Your 2024 Medical Benefits Chart
PPO Plan 0PH
County of Sonoma

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Doctor and hospital choice You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.		
Prior authorization* Benefit categories that include services that require prior authorization are marked with an asterisk (*). Additional information can be found on the last page of the medical benefits chart.		
Annual deductible • The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	$0 Combined in-network and out-of-network	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Inpatient services		
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical therapy, occupational therapy, and speech language therapy • Inpatient substance abuse services • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If the plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines. • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Physician services		If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at an in-network hospital.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, seven days a week.		
Inpatient services in a psychiatric hospital* Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital. In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care*	For Medicare-covered SNF stays:	For Medicare-covered SNF stays:
(For a definition of skilled nursing facility, see the Definition of important words chapter in your Evidence of coverage (EOC).)	$0 copay for days 1-100 per benefit period	$0 copay for days 1-100 per benefit period
Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row.	No prior hospital stay required.	No prior hospital stay required.
Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech language therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors) • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (con't) Generally, you will receive your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Inpatient services covered when the hospital or SNF days are not covered or are no longer covered*	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefits chart at the cost share amounts indicated.	
If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or a skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetic and orthotic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back and neck braces, trusses and artificial legs, arms, and eyes including adjustments, repairs and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, occupational therapy, and speech language therapy		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech language therapy • Medical and social services • Medical equipment and supplies	$0 copay for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	$0 copay for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be an in-network provider or an out-of-network provider. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than this plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. Services covered by Original Medicare include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need nonemergency, nonurgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $0 copay for the one time only hospice consultation	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $0 copay for the one time only hospice consultation

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

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient services		
Physician services, including doctor's office visits*	$0 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services	$0 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services
Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Retail health clinics • Basic hearing and balance exams performed by your Primary Care Physician or specialist, if your doctor orders it to see if you need medical treatment • Telehealth services for some physician or mental health services can be found in the section of this benefit chart titled, Video doctor visits • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	$0 copay per visit to an in-network specialist for Medicare-covered services $0 copay per visit to an in-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing	$0 copay per visit to an out-of-network specialist for Medicare-covered services $0 copay per visit to an out-of-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Physician services, including doctor's office visits (con't) • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ○ You have an in-person visit within six months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past seven days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past seven days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another in-network provider prior to surgery • Physician services rendered in the home • Outpatient hospital services	$0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.	$0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Physician services, including doctor's office visits (con't) • In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. • Allergy testing and allergy injections		
Chiropractic services* • We cover only manual manipulation of the spine to correct subluxation.	$0 copay for each Medicare-covered visit	$0 copay for each Medicare-covered visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain* Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.); • Not associated with surgery; and • Not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:	$0 copay for each Medicare-covered visit	$0 copay for each Medicare-covered visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain (con't) • A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.		
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and disease of the feet (such as hammer toe or heel spurs), in an office setting • Medicare-covered routine foot care for members with certain medical conditions affecting the lower limbs • A foot exam covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations	$0 copay for each Medicare-covered visit	$0 copay for each Medicare-covered visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services*		
Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws	$0 copay for each Medicare-covered professional individual therapy visit	$0 copay for each Medicare-covered professional individual therapy visit
	$0 copay for each Medicare-covered professional group therapy visit	$0 copay for each Medicare-covered professional group therapy visit
Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$0 copay for each Medicare-covered professional partial hospitalization and intensive outpatient services visit	$0 copay for each Medicare-covered professional partial hospitalization and intensive outpatient services visit
Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit
	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit
	$0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit	$0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient substance abuse services, including partial hospitalization services*		
Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$0 copay for each Medicare-covered professional individual therapy visit	$0 copay for each Medicare-covered professional individual therapy visit
Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	$0 copay for each Medicare-covered professional group therapy visit	$0 copay for each Medicare-covered professional group therapy visit
	$0 copay for each Medicare-covered professional partial hospitalization and intensive outpatient services visit	$0 copay for each Medicare-covered professional partial hospitalization and intensive outpatient services visit
	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit
	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit
	$0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit	$0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* Facilities where surgical procedures are performed and the patient is released the same day. **Note:** If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, seven days a week.	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered outpatient observation room visit	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered outpatient observation room visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient hospital observation, non-surgical Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at **www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, seven days a week.	$0 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $0 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $0 copay for each Medicare-covered outpatient observation room visit	$0 copay for a visit to an out-of-network primary care physician in an outpatient hospital setting/ clinic for Medicare-covered non-surgical services $0 copay for a visit to an out-of-network specialist in an outpatient hospital setting/ clinic for Medicare-covered non-surgical services $0 copay for each Medicare-covered outpatient observation room visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Ambulance services • Covered ambulance services, whether for an emergency or nonemergency situation, include fixed wing, rotary wing, water, and ground ambulance services, to the nearest appropriate facility that can provide care only if the services are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. • Ambulance service is not covered for physician office visits.	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $0 copay per one-way trip for Medicare-covered ambulance services	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. 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 (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/ received in the United States. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at an in-network hospital.	$0 copay for each Medicare-covered emergency room visit	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Urgently needed services • Urgently needed services are available on a worldwide basis. If you are outside of the service area for your plan, your plan covers urgently needed services, including urgently required renal dialysis. Urgently needed services are services provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition, but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	$0 copay for each Medicare-covered urgently needed care visit	
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$0 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits	$0 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits
Cardiac rehabilitation services* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copay for Medicare-covered cardiac rehabilitation therapy visits	$0 copay for Medicare-covered cardiac rehabilitation therapy visits

