CARE IMPROVEMENT PLUS

Specialized Care for Medicare Beneficiaries

2012
Summary of Benefits

Missouri and
Arkansas

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Section 1
Introduction to the Summary of Benefits Report for CARE IMPROVEMENT PLUS January 1, 2012 - December 31, 2012 ARKANSAS AND MISSOURI

Thank you for your interest in Care Improvement Plus (Regional PPO). Our plan is offered by CARE IMPROVEMENT PLUS SOUTH CENTRAL INSURANCE CO/Care Improvement Plus, a Medicare Advantage Preferred Provider Organization (PPO). There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

Silver Rx (Regional PPO SNP) and Gold Rx (Regional PPO SNP):

If you have been diagnosed with Chronic Heart Failure and Diabetes you may be eligible to join this plan.

Dual Advantage (Regional PPO SNP):

You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this Summary of Benefits is based on your level of Medicaid eligibility.

Please call Care Improvement Plus to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Care Improvement Plus and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Care Improvement Plus. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you have one or more of the listed diseases you may enroll in the plan at any time but you may only leave the plan at certain times.

Please call Care Improvement Plus at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Care Improvement Plus and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS CARE IMPROVEMENT PLUS AVAILABLE?

The service area for this plan includes: Arkansas and Missouri. You must live in this area to join the plan.

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

WHO IS ELIGIBLE TO JOIN CARE IMPROVEMENT PLUS?

You can join Care Improvement Plus if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area.

However, individuals with End-Stage Renal Disease generally are not eligible to enroll in Care Improvement Plus unless they are members of our organization and have been since their dialysis began.

You must have been diagnosed by your doctor with Chronic Heart Failure and Diabetes to join Care Improvement Plus Silver Rx (Regional PPO SNP) and Gold Rx (Regional PPO SNP).

You must also be enrolled in the Arkansas or Missouri state Medicaid program to join Care Improvement Plus Dual Advantage (Regional PPO SNP).

Please call the plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

Care Improvement Plus has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at http://www.careimprovementplus.com. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Care Improvement Plus has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at http://www.careimprovementplus.com/members/formulary--medicare-drug-plan-coverage.aspx. Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Care Improvement Plus does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Care Improvement Plus uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at http://www.careimprovementplus.com/members/formulary--medicare-drug-plan-coverage.aspx.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/ 7 days a week; and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan.

Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Care Improvement Plus, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Care Improvement Plus, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Care Improvement Plus for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Care Improvement Plus for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs administered through DME.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan.

Our customer service number is listed below.

Please call Care Improvement Plus for more information about Care Improvement Plus.

Visit us at http://www.careimprovementplus.com/ or, call us:

Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern

Current members should call toll-free (800)-204-1002 for questions related to the Medicare Advantage Program. (TTY/TDD (711))

Prospective members should call toll-free (800)-711-1656 for questions related to the Medicare Advantage Program. (TTY/TDD (711))

Current members should call locally (800)-204-1002 for questions related to the Medicare Advantage Program. (TTY/TDD (711))

Prospective members should call locally (800)-711-1656 for questions related to the Medicare Advantage Program. (TTY/TDD (711))

Current members should call toll-free (866)-673-3561 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-673-3563)

Prospective members should call toll-free (800)-711-1656 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-673-3563)

Current members should call locally (866)-673-3561 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-673-3563)

Prospective members should call locally (800)-711-1656 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-673-3563)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats. This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

If you have any questions about this plan's benefits or costs, please contact Care Improvement Plus for details.

Section II — Summary of Benefits

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
IMPORTANT INFORMATION					
1. Premium and Other Important Information	In 2012 the monthly Part B Premium is $99.90 and the annual Part B deductible amount is $140. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. In 2012 the monthly Part B Premium is $0 and the annual Part B deductible amount is $0. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.	**General** $31.80 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available	**General** $0 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available	**General** * Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for original Medicare services ** Please consult with your plan about cost sharing when receiving services from out-of-network providers. $0 monthly plan premium* Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved	**General** $60 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B Premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
1. Premium and Other Important Information *(continued)*		on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.	on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.	amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.	on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.
		In-Network $6,700 out-of-pocket limit for Medicare-covered services.	**In-Network** $6,700 out-of-pocket limit for Medicare-covered services.	**In-Network** $0 annual deductible.* $6,700 out-of-pocket limit for Medicare-covered services. However, in this plan you will have no cost sharing responsibility for Medicare-covered services, based on your level of Medicaid eligibility.	**In-Network** $6,700 out-of-pocket limit for Medicare-covered services.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
1. Premium and Other Important Information *(continued)*		**Out-of-Network** $6,700 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** In 2012 the annual Part B deductible amount is $140. $6,700 out-of-pocket limit for Medicare-covered services.	**Out-of-Network** $6,700 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** $6,700 out-of-pocket limit for Medicare-covered services.	**Out-of-Network** $0 annual deductible.** $6,700 out-of-pocket limit for Medicare-covered services. However, in this plan you will have no cost sharing responsibility for Medicare-covered services, based on your level of Medicaid eligibility.** **In and Out-of-Network** $0 annual deductible.* $6,700 out-of-pocket limit for Medicare-covered services. However, in this plan you will have no cost sharing responsibility for Medicare-covered services, based on your level of Medicaid eligibility.	**Out-of-Network** $6,700 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** $6,700 out-of-pocket limit for Medicare-covered services.
2. Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** Referral required for network specialists (for certain benefits) **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.	**In-Network** Referral required for network specialists (for certain benefits). **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.
INPATIENT CARE					
3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2012 the amounts for each benefit period are: Days 1 - 60: $1156 deductible Days 61 - 90: $289 per day Days 91 - 150: $578 per lifetime reserve day Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once.	**In-Network** Plan covers 90 days each benefit period. In 2012 the amounts for each benefit period are: Days 1 - 60: $1156 deductible Days 61 - 90: $289 per day Days 91 - 150: $578 per lifetime reserve day You will not be charged additional cost sharing for professional services.	**In-Network** Plan covers 90 days each benefit period. For Medicare-covered hospital stays: Days 1 - 15: $155 copay per day Days 16 - 90: $0 copay per day Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: Days 1 - 60: $0 copay per day		**In-Network** Plan covers 90 days each benefit period. For Medicare-covered hospital stays: Days 1 - 15: $175 copay per day Days 16 - 90: $0 copay per day Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: Days 1 - 60: $0 copay per day

