** For manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers, and for evaluation and management services, you pay a copayment of $20. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. For spine X-rays, other chiropractic radiological and chiropractic physical therapy services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers, and for evaluation and management services, you pay a copayment of $40. Not subject to the deductible. These services apply to the out-of-network annual out-of-pocket maximum. For spine X-rays, other chiropractic radiological and chiropractic physical therapy services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum.
Podiatry services Covered services include: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical	**In-network:** For office visits, you pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services
conditions affecting the lower limbs	For some medically necessary foot care services other than office visits, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For office visits, you pay a copayment of $40. Not subject to a deductible. These services apply to the out-of-network annual out-of-pocket maximum. For some medically necessary foot care services other than office visits, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum.
Outpatient mental health care* Covered services include: Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. * Outpatient mental/behavioral health services rendered by plan providers may require prior certification. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior certification.	**In-network:** For mental health services rendered at a mental health facility, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For mental health services in an office setting, you pay a copayment of $20 for each visit. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For mental health services rendered at a mental health facility, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. For mental health services in an office setting, you pay a copayment of $40 for each visit. Not subject to a deductible. These services apply to the out-of-network annual

Services that are covered for you	**What you must pay** when you get these services
	out-of-pocket maximum.
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. * Partial hospitalization services rendered by plan providers will require prior certification. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior certification.	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum.
Outpatient substance abuse services* * Outpatient mental/substance abuse services rendered by plan providers may require prior certification. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior certification.	**In-network:** For substance abuse treatment services rendered at a facility, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For substance abuse treatment services in an office setting, you pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For substance abuse treatment services rendered at a facility, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. For substance abuse treatment services in an office setting, you pay a copayment of $40. Not subject to a deductible. These services apply to the out-of-network annual out-of-

Services that are covered for you	**What you must pay** when you get these services
	pocket maximum.
Outpatient surgery provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	**In-network:** For outpatient surgery, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For outpatient surgery, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum.
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) or if authorized by the plan. The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible, for Medicare-covered ambulance services. Cost-sharing applies for each one-way trip. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible, for Medicare-covered ambulance services. Cost-sharing applies for each one-way trip. These services apply to the out-of-network annual out-of-pocket maximum.
Emergency care Emergency care is care that is 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,	**In-network:** You pay a $50 copayment for Medicare-covered emergency room visits (waived if admitted within 3 days). Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services
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. Worldwide coverage	**Out-of-network:** You pay a $50 copayment for Medicare-covered emergency room visits (waived if admitted within 3 days). Not subject to the deductible. These services apply to the out-of network annual out-of-pocket maximum.
Urgently needed care Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. Worldwide coverage	**In-network:** You pay a copayment of $20. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** You pay a copayment of $40. Not subject to the deductible. These services apply to the out-of-network annual out-of-pocket maximum.
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).	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. Medicare therapy limits apply to rehabilitation services provided. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. Medicare therapy limits apply to rehabilitation services provided.
Cardiac rehabilitation services Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual

Services that are covered for you	**What you must pay** when you get these services
conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum.
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. * You must have a prescription or a Certificate of Medical Necessity from your doctor to obtain Durable Medical Equipment (DME) or Prosthetic and Orthotic (P&O) items and services.	**In-network:** Services are covered at 100% of the approved amount. There is no out-of-pocket maximum for durable medical equipment, prosthetics, orthotics and related supplies. **Out-of-network:** Your coinsurance is 50% of the approved amount. Not subject to a deductible. These services apply to the out-of-network $6000 annual out-of-pocket maximum for durable medical equipment, prosthetics, orthotics and related supplies.
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	**In-network:** Services are covered at 100% of the approved amount. There is no out-of-pocket maximum for durable medical equipment, prosthetics, orthotics and related supplies.