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	$0 copay for Medicare-covered pulmonary rehabilitation therapy visits	$0 copay for Medicare-covered pulmonary rehabilitation therapy visits
Supervised exercise therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copay for Medicare-covered supervised exercise therapy visits	$0 copay for Medicare-covered supervised exercise therapy visits

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Durable medical equipment (DME) and related supplies*	$0 copay for Medicare-covered DME including oxygen supplies and oxygen	$0 copay for Medicare-covered DME including oxygen supplies and oxygen
(For a definition of durable medical equipment, see the Definition of important words chapter in your EOC.)		
Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, continuous blood glucose monitors, hospital bed ordered by a provider for use at home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.		
For additional information on the ownership of DME and the rental of oxygen supplies and oxygen, please see Chapter 3.	The rental period for oxygen equipment and oxygen is 36 months. For the remaining 24 months you will be responsible for the oxygen. After the five-year period, the cost-sharing responsibility for both oxygen supplies and oxygen resumes.	The rental period for oxygen equipment and oxygen is 36 months. For the remaining 24 months you will be responsible for the oxygen. After the five-year period, the cost-sharing responsibility for both oxygen supplies and oxygen resumes.
Copay or coinsurance only applies when you are not currently receiving inpatient care. If you are receiving inpatient care your DME will be included in the copay or coinsurance for those services.		
We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.		
Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines.	$0 copay for Medicare-covered CGMs and related supplies	$0 copay for Medicare-covered CGMs and related supplies
Coverage is limited to three sensors per month and one receiver every two years.	See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.	See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.
This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids (HA). Other brands are covered if deemed medically necessary by the provider. The review of medical necessity for use of HA and any non-preferred brands is part of the plan's prior authorization process.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Prosthetic devices and related supplies* Devices (other than dental) that replace all or a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery. See Vision care later in this section for more detail.	$0 copay for Medicare-covered prosthetics and orthotics	$0 copay for Medicare-covered prosthetics and orthotics
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefits • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Separately from the home infusion therapy professional services, home infusion requires a durable medical equipment component: • Durable medical equipment – the external infusion pump, the related supplies and the infusion drug(s), pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items	$0 copay for Medicare-covered professional services provided by a qualified home infusion supplier in the patient's home $0 copay for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)	$0 copay for Medicare-covered professional services provided by a qualified home infusion supplier in the patient's home $0 copay for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users) Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors • Blood glucose monitors are limited to one every year • Up to 200 blood glucose test strips and lancets for a 30-day supply • One pair per year of therapeutic custom molded shoes (including inserts provided with such shoes) and two additional pairs of inserts or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Diabetes self-management training is covered under certain conditions	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions $0 copay for Medicare-covered blood glucose monitors $0 copay for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training See the Durable Medical Equipment (DME) benefit section for continuous glucose monitors (CGMs) cost sharing.	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions $0 copay for Medicare-covered blood glucose monitors $0 copay for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training See the Durable Medical Equipment (DME) benefit section for continuous glucose monitors (CGMs) cost sharing.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies*	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test
Covered services include, but are not limited to: • X-rays • Complex diagnostic tests and radiology services • Radiation (radium and isotope) therapy, including technician materials and supplies • Testing to confirm chronic obstructive pulmonary disease (COPD) • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint • Other outpatient diagnostic tests Certain diagnostic tests and radiology services are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans.	$0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease $0 copay for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood	$0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease $0 copay for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Opioid treatment program services* Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA) approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$0 copay per visit for Medicare-covered opioid treatment program services	$0 copay per visit for Medicare-covered opioid treatment program services