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
3. Inpatient Hospital Care *(continued)*	A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. For each benefit period: Days 1 - 60: $0 deductible Days 61 - 90: $0 per day Days 91 - 150: $0 per lifetime reserve day Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** In 2012 the amounts for each benefit period are: Days 1 - 60: $1156 deductible Days 61 - 90: $289 per day Days 91 - 150: $578 per lifetime reserve day	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** For hospital stays: Days 1 - 15: $155 copay per day Days 16 - 90: $0 copay per day	**In-Network** Plan covers 90 days each benefit period. You will not be charged additional cost sharing for professional services. $0 annual deductible* $0 copay* Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** In 2012 the amounts for each benefit period are: Days 1 - 60: $1156 deductible** Days 61 - 90: $289 per day** Days 91 - 150: $578 per lifetime reserve day** *See page 62 for information about Inpatient Hospital Care.*	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** For hospital stays: Days 1 - 15: $175 copay per day Days 16 - 90: $0 copay per day

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
4. Inpatient Mental Health Care	In 2012 the amounts for each benefit period are: Days 1 - 60: $1156 deductible Days 61 - 90: $289 per day Days 91 - 150: $578 per lifetime reserve day You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For each benefit period: Days 1 - 60: $0 deductible Days 61 - 90: $0 per day Days 91 - 150: $0 per lifetime reserve day You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** In 2012 the amounts for each benefit period are: Days 1 - 60: $1156 deductible Days 61 - 90: $289 per day Days 91 - 150: $578 per lifetime reserve day You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $1,000 copay for each Medicare-covered hospital stay. Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: Days 1 - 60: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **In-Network** $0 copay* You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $0 annual deductible* Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.		**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $1,000 copay for each Medicare-covered hospital stay. Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: Days 1 - 60: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
4. Inpatient Mental Health Care *(continued)*		**Out-of-Network** In 2012 the amounts for each benefit period are: Days 1 - 60: $1156 deductible Days 61 - 90: $289 per day Days 91 - 150: $578 per lifetime reserve day Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care")	**Out-of-Network** $1,000 copay for each hospital stay.	**Out-of-Network** In 2012 the amounts for each benefit period are: Days 1 - 60: $1156 deductible** Days 61 - 90: $289 per day** Days 91 - 150: $578 per lifetime reserve day** Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care") *See page 62 for information about Inpatient Mental Health Care.*	**Out-of-Network** $1,000 copay for each hospital stay.
5. Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: $0 per day Days 21 - 100: $144.50 per day 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. In 2012 the amounts for each benefit period are: Days 1 - 20: $0 per day Days 21 - 100: $144.50 per day You will not be charged additional cost sharing for professional services.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $130 copay per day	**General** Authorization rules may apply.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $130 copay per day

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
5. Skilled Nursing Facility (SNF) *(continued)*	In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: $0 per day Days 21 - 100: $0 per day 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	**Out-of-Network** In 2012 the amounts for each benefit period are: Days 1 - 20: $0 per day Days 21 - 100: $144.50 per day	**Out-of-Network** For each SNF stay: Days 1 - 20: $0 copay per SNF day Days 21 - 100: $130 copay per SNF day	**In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. $0 annual deductible* $0 copay for SNF services* You will not be charged additional cost sharing for professional services. For Non-Medicare Supplemental SNF stays: Days 1 - 20: $0 per day Days 21 - 100: $0 per day **Out-of-Network** In 2012 the amounts for each benefit period are: Days 1 - 20: $0 per day** Days 21 - 100: $144.50 per day** *See page 62 for information about Skilled Nursing Facility (SNF).*	**Out-of-Network** For each SNF stay: Days 1 - 20: $0 copay per SNF day Days 21 - 100: $130 copay per SNF day
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered home health visit. **Out-of-Network** $0 copay for home health visits.	**General** Authorization rules may apply. **In-Network** 0% of the cost for each Medicare-covered home health visit. **Out-of-Network** 40% of the cost for home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.* **Out-of-Network** $0 copay for Medicare-covered health visits.**	**General** Authorization rules may apply. **In-Network** 0% of the cost for each Medicare-covered home health visit. **Out-of-Network** 40% of the cost for home health visits.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
7. Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE					
8. Doctor Office Visits	20% coinsurance 0% coinsurance	**In-Network** 20% of the cost for each primary care doctor visit for Medicare-covered benefits. 20% of the cost for each in-area, network urgent care Medicare-covered visit. 20% of the cost for each specialist visit for Medicare-covered benefits. **Out-of-Network** 20% of the cost for each primary care doctor visit. 20% of the cost for each specialist visit.	**In-Network** $35 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each in-area, network urgent care Medicare-covered visit. $50 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** $35 copay for each primary care doctor visit. $50 copay for each specialist visit.	**In-Network** $0 copay for each primary care doctor visit for Medicare-covered benefits.* $0 copay for the cost of each in-area, network urgent care Medicare-covered visit.* $0 copay for each specialist doctor visit for Medicare-covered benefits.* **Out-of-Network** 20% of the cost for each primary care doctor visit.** 20% of the cost for each specialist visit.** *See page 62 for information about Doctor Office Visits.*	**In-Network** $35 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each in-area, network urgent care Medicare-covered visit. $50 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** $35 copay for each primary care doctor visit. $50 copay for each specialist visit.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
9. Chiropractic Services	Supplemental routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. Supplemental routine care not covered. 0% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** 20% of the cost for each Medicare-covered visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. **Out-of-Network** 20% of the cost for chiropractic benefits.	**In-Network** $20 copay for each Medicare-covered visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. **Out-of-Network** $20 copay for chiropractic benefits.	**In-Network** $0 copay for Medicare-covered chiropractic visits* Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. **Out-of-Network** 20% of the cost for chiropractic benefits.** *See page 62 for information about Chiropractic Services.*	**In-Network** $20 copay for each Medicare-covered visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. **Out-of-Network** $20 copay for chiropractic benefits.
10. Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. Supplemental routine care not covered. 0% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** 20% of the cost for each Medicare-covered visit. 0% of the cost for up to 6 supplemental routine visit(s) every year. Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** 0% to 20% of the cost for podiatry benefits.	**In-Network** $50 copay for each Medicare-covered visit. $0 copay for up to 6 supplemental routine visit(s) every year. Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** $0 to $50 copay for podiatry benefits.	**In-Network** $0 copay for Medicare-covered podiatry benefits.* Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** 20% of the cost for podiatry benefits.** *See page 62 for information about Podiatry Services.*	**In-Network** $50 copay for each Medicare-covered visit. $0 copay for up to 6 supplemental routine visit(s) every year. Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** $0 to $50 copay for podiatry benefits.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
11. Outpatient Mental Health Care	40% coinsurance for most outpatient mental health services. Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. 0% coinsurance for most outpatient mental health services. 0% coinsurance of the Medicare-approved amount for each service you get from a qualified professional as part of a Partial Hospitalization Program. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**General** Authorization rules may apply. **In-Network** 40% of the cost for each Medicare-covered individual therapy visit 40% of the cost for each Medicare-covered group therapy visit 40% of the cost for each Medicare-covered individual therapy visit with a psychiatrist 40% of the cost for each Medicare-covered group therapy visit with a psychiatrist 20% of the cost for Medicare-covered partial hospitalization program services **Out-of-Network** 40% of the cost for Mental Health benefits with a psychiatrist 40% of the cost for Mental Health benefits 20% of the cost for partial hospitalization program services	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered individual therapy visit $35 copay for each Medicare-covered group therapy visit $40 copay for each Medicare-covered individual therapy visit with a psychiatrist $35 copay for each Medicare-covered group therapy visit with a psychiatrist $40 copay for Medicare-covered partial hospitalization program services **Out-of-Network** $40 copay for partial hospitalization program services $35 to $40 copay for Mental Health benefits with a psychiatrist $35 to $40 copay for Mental Health benefits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Mental Health visits* $0 copay for each Medicare-covered visit with a psychiatrist* $0 copay for Medicare-covered partial hospitalization program services* **Out-of-Network** 40% of the cost for Mental Health benefits with psychiatrist** 40% of the cost for Mental Health benefits** 20% of the cost for partial hospitalization program services** *See page 62 for information about Outpatient Mental Health Care.*	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered individual therapy visit $35 copay for each Medicare-covered group therapy visit $40 copay for each Medicare-covered individual therapy visit with a psychiatrist $35 copay for each Medicare-covered group therapy visit with a psychiatrist $40 copay for Medicare-covered partial hospitalization program services **Out-of-Network** $35 to $40 copay for Mental Health benefits with a psychiatrist $35 to $40 copay for Mental Health benefits $40 copay for partial hospitalization program services