Services that are covered for you	**What you must pay** when you get these services
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. * You must have a prescription or a Certificate of Medical Necessity from your doctor to obtain Durable Medical Equipment (DME) or Prosthetic and Orthotic (P&O) items and services.	**Out-of-network:** Your coinsurance is 50% of the approved amount. Not subject to a deductible. These services apply to the out-of-network $6000 annual out-of-pocket maximum for durable medical equipment, prosthetics, orthotics and related supplies.
Diabetes self-management training, diabetic services 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 • For people with diabetes who have severe diabetic foot 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 • For persons at high risk of diabetes: Fasting plasma glucose tests (up to two screenings per year)	**In-network and Out-of-network:** Services are covered at 100% of the approved amount for diabetes screenings, diabetes-related durable medical equipment or supplies, and self-management training. You may pay a pharmacy coinsurance for medical supplies obtained from a pharmacy. These services apply toward the annual out-of-pocket maximum.
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. Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need.	Diagnostic lab services must be rendered at a Joint Venture Hospital Lab (JVHL) or Quest Diagnostics Lab in order to be considered in-network. These labs represent the PPO lab network. Services are covered at 100% of the approved amount for Medicare-approved clinical lab services. **In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services
• Other outpatient diagnostic tests * High-tech radiology services (i.e. CAT scans, MRAs, MRIs, PET scans, or nuclear medicine) rendered by plan providers require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. 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. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	**In-network:** For diagnosis and treatment of diseases and conditions of the eye, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For medical vision office visits, you pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. Services are covered at 100% of the approved amount for corrective lenses following cataract surgery. Services are covered at 100% of the approved amount for annual glaucoma screenings for those members at risk. Routine eye exams and glasses are not covered by this plan. LASIK Surgery: These services are not covered. RK Surgery: These services are not covered. **Out-of-network:** For diagnosis and treatment of diseases and conditions of the eye, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply

Services that are covered for you	**What you must pay** when you get these services
	to the out-of-network annual out-of-pocket maximum. For medical vision office visits, you pay a copayment of $40. Not subject to a deductible. These services apply to the out-of-network annual out-of-pocket maximum. Services are covered at 100% of the approved amount for corrective lenses following cataract surgery. Services are covered at 100% of the approved amount for annual glaucoma screenings for those members at risk. Routine eye exams and glasses are not covered by this plan. LASIK Surgery: These services are not covered. RK Surgery: These services are not covered.
Preventive	
Note: For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.	
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.	**In-network or out-of-network:** Services are covered at 100% of the approved amount.
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 once annually 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.	**In-network or out-of-network:** Services are covered at 100% of the approved amount.

<table>
<tr><th>Services that are covered for you</th><th>What you must pay when you get these services</th></tr>
<tr><td>Colorectal cancer screening
For people 50 and older, the following are covered once annually:
• Flexible sigmoidoscopy (or screening barium enema as an alternative)
• Fecal occult blood test
• Screening colonoscopy (or screening barium enema as an alternative)</td><td>In-network or out-of-network:
Services are covered at 100% of the approved amount.</td></tr>
<tr><td>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</td><td>In-network or out-of-network:
Services are covered at 100% of the approved amount.</td></tr>
<tr><td>Immunizations
Covered Medicare Part B services include:
• Pneumonia vaccine, covered once per lifetime; additional immunizations may be covered if medically necessary.
• 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 outpatient prescription drug benefit.</td><td>In-network or out-of-network:
Services are covered at 100% of the approved amount.</td></tr>
<tr><td>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 annually</td><td>In-network or out-of-network:
Services are covered at 100% of the approved amount.</td></tr>
</table>

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 annually	**In-network or out-of-network:** Services are covered at 100% of the approved amount.
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	**In-network or out-of-network:** Services are covered at 100% of the approved amount.
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).	**In-network or out-of-network:** Services are covered at 100% of the approved amount.
"Welcome to Medicare" physical exam The plan covers a one-time "Welcome to Medicare" physical exam, which 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:** You must have the physical exam within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" physical exam.	**In-network and Out-of-network:** A "Welcome (Physical)" Exam is covered at 100% of the approved amount once within the first 12 months after you have your Medicare Part B coverage.
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" exam. However, you don't need to have had a "Welcome to Medicare" exam to be covered for annual wellness visits after you've had Part B for 12 months.	**In-network or out-of-network:** Services are covered at 100% of the approved amount.
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	**In-network or out-of-network:** Services are covered at 100% of the approved amount.

Services that are covered for you	**What you must pay** when you get these services
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.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a 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 order. A physician must prescribe these services and renew their order yearly if your treatment is needed into another calendar year.	**In-network or out-of-network:** Services are covered at 100% of the approved amount.
Smoking and tobacco use cessation (counseling to stop smoking) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: we cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: we cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits, however, you will pay the applicable inpatient or outpatient cost sharing.	**In-network or out-of-network:** Services are covered at 100% of the approved amount.
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)	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. Home dialysis equipment and supplies are covered at 100% of the approved amount. Inpatient kidney dialysis services covered at 100% of the approved amount.