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

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Preventive services care and screening tests  You will see this apple next to preventive services throughout this chart. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you in-network. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received. In addition, if an office visit is billed for the existing medical condition care or an additional non-preventive service received, the applicable in-network primary care physician or in-network specialist copay or coinsurance will apply.		
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.
 **Bone mass measurement** For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months, or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Colorectal cancer screening and colorectal services The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high-risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Barium enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal services: • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Colorectal cancer screening and colorectal services (con't) Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.		
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Medicare Part B immunizations Covered services include: • Pneumonia vaccine • Flu shots, including H1N1, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules **If you have Part D prescription drug coverage, some vaccines are covered under your Part D benefit (for example, the shingles vaccine). Please refer to your Part D prescription drug benefits.**	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.
Cervical and vaginal cancer screening Covered services include: • For all women, Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Prostate cancer screening exams For men aged 50 and older, the following are covered once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Welcome to Medicare preventive visit The plan covers a one-time Welcome to Medicare preventive visit. The visit includes a review of your health, measurements of height, weight, body mass index, blood pressure, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered Welcome to Medicare preventive visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered Welcome to Medicare preventive visit.
Annual wellness visit If you've had Medicare Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare preventive visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible enrollees are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the enrollee must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another plan year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Smoking and tobacco use cessation (counseling to quit smoking) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover 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. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Other services		
Services to treat outpatient kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area or when your provider for this service is temporarily unavailable or inaccessible) • Home dialysis or certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home and outpatient dialysis equipment and supplies Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section below, Medicare Part B prescription drugs.	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. $0 copay for each Medicare-covered kidney disease education session $0 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $0 copay for Medicare-covered self-dialysis training $0 copay for Medicare-covered home dialysis equipment and supplies	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. $0 copay for each Medicare-covered kidney disease education session $0 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $0 copay for Medicare-covered self-dialysis training $0 copay for Medicare-covered home dialysis equipment and supplies

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Services to treat outpatient kidney disease (con't)	$0 copay for Medicare-covered outpatient dialysis equipment and supplies	$0 copay for Medicare-covered outpatient dialysis equipment and supplies

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Medicare Part B prescription drugs covered under your medical plan (Part B drugs)*	$0 copay for Medicare-covered Part B drugs	$0 copay for Medicare-covered Part B drugs
These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan.	$0 copay for Medicare-covered Part B drug administration	$0 copay for Medicare-covered Part B drug administration
Covered drugs include: • Drugs include substances that are naturally present in the body, such as blood clotting factors • Drugs that usually are not self-administered by the patient and are injected or infused while receiving physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically-necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home and outpatient dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents such as Erythropoietin (Epogen®), Procrit®, or Epoetin Alfa, and Darbepoetin Alfa (Aranesp®)	$0 copay for Medicare-covered Part B chemotherapy drugs $0 copay for Medicare-covered Part B chemotherapy drug administration	$0 copay for Medicare-covered Part B chemotherapy drugs $0 copay for Medicare-covered Part B chemotherapy drug administration