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
12. Outpatient Substance Abuse Care	20% coinsurance 0% coinsurance	**In-Network** 40% of the cost for Medicare-covered individual visits. 40% of the cost for Medicare-covered group visits. **Out-of-Network** 40% of the cost for outpatient substance abuse benefits.	**In-Network** $40 copay for Medicare-covered individual visits. $35 copay for Medicare-covered group visits. **Out-of-Network** $35 to $40 copay for outpatient substance abuse benefits.	**In-Network** $0 copay for Medicare-covered visits.* **Out-of-Network** 40% of the cost for outpatient substance abuse benefits.** *See page 62 for information about Outpatient Substance Abuse Care.*	**In-Network** $40 copay for Medicare-covered individual visits. $35 copay for Medicare-covered group visits. **Out-of-Network** $35 to $40 copay for outpatient substance abuse benefits.
13. Outpatient Services/Surgery	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services 0% coinsurance for the doctor's services 0% coinsurance for ambulatory surgical center facility services	**General** Authorization rules may apply. **In-Network** 20% of the cost for each Medicare-covered ambulatory surgical center visit. 20% of the cost for each Medicare-covered outpatient hospital facility visit. **Out-of-Network** 20% of the cost for outpatient hospital facility benefits. 20% of the cost for ambulatory surgical center benefits.	**General** Authorization rules may apply. **In-Network** $150 copay for each Medicare-covered ambulatory surgical center visit. $150 copay for each Medicare-covered outpatient hospital facility visit. **Out-of-Network** $150 copay for outpatient hospital facility benefits. $150 copay for ambulatory surgical center benefits.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered ambulatory surgical center visit.* $0 copay for each Medicare-covered outpatient hospital facility visit.* **Out-of-Network** 20% of the cost for outpatient hospital facility benefits.** 20% of the cost for ambulatory surgical center benefits.** *See page 62 for information about Outpatient Services/Surgery.*	**General** Authorization rules may apply. **In-Network** $150 copay for each Medicare-covered ambulatory surgical center visit. $150 copay for each Medicare-covered outpatient hospital facility visit. **Out-of-Network** $150 copay for outpatient hospital facility benefits. $150 copay for ambulatory surgical center benefits.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
14. Ambulance Services (medically necessary ambulance services)	20% coinsurance 0% coinsurance	**In-Network** 20% of the cost for Medicare-covered ambulance benefits. **Out-of-Network** 20% of the cost for ambulance benefits.	**In-Network** $150 copay for Medicare-covered ambulance benefits. **Out-of-Network** $150 copay for ambulance benefits.	**In-Network** $0 copay for Medicare-covered ambulance benefits.* **Out-of-Network** 20% of the cost for ambulance benefits.** *See page 62 for information about Ambulance Services.*	**In-Network** $150 copay for Medicare-covered ambulance benefits. **Out-of-Network** $150 copay for ambulance benefits.
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances. 0% coinsurance for the doctor's services. 0% outpatient hospital facility emergency services. Not covered outside the U.S. except under limited circumstances.	**General** 20% of the cost (up to $65) for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $0 copay for Medicare-covered emergency room visits* Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay. NOT covered outside the U.S. except under limited circumstances. 0% coinsurance NOT covered outside the U.S. except under limited circumstances.	**General** 20% of the cost for Medicare-covered urgently-needed-care visits.	**General** $30 copay for Medicare-covered urgently-needed-care visits.	**General** $0 copay for Medicare-covered urgently-needed-care visits.*	**General** $40 copay for Medicare-covered urgently-needed-care visits.
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance 0% coinsurance	**General** Authorization rules may apply. **In-Network** There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits. 20% of the cost for Medicare-covered Occupational Therapy visits. 20% of the cost for Medicare-covered Physical and/or Speech and Language Therapy visits.	**General** Authorization rules may apply. **In-Network** There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits. $50 copay for Medicare-covered Occupational Therapy visits. $50 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.	**General** Authorization rules may apply. **In-Network** There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits. $0 copay for Medicare-covered Occupational Therapy visits.* $0 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.*	**General** Authorization rules may apply. **In-Network** There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits. $50 copay for Medicare-covered Occupational Therapy visits. $50 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
17. Outpatient Rehabilitation Services *(continued)*		**Out-of-Network** 20% of the cost for Physical and/or Speech and Language Therapy visits. 20% of the cost for Occupational Therapy benefits.	**Out-of-Network** $50 copay for Physical and/or Speech and Language Therapy visits. $50 copay for Occupational Therapy benefits.	**Out-of-Network** 20% of the cost for Physical and/or Speech and Language Therapy visits.** 20% of the cost for Occupational Therapy benefits.** *See page 62 for information about Outpatient Rehabilitation Services.*	**Out-of-Network** $50 copay for Physical and/or Speech and Language Therapy visits. $50 copay for Occupational Therapy benefits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES					
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance 0% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 20% of the cost for durable medical equipment.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 40% of the cost for durable medical equipment.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered items.* **Out-of-Network** 20% of the cost for durable medical equipment.** *See page 62 for information about Durable Medical Equipment.*	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 30% of the cost for durable medical equipment.
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance 0% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 20% of the cost for prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 20% of the cost for prosthetic devices.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered items.* **Out-of-Network** 20% of the cost for prosthetic devices.** *See page 62 for information about Prosthetic Devices.*	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 20% of the cost for prosthetic devices.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
20. Diabetes Programs and Supplies	20% coinsurance for Diabetes self-management training 20% coinsurance for Diabetes supplies 20% coinsurance for Diabetic therapeutic shoes or inserts 0% coinsurance for Diabetes self-management training 0% coinsurance for Diabetes supplies 0% coinsurance for Diabetic therapeutic shoes or inserts	**In-Network** $0 copay for Diabetes self-management training 20% of the cost for Diabetes monitoring supplies 20% of the cost for Therapeutic shoes or inserts **Out-of-Network** $0 copay for Diabetes self-management training 20% of the cost for Diabetes monitoring supplies 20% of the cost for Therapeutic shoes or inserts	**In-Network** $0 copay for Diabetes self-management training $0 copay for Diabetes monitoring supplies $0 copay for Therapeutic shoes or inserts **Out-of-Network** $0 copay for Diabetes self-management training $0 copay for Diabetes monitoring supplies $0 copay for Therapeutic shoes or inserts	**In-Network** $0 copay for Diabetes self-management training* $0 copay for: - Diabetes monitoring supplies* - Therapeutic shoes or inserts* **Out-of-Network** $0 copay for Diabetes self-management training** 20% of the cost for Diabetes monitoring supplies** 20% of the cost for Therapeutic shoes or inserts** *See page 62 for information about Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies.*	**In-Network** $0 copay for Diabetes self-management training $0 copay for Diabetes monitoring supplies $0 copay for Therapeutic shoes or inserts **Out-of-Network** $0 copay for Diabetes self-management training $0 copay for Diabetes monitoring supplies $0 copay for Therapeutic shoes or inserts
21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and X-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered lab services 20% of the cost for Medicare-covered diagnostic procedures and tests 20% of the cost for Medicare-covered X-rays 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays) 20% of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered lab services 20% of the cost for Medicare-covered diagnostic procedures and tests 20% of the cost for Medicare-covered X-rays 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays) 20% of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and		**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered lab services 20% of the cost for Medicare-covered diagnostic procedures and tests 20% of the cost for Medicare-covered X-rays 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays) 20% of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services *(continued)*	20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50. 0% coinsurance for diagnostic tests and X-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol. 0% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.	Lab Services, separate cost sharing of 20% of the cost may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of 20% of the cost may apply **Out-of-Network** 20% of the cost for therapeutic radiology services 20% of the cost for outpatient X-rays 20% of the cost for diagnostic radiology services 20% of the cost for diagnostic procedures, tests, and lab services	Lab Services, separate cost sharing of $35 to $50 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $35 to $50 may apply **Out-of-Network** 20% of the cost for therapeutic radiology services 20% of the cost for outpatient X-rays 20% of the cost for diagnostic radiology services 20% of the cost for diagnostic procedures, tests, and lab services	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare covered: - lab services* - diagnostic procedures and tests* - X-rays* - diagnostic radiology services (not including X-rays)* - therapeutic radiology services* **Out-of-Network** 20% of the cost for therapeutic radiology services** 20% of the cost for outpatient X-rays** 20% of the cost for diagnostic radiology services** 20% of the cost for diagnostic procedures, tests, and lab services** *See page 62 for information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services.*	Lab Services, separate cost sharing of $35 to $50 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $35 to $50 may apply **Out-of-Network** 20% of the cost for therapeutic radiology services 20% of the cost for outpatient X-rays 20% of the cost for diagnostic radiology services 20% of the cost for diagnostic procedures, tests, and lab services
22. Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered Cardiac Rehabilitation Services 20% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services 20% of the cost for Medicare-covered Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $50 copay for Medicare-covered Cardiac Rehabilitation Services $50 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $50 copay for Medicare-covered Pulmonary Rehabilitation Services		**General** Authorization rules may apply. **In-Network** $50 copay for Medicare-covered Cardiac Rehabilitation Services $50 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $50 copay for Medicare-covered Pulmonary Rehabilitation Services