Services that are covered for you	**What you must pay** when you get these services
• 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 below, "Medicare Part B prescription drugs."	Kidney disease education services are covered at 100% of the approved amount. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. Home dialysis equipment and supplies are covered at 100% of the approved amount. Kidney disease education services are covered at 100% of the approved amount.
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 was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Chapter 5 of your Evidence of Coverage explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. Retail and mail-order drugs are covered by your BCBSM Part D prescription drug plan and are subject to copayments. Services are covered at 100% of the approved amount for drugs used in covered durable medical equipment, certain oral anti-cancer and anti-nausea drugs, and certain immunosuppressive drugs following a Medicare-covered transplant. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. Retail and mail-order drugs are covered by your BCBSM Part D prescription drug plan and are subject to copayments. Services are covered at 100% of the approved amount for drugs used in covered

Services that are covered for you	**What you must pay** when you get these services
prescription drugs through our plan is listed in Chapter 6 of your Evidence of Coverage.	durable medical equipment, certain oral anti-cancer and anti-nausea drugs, and certain immunosuppressive drugs following a Medicare-covered transplant.
Additional Benefits	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.	Original Medicare covers very limited medically necessary dental services. Your Medicare Advantage plan will cover those same medically necessary services. The cost-sharing for those services (e.g. surgery, office visits, X-rays) is referenced in other areas of the benefit chart. For more information, contact Member Services.
Hearing services Basic hearing evaluations performed by your provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	**In-network:** For diagnostic testing services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For diagnostic hearing office visits, you pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For diagnostic testing services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum. For diagnostic hearing office visits, you pay a copayment of $40. Not subject to the deductible. These services apply to the out-of-network annual out-of-pocket maximum.
Hearing Services - Routine Exams	**In-network:** You pay a copayment of $20. Not subject to a deductible. These services apply to the in-

Services that are covered for you	**What you must pay** when you get these services
	network annual out-of-pocket maximum. **Out-of-network:** You pay a copayment of $40. Not subject to a deductible. These services apply to the out-of-network annual out-of-pocket maximum.
Hearing Aids	**In-network:** Monaural standard hearing aids are covered at 100% of the approved amount every 36 months. **Out-of-network:** Monaural standard hearing aids are covered at 100% of the approved amount every 36 months.
Hospice Respite Care - Cost Share for Respite and Drugs	**In-network:** Services are covered at 100% of the approved amount. **Out-of-network:** Services are covered at 100% of the approved amount.
Foreign travel health care – not restricted to emergency/urgent care	Your cost-share amount is the same as if services are rendered in the United States.
Clinical psychologist consultation service	**In-network:** You pay a copayment of $20. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** You pay a copayment of $40. Not subject to a deductible. These services apply to the out-of-network annual out-of-pocket maximum.
Human organ transplants – additional coverage You have additional coverage for certain human organ transplants not covered by Original Medicare. There is no lifetime maximum for non-Medicare covered organs.	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved

Services that are covered for you	**What you must pay** when you get these services
	amount, after you meet your annual deductible. These services apply to the out-of-network annual out-of-pocket maximum.

(The information below is taken from Chapter 4 of the *Evidence of Coverage*)

SECTION 3 What benefits are not covered by the plan?

Section 3.1 Benefits we do *not* cover (exclusions)

This section tells you what kinds of benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in the *Evidence of Coverage*.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3 of the Evidence of Coverage booklet, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare. Your *Medical Benefits Chart* indicates whether this service is covered under your plan.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses, unless your employer or union group has selected the Private Duty Nursing benefit. See the *Medical Benefits Chart.*
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home, unless your employer or union group has selected the Private Duty Nursing benefit. See the *Medical Benefits Chart.*

- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as fillings or dentures, as well as other routine dental care not provided by the dental benefits of this plan. However, non-routine dental care received at a hospital may be covered.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, unless your employer or union group has selected the Chiropractic Enhanced Services benefit. See the *Medical Benefits Chart.*
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids and routine hearing examinations, unless your employer or union group has selected Additional Hearing Service benefits. See the *Medical Benefits Chart.*
- Radial keratotomy, LASIK surgery, unless your employer or union group has selected one or both of these benefits. See the *Medical Benefits Chart*.
- Eyeglasses, routine eye examinations, vision therapy and other low vision aids (unless your employer or union group has selected this benefit). However, eyeglasses are covered for people after cataract surgery. *See the Medical Benefits Chart.*
- Outpatient prescription drugs including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

- Any services listed above that aren't covered will remain not covered even if received at an emergency facility.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

(The information below is taken from Chapter 6 of the *Evidence of Coverage*)

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for Medicare Plus Blue Group PPO members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under Medicare Plus Blue Group PPO. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 ***Yearly Deductible Stage***	**Stage 2** ***Initial Coverage Stage***	**Stage 3** ***Coverage Gap Stage***	**Stage 4** ***Catastrophic Coverage Stage***
This stage is not applicable to your plan.	During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $2,930. (Details are in Section 5 of this chapter.)	For generic drugs, you pay your copay for the drug based on the corresponding drug tier or 86% of the costs, whichever is lower. For brand-name drugs, you pay 50% of the price (plus the dispensing fee). You stay in this stage until your out-of-pocket costs reach: $4,700 This is the amount you must pay out-of-pocket to leave the Coverage Gap Stage and qualify for Catastrophic Coverage. (Details are in Section 6 of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2012). (Details are in Section 7 of the *Evidence of Coverage*.)

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Explanation of Benefits" (the "EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs.**" This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of the *Evidence of Coverage*.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 Yearly Deductible Stage

Section 4.1 Yearly Deductible Stage

This stage is not applicable to your plan

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has five cost-sharing tiers

Every drug on the plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1, the lowest tier, includes preferred generic drugs.
- Tier 2, includes preferred brand drugs.
- Tier 3, includes non-preferred brand.
- Tier 4, includes non self-administered injectable drugs.
- Tier 5, the highest tier, includes specialty drugs.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A preferred retail pharmacy that is in our plan's network
- A non-preferred network retail pharmacy

- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 of your Evidence of Coverage booklet and the plan's *Pharmacy Directory.*

Preferred pharmacies are pharmacies in our network where members have lower cost sharing for covered drugs than at non-preferred pharmacies. However, you will usually have lower drug prices at non-preferred pharmacies than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs.

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 3.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a *one-month* supply (or less) of a covered Part D prescription drug from:

	Preferred and non-preferred network pharmacy (up to a 31-day supply)	The plan's mail-order service (up to a 31-day supply)	Network long-term care pharmacy (up to a 31-day supply)	Out-of-network pharmacy (coverage is limited to certain situations; see Chapter 3 for details) (up to a 31-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	**$10**	**$10**	**$10**	**$10**
Cost-Sharing Tier 2 *(Preferred Brand Drugs)*	**$40**	**$40**	**$40**	**$40**
Cost-Sharing Tier 3 (Non-Preferred Brand Drugs)	**$80**	**$80**	**$80**	**$80**

Cost-Sharing Tier 4 (Non-Self Administered Injectable Drugs)	**$80**	**Not Available**	**$80**	**$80**
Cost-Sharing Tier 5 (Specialty Tier Drugs)	**$80**	**$80**	**$80**	**$80**
Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.				

Section 5.3 A table that shows your costs for a *long-term* (90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

The table below shows what you pay when you get a long-term up to a 90-day supply of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug from:

	Preferred retail or mail order network pharmacy (up to a 90-day supply)	Non-preferred network pharmacy (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	**$25.00**	**$30.00**
Cost-Sharing Tier 2 (Preferred Brand Drugs)	**$100.00**	**$120.00**
Cost-Sharing Tier 3 (Non-Preferred Brand Drugs)	**$200.00**	**$240.00**
Cost-Sharing Tier 4 (Non Self-Administered Injectable Drugs)	A long-term supply is not available for drugs in Tier 4.	
Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.	
Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.		

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $2,930

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the $2,930 **limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The $0 you paid when you were in the Deductible Stage.
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the $2,930 limit in a year.

We will let you know if you reach this $2,930 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. .

SECTION 6 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 86% of the costs for generic drugs

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $4,700

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 50% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more 86% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (14%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 86% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2012, that amount is $4,700.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $4,700, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.