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Medicare Part B prescription drugs covered under your medical plan (Part B drugs) (con't) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Part B prescription drug benefit. Some of Part B covered drugs listed above may be subject to step therapy. You may log into your secure member portal to find the list of Part B drugs that may be subject to step therapy. This list is located with your Plan Documents under your Benefits section. **If you have Part D prescription drug coverage, please refer to your *Evidence of Coverage* for information on your Part D prescription drug benefits.**		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Additional supplemental benefits, services, and discounts		
Routine hearing services • Routine hearing exams are limited to one every calendar year • Hearing aid fitting evaluations are limited to one per covered hearing aid Routine hearing exams and fitting evaluations are limited to a $70 maximum benefit every calendar year combined in-network and out-of-network. • Hearing aids Hearing aids are limited to a $500 benefit per ear with a $1,000 maximum benefit every three calendar years through Hearing Care Solutions. The maximum benefit coverage amount applies to covered, prescribed hearing aids. Includes digital hearing aid technology and inner ear, outer ear, and over the ear models. Fitting adjustment after hearing aid is received, if necessary. This benefit is limited to two devices. The hearing aid benefit does not provide coverage for over-the-counter hearing aids, amplifiers, internet purchases, over the phone purchases, assistive listening devices (ALDs), disposable hearing aids, earmolds or accessories. We have partnered with Hearing Care Solutions to bring you these discounts and services. Although you can see an out-of-network provider for your exam, you must select a hearing aid from the list available through Hearing Care Solutions. They will send the hearing aid(s) directly to your provider. Hearing Aids must be supplied by the plan's hearing network vendor, Hearing Care Solutions. The plan does not reimburse for devices received from other vendors or providers under this supplemental benefit.	Must use a Hearing Care Solutions participating provider. $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids	Out-of-network providers must order hearing aids through Hearing Care Solutions. $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids through Hearing Care Solutions Hearing aid must be ordered through Hearing Care Solutions and selected from the list of available devices. Hearing Care Solutions will send the device directly to your provider.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Routine hearing services (con't) For more information on your benefit, covered devices or to locate a Hearing Care Solutions provider please contact Hearing Care Solutions at **1-855-312-2545**. Hearing benefit management administered by Hearing Care Solutions, an independent company.	Members receive a free battery supply for non-rechargeable hearing aids during the first three years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.	Members receive a free battery supply for non-rechargeable hearing aids during the first three years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.
Routine vision services • Routine vision exams Routine vision exams are limited to one every calendar year. The routine vision exam is limited to a $70 maximum benefit every calendar year combined in-network and out-of-network. • Eyewear Eyewear is limited to a $100 maximum benefit* every two calendar years combined in-network and out-of-network. Covered eyewear includes prescription glasses, lenses, frames, and contacts.	Must use a Blue View Vision provider. $0 copay for routine vision exams $0 copay for eyewear After the plan pays benefits for routine vision exams and eyewear, you are responsible for any remaining cost.	$0 copay for routine vision exams $0 copay for eyewear After the plan pays benefits for routine vision exams and eyewear, you are responsible for any remaining cost.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Routine vision services (con't) This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. This information is intended to be a brief outline of coverage. For additional benefit information, including exclusions and limitations or to locate a participating Blue View Vision provider, please contact Member Services. If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. In-network benefits and discounts will not apply. * Any remaining unused eyewear benefit amount must be used in the same calendar year of the first eyewear purchase. Unused amounts cannot carry over to the following calendar year or benefit period.		
Routine foot care • Up to 12 covered visits per year combined in-network and out-of-network Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails, and other hygienic and preventive maintenance care.	$0 copay for each routine foot care visit After the plan pays benefits for routine foot care, you are responsible for any remaining cost.	$0 copay for each routine foot care visit After the plan pays benefits for routine foot care, you are responsible for any remaining cost.
Annual routine physical exam The annual routine physical exam benefit covers a standard physical exam in addition to the Medicare-covered Welcome to Medicare or Annual Wellness Visit.	$0 copay for an annual physical exam	$0 copay for an annual physical exam