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
22. Cardiac and Pulmonary Rehabilitation Services *(continued)*	0% coinsurance for Cardiac Rehabilitation services 0% coinsurance for Pulmonary Rehabilitation services 0% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**Out-of-Network** 20% of the cost for Cardiac Rehabilitation Services 20% of the cost for Intensive Cardiac Rehabilitation Services 20% of the cost for Pulmonary Rehabilitation Services	**Out-of-Network** $50 copay for Cardiac Rehabilitation Services $50 copay for Intensive Cardiac Rehabilitation Services $50 copay for Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: - Medicare-covered Cardiac Rehabilitation Services* - Medicare-covered Intensive Cardiac Rehabilitation Services* - Medicare-covered Pulmonary Rehabilitation Services* **Out-of-Network** 20% of the cost for Cardiac Rehabilitation Services** 20% of the cost for Intensive Cardiac Rehabilitation Services** 20% of the cost for Pulmonary Rehabilitation Services**	**Out-of-Network** $50 copay for Cardiac Rehabilitation Services $50 copay for Intensive Cardiac Rehabilitation Services $50 copay for Pulmonary Rehabilitation Services
PREVENTIVE SERVICES					
23. Preventive Services and Wellness/Education Programs	No coinsurance, copayment or deductible for the following: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening - Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine for people with Medicare who are at risk	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement - Cardiovascular Screening - Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine - HIV Screening - Breast Cancer Screening (Mammogram) - Medical Nutrition Therapy Services - Personalized Prevention Plan Services (Annual Wellness Visits)	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement - Cardiovascular Screening - Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine - HIV Screening - Breast Cancer Screening (Mammogram) - Medical Nutrition Therapy Services - Personalized Prevention Plan Services (Annual Wellness Visits)	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement - Cardiovascular Screening - Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine - HIV Screening - Breast Cancer Screening (Mammogram) - Medical Nutrition Therapy Services - Personalized Prevention Plan Services (Annual Wellness Visits)	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement - Cardiovascular Screening - Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine - HIV Screening - Breast Cancer Screening (Mammogram) - Medical Nutrition Therapy Services - Personalized Prevention Plan Services (Annual Wellness Visits)

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
23. Preventive Services and Wellness/Education Programs *(continued)*	- HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. - Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. - Medical Nutrition Therapy Services. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease - Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. - Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.	- Pneumococcal Vaccine - Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) - Smoking Cessation (Counseling to stop smoking) - Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** The plan covers the following supplemental education/wellness programs: - Written health education materials, including Newsletters - Additional Smoking Cessation - Nursing Hotline **Out-of-Network** $0 copay for Medicare-covered preventive services $0 copay for supplemental education/wellness programs	- Pneumococcal Vaccine - Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) - Smoking Cessation (Counseling to stop smoking) - Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** The plan covers the following supplemental education/wellness programs: - Written health education materials, including Newsletters - Additional Smoking Cessation - Nursing Hotline **Out-of-Network** $0 copay for Medicare-covered preventive services $0 copay for supplemental education/wellness programs	- Pneumococcal Vaccine - Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) - Smoking Cessation (Counseling to stop smoking) - Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** The plan covers the following supplemental education/wellness programs: - Written health education materials, including Newsletters - Additional Smoking Cessation - Nursing Hotline **Out-of-Network** $0 copay for Medicare-covered preventive services** $0 copay for supplemental education/wellness programs	- Pneumococcal Vaccine - Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) - Smoking Cessation (Counseling to stop smoking) - Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** The plan covers the following supplemental education/wellness programs: - Written health education materials, including Newsletters - Additional Smoking Cessation - Nursing Hotline **Out-of-Network** $0 copay for Medicare-covered preventive services $0 copay for supplemental education/wellness programs

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
23. Preventive Services and Wellness/Education Programs *(continued)*	- Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. - Welcome to Medicare Physical Exam (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.				
24. Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services 0% coinsurance for renal dialysis 0% coinsurance for kidney disease education services	**In-Network** 20% of the cost for renal dialysis $0 copay for kidney disease education services **Out-of-Network** $0 copay for kidney disease education services 20% of the cost for renal dialysis	**In-Network** 20% of the cost for renal dialysis $0 copay for kidney disease education services **Out-of-Network** $0 copay for kidney disease education services 20% of the cost for renal dialysis	**In-Network** $0 copay for renal dialysis* $0 copay for kidney disease education services* **Out-of-Network** $0 copay for kidney disease education services** 20% of the cost for renal dialysis** *See page 62 for information about Kidney Disease and Conditions.*	**In-Network** 20% of the cost for renal dialysis $0 copay for kidney disease education services **Out-of-Network** $0 copay for kidney disease education services 20% of the cost for renal dialysis

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
25. Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 20% of the cost for Part B drugs out-of-network. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.careimprovementplus.com/members/formulary--medicare-drug-plan-coverage.aspx on the web. Different out-of-pocket costs may apply for people who - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.	**Drugs covered under Medicare Part B** **General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 20% of the cost for Part B drugs out-of-network **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.careimprovementplus.com/members/formulary--medicare-drug-plan-coverage.aspx on the web. Different out-of-pocket costs may apply for people who - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.	**Drugs covered under Medicare Part B** **General** $0 annual deductible for Part B-covered drugs.* $0 copay for Part B covered chemotherapy drugs and other Part-B covered drugs.* 20% of the cost for Part B drugs out-of-network.** **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.careimprovementplus.com/members/formulary--medicare-drug-plan-coverage.aspx on the web. Different out-of-pocket costs may apply for people who - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.	**Drugs covered under Medicare Part B** **General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 20% of the cost for Part B drugs out-of-network. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.careimprovementplus.com/members/formulary--medicare-drug-plan-coverage.aspx on the web. Different out-of-pocket costs may apply for people who - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
25. Outpatient Prescription Drugs *(continued)*		Some drugs have quantity limits. Your provider must get prior authorization from Care Improvement Plus Silver Rx (Regional PPO SNP) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Care Improvement Plus Silver Rx (Regional PPO SNP) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug. **In-Network** $150 annual deductible. **Initial Coverage** After you pay your yearly deductible, you pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** Tier 1: Generic Drugs - $10 copay for a one-month (30-day) supply of drugs in this tier - $30 copay for a three-month (90-day) supply of drugs in this tier	Some drugs have quantity limits. Your provider must get prior authorization from Care Improvement Plus Gold Rx (Regional PPO SNP) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Care Improvement Plus Gold Rx (Regional PPO SNP) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** Tier 1: Generic Drugs - $8 copay for a one-month (30-day) supply of drugs in this tier - $24 copay for a three-month (90-day) supply of drugs in this tier	Some drugs have quantity limits. Your provider must get prior authorization from Care Improvement Plus Dual Advantage (Regional PPO SNP) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Care Improvement Plus Dual Advantage (Regional PPO SNP) approves the exception, you will pay the generic cost share for generic drugs and the brand cost share for brand drugs. **In-Network** You pay a $0 annual deductible. **Initial Coverage** Depending on your income and institutional status, you pay the following: For generic drugs (including brand drugs treated as generic), either: - A $0 copay; or - A $1.10 copay; or - A $2.60 copay For all other drugs, either: - A $0 copay; or - A $3.30 copay; or - A $6.50 copay.	Some drugs have quantity limits. Your provider must get prior authorization from Care Improvement Plus Medicare Advantage (Regional PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Care Improvement Plus Medicare Advantage (Regional PPO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug. **In-Network** $215 annual deductible. **Initial Coverage** After you pay your yearly deductible, you pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** Tier 1: Generic Drugs - $10 copay for a one-month (30-day) supply of drugs in this tier - $30 copay for a three-month (90-day) supply of drugs in this tier