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Video doctor visits LiveHealth Online lets you see board-certified doctors and licensed therapists, psychologists and psychiatrists through live, two-way video on your smartphone, tablet or computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your plan membership card ready – you'll need it to answer some questions. **Sign up for Free:** • You must enter your health insurance information during enrollment, so have your plan membership card ready when you sign up. **Benefits of a video doctor visit:** • The visit is just like seeing your regular doctor face-to-face, but just by web camera. • It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye, and more. • The doctor can send prescriptions to the pharmacy of your choice, if needed.[1] • If you're feeling stressed, worried or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road. In most cases, you can make an appointment and talk with a therapist[2] or make an appointment and talk with a psychiatrist[3] from the privacy of your home. Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care.	$0 copay for video doctor visits using LiveHealth Online	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Video doctor visits (con't) LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this Plan. 1. Prescription is prescribed based on physician recommendations and state regulations (rules). 2. Appointments are typically scheduled within seven days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. 3. Appointments are typically scheduled within 28 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Health and wellness education programs **SilverSneakers® Membership** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers online and at participating locations[1]. You have access to a nationwide network of participating locations where you can take classes[2] and use exercise equipment and other amenities. Enroll in as many locations as you like, at any time. You also have access to instructors who lead specially designed group exercise classes in-person and online, seven days a week. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks, and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers LIVE classes, SilverSneakers On Demand videos and the SilverSneakers GO mobile app. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call **1-888-423-4632 (TTY: 711)** Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. 1. Participating locations (PL) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.	$0 copay for the SilverSneakers fitness benefit	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
24/7 NurseLine Also, as a member, you have access to a 24-hour nurse line, seven days a week, 365 days a year. When you call our nurse line, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the nurse line at **1-800-700-9184**. TTY users should call **711**. Only 24/7 NurseLine is included in our plan. All other nurse access programs are excluded.	$0 copay for 24/7 NurseLine	
Foreign travel emergency and urgently needed services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months. • Emergency outpatient care • Urgently needed services • Inpatient care (60 days per lifetime) This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/ received in the United States. If you are in need of emergency care outside of the United States or its territories, you should call the Blue Cross Blue Shield Global Core Program at **800-810-BLUE** or collect at **804-673-1177**. Representatives are available 24 hours a day, seven days a week, 365 days a year to assist you. When you are outside the United States or its territories, this plan provides coverage for emergency/urgent services only. This is a Supplemental Benefit and not a benefit covered under the federal Medicare program. For more coverage, you may have the option of purchasing additional travel insurance through an authorized agency.	$0 copay for emergency care $0 copay for urgently needed services $0 copay per admission for emergency inpatient care	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Medicare Community Resource Support Need help with a specific issue? Your plan benefits are designed to cover what Medicare covers, as well as some additional supplemental benefits as described in this benefits chart, but we know that you might need additional help. As a member, your plan provides a Medicare Community Resource Support benefit to help bridge the gap between your medical benefits and your optimal health, by connecting you to resources available to you in your community. The Medicare Education and Outreach team can help you locate helpful resources within your community, such as food pantries, home maintenance programs, utility assistance programs, social activities, and much more. If you need assistance or have questions about this benefit, call Member Services at the number listed on the back of your plan membership card.	$0 copay for Medicare Community Resource Support	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Healthy Meals*	$0 copay for Healthy Meals	
Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total). • A qualifying event includes when you are in a hospital or a skilled nursing facility and are discharged home or when you have a Body Mass Index (BMI) of 18.5 or under, you have a BMI of 25 or higher or an A1C level more than 9.0 as determined by your provider. • This benefit also qualifies as a Special Supplemental Benefit for the Chronically Ill (SSBCI). To receive meals as a Special Supplemental Benefit for the Chronically Ill, you must: ○ Meet the CMS mandated criteria, which may include providing supporting information from you or at times your physician. This criteria can be found in the Chapter Medical benefits (what is covered and what you pay) in your *Evidence of Coverage*. You can contact Member Services on the back of your plan membership card to begin the process to validate your eligibility. Under most circumstances, we are unable to initiate your benefit without speaking to you. By requesting this benefit you are expressly authorizing us to contact you by telephone.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Adult day center* • Coverage is available for up to one day per week (up to eight hours per day) for adult day center services. • The center must be licensed by the state to provide adult day center services. • We will reimburse up to $80 for each covered visit. You are responsible for any remaining costs. A visit is defined as less than or equal to eight hours. It cannot be split over multiple days. Any portion of a day used is considered one day. • Adult day center covered days is a direct member reimbursed benefit. Claims for reimbursement must be submitted by the member to the plan with appropriate documentation. To qualify, you must: • Get prior approval from the plan. • Need help with at least two activities of daily living (ADLs) as determined and recommended by your health care provider. For more information about this benefit please contact Member Services.	$0 copay for each adult day center visit After the plan pays benefits for adult day center you are responsible for any remaining cost.	