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
25. Outpatient Prescription Drugs *(continued)*		Tier 2: Preferred Brand Drugs - $45 copay for a one-month (30-day) supply of drugs in this tier - $135 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (30-day) supply of drugs in this tier - $285 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 29% coinsurance for a one-month (30-day) supply of drugs in this tier - 29% coinsurance for a three-month (90-day) supply of drugs in this tier **Long Term Care Pharmacy** Tier 1: Generic Drugs - $10 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $45 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (31-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 29% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** Tier 1: Generic Drugs - $10 copay for a one-month (30-day) supply of drugs in this tier	Tier 2: Preferred Brand Drugs - $45 copay for a one-month (30-day) supply of drugs in this tier - $135 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (30-day) supply of drugs in this tier - $285 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Long Term Care Pharmacy** Tier 1: Generic Drugs - $8 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $45 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (31-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** Tier 1: Generic Drugs - $8 copay for a one-month (30-day) supply of drugs in this tier		Tier 2: Preferred Brand Drugs - $45 copay for a one-month (30-day) supply of drugs in this tier - $135 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one month (30-day) supply of drugs in this tier - $285 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 27% coinsurance for a one-month (30-day) supply of drugs in this tier - 27% coinsurance for a three-month (90-day) supply of drugs in this tier **Long Term Care Pharmacy** Tier 1: Generic Drugs - $10 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $45 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (31-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 27% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** Tier 1: Generic Drugs - $10 copay for a one-month (30-day) supply of drugs in this tier

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
25. Outpatient Prescription Drugs *(continued)*		- $25 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $45 copay for a one-month (30-day) supply of drugs in this tier - $112.50 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (30-day) supply of drugs in this tier - $237.50 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 29% coinsurance for a one-month (30-day) supply of drugs in this tier - 29% coinsurance for a three-month (90-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach $4,700.	- $20 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $45 copay for a one-month (30-day) supply of drugs in this tier - $112.50 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (30-day) supply of drugs in this tier - $237.50 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach $4,700. **Additional Coverage Gap** After your total yearly drug costs reach $2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach $4,700.		- $25 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $45 copay for a one-month (30-day) supply of drugs in this tier - $112.50 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (30-day) supply of drugs in this tier - $237.50 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 27% coinsurance for a one-month (30-day) supply of drugs in this tier - 27% coinsurance for a three-month (90-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach $4,700.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
25. Outpatient Prescription Drugs *(continued)*		**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: - 5% coinsurance, or - $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Care Improvement Plus Silver Rx (Regional PPO SNP). **Out-of-Network Initial Coverage** After you pay your yearly deductible, you will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach $2,930: Tier 1: Generic Drugs - $10 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $45 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (30-day) supply of drugs in this tier	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: - 5% coinsurance, or - $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Care Improvement Plus Gold Rx (Regional PPO SNP). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: Tier 1: Generic Drugs - $8 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $45 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (30-day) supply of drugs in this tier	**Catastrophic Coverage** You pay a $0 copay. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive imbursement from Care Improvement Plus Dual Advantage (Regional PPO SNP). **Out-of-Network Initial Coverage** Depending on your income and institutional status, you will be reimbursed by Care Improvement Plus Dual Advantage (Regional PPO SNP) up to the plan's cost of the drug minus the following: For generic drugs purchased out-of-network (including brand drugs treated as generic),either: - A $0 copay; or - A $1.10 copay; or - A $2.60 copay For all other drugs purchased out-of-network, (including brand drugs treated as generic),either: - A $0 copay; or - A $3.30 copay; or - A $6.50 copay	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: - 5% coinsurance, or - $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy’s full charge for the drug and submit documentation to receive reimbursement from Care Improvement Plus Medicare Advantage (Regional PPO). **Out-of-Network Initial Coverage** After you pay your yearly deductible, you will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach $2,930: Tier 1: Generic Drugs - $10 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $45 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Non-Preferred Brand Drugs - $95 copay for a one-month (30-day) supply of drugs in this tier