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Assistive devices The Assistive Devices benefit provides an annual spending allowance on your Benefits Prepaid Card. This spending allowance can be used to buy assistive and safety devices like ADA toilet seats, shower stools, hand-held shower heads, reaching devices, temporary wheelchair threshold ramps, and more. The Benefits Prepaid Card is automatically loaded with the spending allowance amount. Unused amounts do not rollover and must be used by the end of the benefit year. You can only pay for your own items and cannot convert the card to cash. You have a variety of convenient ways to use your benefit: 1) Shop online on the approved vendor website 2) Shop on the approved vendor mobile app 3) Call to place an order 4) Order by mail **Note:** • Once you've used your annual spending allowance, you are responsible for the remaining cost of your purchases. • All orders must be placed through the plan's approved vendor. • Any repair or replacement of items selected is limited to the manufacturer's warranty. • Items are limited to those offered by the approved vendor and are subject to availability. • Quantity limits may apply. • Installation services are not included. In the event you have an issue using your Benefits Prepaid Card, you may submit a claim form for reimbursement along with proof of payment. Contact information is listed on the back of your Benefits Prepaid Card. Claims must be submitted within 90 days of the date of payment on your receipt.	This plan provides a $200 annual spending allowance toward covered assistive devices. Unused allowance amounts do not roll over to the next benefit year. After the plan pays benefits for assistive devices, you are responsible for any remaining cost.	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Assistive devices (con't) For more information about this benefit please contact Member Services or the phone number located on the back of your Benefits Prepaid Card.		
Health and fitness tracker for your body & mind health Coverage includes a fitness tracking device to track your physical activity with access to a website, designed to provide guidance and to promote an active lifestyle. Limit is one device every two years provided through our contracted vendor. Additionally, this benefit includes membership to a web-based memory fitness program designed to help maintain or improve your focus, attention, reaction time, brain speed, and memory. Register at https://healthandfitness.brainhq.com. For more information about these benefits or to order your device please contact Member Services. Posit Corporation, an independent company, is providing BrainHQ services on behalf of the plan.	$0 copay for health and fitness tracker	
Personal emergency response system (PERS) Coverage of one personal emergency response system and monthly monitoring in the member's home when arranged by the plan with our contracted vendor. The personal emergency response system benefit provides an in-home device to notify appropriate personnel of an emergency (e.g., a fall). For more information about this benefit or to request the device please call Member Services.	$0 copay for personal emergency response system	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Routine transportation • Routine transportation covers up to 12 non-emergency one-way trips each year, to locations within the local service area, when obtaining plan covered services. A trip is limited to 60 miles per one-way trip. • Trips can be used for getting to and from covered medical visits, SilverSneakers locations, and visits to a pharmacy to pick up prescriptions. Short stops at a pharmacy to pick up a prescription, after a covered medical visit, can be made as part of the return trip and will not require a separate trip. Ask the provider/facility to call in the prescription so you have a shorter wait. • You must schedule trips 48 hours (excluding weekends) in advance. When scheduling your ride, let the vendor know if you are in a wheelchair, if you need help, or if someone will be coming with you. • Modes of approved transportation may include taxi, rideshare, wheelchair van and public transportation. • Trips will not be covered for personal errands or other reasons when accessing non-covered services. We have partnered with Access2Care to bring you these discounts and services. You must use the plan approved vendor. For more information about this benefit please contact Member Services or to schedule a trip contact Access2Care at **(888) 479-3249**. Access2Care, an independent company, is providing routine transportation on behalf of the plan.	$0 copay for routine transportation	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Additional acupuncture services* Coverage includes acupuncture services, not covered by Medicare, rendered by a licensed acupuncturist to treat a disease, illness or injury. Benefits include: • Initial patient exam, as well as acupuncture treatment, re-examinations and other services in various combinations Medicare non-covered acupuncture services are limited to 20 visits per year combined in-network and out-of-network. For more information about this benefit please contact Member Services.	$0 copay per visit After the plan pays benefits for Medicare non-covered acupuncture services, you are responsible for any remaining cost.	$0 copay per visit After the plan pays benefits for Medicare non-covered acupuncture services, you are responsible for any remaining cost.
Additional chiropractic services* Coverage includes chiropractic services, not covered by Medicare, rendered by a physician to treat a disease, illness or injury. Benefits include: • Diagnostic services, other than diagnostic scanning, when provided during an initial examination or re-examination; • Adjustments; • Radiological x-rays and laboratory tests; and • Medically necessary therapy when provided in conjunction with the visit specifically for spinal or joint adjustment. Medicare non-covered chiropractic services are limited to 20 visits per year combined in-network and out-of-network. For more information about this benefit please contact Member Services.	$0 copay per visit After the plan pays benefits for Medicare non-covered chiropractic services, you are responsible for any remaining cost.	$0 copay per visit After the plan pays benefits for Medicare non-covered chiropractic services, you are responsible for any remaining cost.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Medicare-approved clinical research studies A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.	After Original Medicare has paid its share of the Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's cost sharing for like services. Any remaining plan cost sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.	
Annual out-of-pocket maximum All copays, coinsurance, and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of routine hearing services and routine vision services. Part D prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.	$0 Combined in-network and out-of-network	