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
25. Outpatient Prescription Drugs *(continued)*		Tier 4: Specialty Tier Drugs - 29% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	**Out-of-Network Catastrophic Coverage** You will be reimbursed in full for drugs purchased out-of-network. *See page 62 for information about Prescription Drugs.*	Tier 4: Specialty Tier Drugs - 27% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
26. Dental Services	Preventive dental services (such as cleaning) not covered.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered dental benefits $15 copay for an office visit that includes: - up to 1 oral exam(s) every year - up to 1 cleaning(s) every year - up to 1 dental X-ray(s) every year **Out-of-Network** $15 copay for preventive dental benefits 20% of the cost for comprehensive dental benefits **In and Out-of-Network** Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.	**In-Network** $0 copay for Medicare-covered dental benefits $10 copay for an office visit that includes: - up to 1 oral exam(s) every year - up to 1 cleaning(s) every year - up to 1 dental X-ray(s) every year **Out-of-Network** $10 copay for preventive dental benefits $0 to $10 copay for comprehensive dental benefits **In and Out-of-Network** Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered dental benefits* $0 copay for an office visit that includes: - up to 1 oral exam(s) every year - up to 1 cleaning(s) every year - up to 1 dental X-ray(s) every year **Out-of-Network** $0 copay for preventive dental benefits 20% of the cost for comprehensive dental benefits** **In and Out-of-Network** Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.	**In-Network** $0 copay for Medicare-covered dental benefits $10 copay for an office visit that includes: - up to 1 oral exam(s) every year - up to 1 cleaning(s) every year - up to 1 dental X-ray(s) every year **Out-of-Network** $0 copay for comprehensive dental benefits $10 copay for preventive dental benefits
27. Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams. Supplemental routine hearing exams and hearing aids not covered. 0% coinsurance for diagnostic hearing exams.	**In-Network** In general, supplemental routine hearing exams and hearing aids not covered. - 20% of the cost for Medicare-covered diagnostic hearing exams **Out-of-Network** 20% of the cost for hearing exams.	**In-Network** In general, supplemental routine hearing exams and hearing aids not covered. - $50 copay for Medicare-covered diagnostic hearing exams **Out-of-Network** $50 copay for hearing exams.	**In-Network** In general, supplemental routine hearing exams and hearing aids not covered. $0 copay for Medicare-covered diagnostic hearing exams* **Out-of-Network** 20% of the cost for hearing exams.** *See page 62 for information about Hearing Services.*	**In-Network** In general, supplemental routine hearing exams and hearing aids not covered. - $50 copay for Medicare-covered diagnostic hearing exams **Out-of-Network** $50 copay for hearing exams.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
28. Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** - 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery. - 20% of the cost for exams to diagnose and treat diseases and conditions of the eye. - 0% of the cost for up to 1 supplemental routine eye exam(s) every year. - 0% of the cost for glasses. - 0% of the cost for contacts.	**In-Network** - $50 copay for one pair of eyeglasses or contact lenses after cataract surgery. - $50 copay for exams to diagnose and treat diseases and conditions of the eye. - $30 copay for up to 1 supplemental routine eye exam(s) every year. - $0 copay for glasses. - $0 copay for contacts.		**In-Network** - $50 copay for one pair of eyeglasses or contact lenses after cataract surgery. - $50 copay for exams to diagnose and treat diseases and conditions of the eye. - $30 copay for up to 1 supplemental routine eye exam(s) every year. - $0 copay for glasses. - $0 copay for contacts.
	0% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.			**In-Network** $0 copay for diagnosis and treatment for diseases and conditions of the eye* $0 copay for - one pair of eyeglasses or contact lenses after cataract surgery.* - 0% of the cost for up to 1 supplemental routine eye exam(s) every year. - 0% of the cost for glasses. - 0% of the cost for contacts.	
		Out-of-Network 0% to 20% of the cost for eye wear. 20% of the cost for eye exams.	**Out-of-Network** $0 to $50 copay for eye wear. $30 to $50 copay for eye exams.	**Out-of-Network** - 0% to 20% of the cost for eye wear.** - 20% of the cost for eye exams.**	**Out-of-Network** $0 to $50 copay for eye wear. $30 to $50 copay for eye exams.
		In and Out-of-Network $200 plan coverage limit for eye wear every year. This limit applies to both in-network and out-of-network benefits.	**In and Out-of-Network** $150 plan coverage limit for eye wear every year. This limit applies to both in-network and out-of-network benefits.	**In and Out-of-Network** $200 plan coverage limit for eye wear every year. This limit applies to both in-network and out-of-network benefits. *See page 62 for information about Vision Services.*	**In and Out-of-Network** $150 plan coverage limit for eye wear every year. This limit applies to both in-network and out-of-network benefits.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
Over-the-Counter Items	Not covered.	**General** Please visit our plan website to see our list of covered Over-the-Counter items. OTC items may be purchased only for the enrollee. Please contact the plan for specific instructions for using this benefit.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	**General** Authorization rules may apply. **In-Network** $0 copay for up to 24 one-way trip(s) to plan approved location every year **Out-of-Network** 20% of the cost for transportation.	**General** Authorization rules may apply. **In-Network** $0 copay for up to 6 one-way trip(s) to plan approved location every year. **Out-of-Network** $0 copay for transportation.	**General** Authorization rules may apply. **In-Network** $0 copay for up to 34 one-way trip(s) to plan approved location every year. **Out-of-Network** 20% of the cost for transportation.	**General** Authorization rules may apply. **In-Network** $0 copay for up to 12 one-way trip(s) to plan approved location every year. **Out-of-Network** $0 copay for transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.

Section III

Clarification to Section I

You must have been diagnosed by your doctor with Chronic Heart Failure and/or Diabetes to join Care Improvement Plus Silver Rx (Regional PPO SNP) and Gold Rx (Regional PPO SNP).

Clarification to Benefits in Section II

Out-of-Network benefits

Out-of-Network benefits are offered at a $0 copay with the exception of Dentures (item #26) and Vision routine eye exam (item #28) which are correctly stated in Section II and are offered at 20% coinsurance. $0 copay applies to all in-network and out-of-network Medicare-covered benefits where a healthcare provider accepts both Medicare and Medicaid.

#3 Inpatient Hospital Care

#4 Inpatient Mental Health Care

#5 Skilled Nursing Facility (SNF)

#8 Doctor Office Visits

#9 Chiropractic Services

#10 Podiatry Services

#11 Outpatient Mental Health Care

#12 Outpatient Substance Abuse Care

#13 Outpatient Services/Surgery

#14 Ambulance Services

#17 Outpatient Rehabilitation Services

#18 Durable Medical Equipment

#19 Prosthetic Devices

#20 Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies

#21 Diagnostic Tests, X-Rays, Lab Services, and Radiology Services

#24 Kidney Disease and Conditions

#25 Prescription Drugs

#27 Hearing Services

#28 Vision Services

Section IV— Medicaid Benefits (Arkansas)