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

Note: While you can get your care from an out-of-network provider for Medicare-covered services, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Providers that do not contract with us are under no obligation to treat you, except in emergency situations.

Your 2024 Prescription Drug Benefits Chart
Formulary E3, 5/10/10 (with Senior Rx Plus)
County of Sonoma

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

Formulary	E3
Deductible	$0
Covered Services	What you pay
Part D Initial Coverage	
Below is your payment responsibility until the amount paid by you and the Coverage Gap Discount Program for covered Part D prescriptions reaches your True Out of Pocket limit of $8,000.	
Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Generics	$5 copay
• Preferred Brands	$10 copay
• Non-Preferred Drugs, including Specialty Drugs	$10 copay
Retail Pharmacy	per 90-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Generics	$15 copay
• Preferred Brands	$30 copay
• Non-Preferred Drugs, including Specialty Drugs	$30 copay

Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.

Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)
• Select Generics	$0 copay
• Generics	$10 copay
• Preferred Brands	$20 copay
• Non-Preferred Drugs, including Specialty Drugs	$20 copay

Covered Services	What you pay
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $8,000.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
• Select Generics	$0 copay
• Generics	$0 copay
• Brand-Name Drugs	$0 copay

- **Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.

- **Important Message About What You Pay for Insulin:** You won't pay more than $35 for a one month supply of each insulin product covered by your plan, no matter what cost-sharing tier it is on.

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

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

Your 2024 Extra Covered Drugs Benefits Chart

Covered Services	What you pay
Extra Covered Drugs	
These are prescription drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These prescription drugs are covered by your Senior Rx Plus benefits. Some of these drugs may be required on your retiree drug plan by state regulations. These drugs do not count towards your deductible or True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.	
Retail Pharmacy	per 30-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered
• Generics	$5 copay
• Preferred Brands	$10 copay
• Non-Preferred Drugs	$10 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$5 copay
• Preferred Brands	$10 copay
• Non-Preferred Drugs	$10 copay
Other Non-Part D Coverage	Copay or coinsurance
• Contraceptive Devices	$10 copay per Covered Device

Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered
• Generics	$10 copay
• Preferred Brands	$20 copay
• Non-Preferred Drugs	$20 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$10 copay
• Preferred Brands	$20 copay
• Non-Preferred Drugs	$20 copay
Other Non-Part D Coverage	Copay or coinsurance
• Contraceptive Devices	$10 copay per Covered Device

- **Over the Counter Drugs:** To get over the counter drugs listed as covered under your drug plan, you must have a prescription from your provider and have the prescribed drug filled by the pharmacist.

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC

Health Insurance Company depends on contract renewal. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association.