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Institutional and Clinic Services					
Clinic Services, by an organized facility or clinic not part of a hospital: Freestanding Ambulatory Surgery Center					
Yes		Specified surgical procedures		Fee for service	CN & MN
Clinic Services, by an organized facility or clinic not part of a hospital: Public Health and Mental Health Clinics					
Yes			Developmental day treatment clinic services up to 4 time units/year for physical, occupational and speech evaluations, 4 time units/day (15 minutes each) for individual and group therapy	Fee for service	CN & MN
Federally Qualified Health Center Services					
Yes			12 ambulatory encounters/year irrespective of setting	Greater of prospective rate/encounter or allowable cost	CN & MN
Inpatient Hospital Services, other than in an Institution for Mental Diseases					
Yes	10% of first day's per diem rate up to specified limit	Admissions for specified procedures, elective surgery admissions	24 days/year	Cost based payment for pediatric, teaching and critical access hospitals; cost based payment with daily cap for other acute hospitals; prospective per diem for rehab hospitals	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Outpatient Hospital Services					
Yes		Specified surgical procedures	12 non-emergency visits/year	Cost based payment for pediatric, teaching and critical access hospitals; fee for service for other hospitals	CN & MN
Rehabilitation Services: Mental Health and Substance Abuse					
Yes		Specified services	Substance abuse services require mental health primary diagnosis Medicaid Beneficiaries will be limited to a maximum of eight hours per 24 hour day of outpatient services with the exception of Crisis Intervention, Crisis Stabilization Intervention by Mental Health Professional and Crisis Stabilization Intervention by Mental Health Paraprofessional. Beneficiaries will be eligible for an extension of the daily maximum amount of services based on a medical necessity review by the contracted utilization management entity	Fee for service	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Rural Health Clinic Services					
			12 visits/year irrespective of setting included in limits for other specified practitioners	Prospective cost based rate/encounter	CN & MN
Practitioner Services					
Certified Registered Nurse Anesthetist Services					
				Fee for service at 80% of physician fee	CN & MN
Chiropractor Services					
			12 visits/year	Fee for service	CN & MN
Dental Services					
Medical and Remedial Care - Other Practitioners					
Medical/Surgical Services of a Dentist					
			12 visits/year irrespective of setting included in limits for other specified practitioners	Fee for service	CN & MN
Nurse Midwife Services					
			12 visits/year irrespective of setting included in limits for other specified practitioners	Fee for service at 80% of physician fee	CN & MN
Nurse Practitioner Services					
			12 visits/year irrespective of setting included in limits for other specified practitioners	Fee for service at 80% of physician fee	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Optometrist Services					
Yes			1 refractive exam/2 years, 12 visits/year irrespective of setting included in limits for other specified practitioners	Fee for service	CN & MN
Physician Services					
Yes		Specified surgical procedures	12 visits/year irrespective of setting included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/year	Fee for service	CN & MN
Podiatrist Services					
Yes			2 visits/year	Fee for service, lab services reimbursed up to Medicare payment ceilings	CN & MN
Psychologist Services					
No					
Prescription Drugs					
Prescription Drugs					
Yes	$.50-$3/Rx depending on drug cost	More than 3 prescriptions per month for non-institutionalized beneficiaries	6 Rxs/month except for persons in nursing facilities or participating in HCBS waivers	AWP-14% for brand Rx, AWP-20% for generic Rx, plus $5.51 dispensing fee for each, additional $2.00 dispensing fee for generic Rx with no FUL or state MAC	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Physical Therapy and Other Services					
Occupational Therapy Services					
No					
Physical Therapy Services					
No					
Services for Speech, Hearing and Language Disorders					
No					
Products and Devices					
Dentures					
No					
Eyeglasses					
Yes	$2/dispensing service	2 pair eyeglasses rather than bifocals	1 pair eyeglasses/year, contact lenses limited to post-cataract surgery	Products provided by state's volume purchase contractor, dispensing provider paid fee for service	CN & MN
Hearing Aids					
No					
Medical Equipment and Supplies					
Yes		Specified med equipment and med supply items	Med supplies limited to $250/month	Fee for service for med equipment, med supplies paid up to Medicare payment ceilings	CN & MN
Prosthetic and Orthotic Devices					
Yes		Augmentative communication devices	Orthotic appliances limited to $3,000/year, prosthetic devices limited to $20,000/year	Fee for service, some items paid percentage of item invoice cost	CN & MN
Transportation Services					
Ambulance Services					
Yes				Fee for service	CN & MN
Non-Emergency Medical Transportation Services					
Yes				See service-specific FN	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Other Services					
Diagnostic, Screening and Preventive Services					
No					
Early and Periodic Screening, Diagnosis and Treatment					
See service-specific FN.					
Extended Services for Pregnant Women					
Family Planning Services					
See service-specific FN.					
Laboratory and X-Ray Services, outside Hospital or Clinic					
Yes			$500/year limit on all lab and most x-ray services	Fee for service, and using Medicare payment ceilings for lab services	CN & MN
Targeted Case Management					
Yes				Fee for service, negotiated rate or cost based payment	CN & MN

Long-Term Care Services

Community Based Care					
Home and Community Based Services Waiver					
Yes			Services for the following populations: 2, 4 & 8 - See service-specific FN	Dependent upon the services provided	CN & MN
Home Health Services, includes nursing services, home health aides, and medical supplies/equipment					
Yes		Specified med equipment	50 visits/year, only specified med equipment covered, med supplies covered up to $250/month and included in limitations with other providers	Fee for service, med supplies paid up to Medicare payment ceilings	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Hospice Care					
Yes			Two 90-day periods with additional 60-day periods as necessary	Prospective rate using Medicare wage index	CN & MN
Personal Care Services					
Yes			64 hours/month	Fee for service using hourly rates	CN
Private Duty Nursing Services					
Yes		Yes	Limited to ventilator dependent beneficiaries and those with functioning tracheostomy requiring suctioning and oxygen supplementation, $80 maximum payment for medical supplies/month	Fee for service	CN & MN
Program of All-Inclusive Care for the Elderly					
Yes		Yes		Capitated payment	CN
Institutional Care					
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services In Institutions for Mental Diseases, age 65 and older					
No					
Inpatient Psychiatric Services, under age 21					
Yes		Yes	7 consecutive therapeutic leave days	Prospective cost based per diem	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Intermediate Care Facility Services for the Mentally Retarded					
Yes			5hosp leave days/ hospitalization, facility must have 85% occupancy rate to be paid, unlimited therapeutic leave days up to 14 consecutive days	Prospective cost based class rate for facilities with fewer than 16 beds, prospective cost based per diem for larger private facilities, cost based payment for public facilities	CN
Nursing Facility Services, other than in an Institution for Mental Diseases					
Yes			5hosp leave days/ hospitalization, facility must have 85% occupancy rate to be paid, unlimited therapeutic leave days up to 14 days consecutively	Prospective cost based per diem	CN
Religious Non-Medical Health Care Institution and Practitioner Services					
No					

Section IV— Medicaid Benefits (Missouri)

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Institutional and Clinic Services					
Clinic Services, by an organized facility or clinic not part of a hospital: Freestanding Ambulatory Surgery Center					
Yes			Coverage limited to specified procedures	Fee for service, using an all-inclusive payment per episode of care	CN & MN
Clinic Services, by an organized facility or clinic not part of a hospital: Public Health and Mental Health Clinics					
Yes	$.50/day			Fee for service	CN & MN
Federally Qualified Health Center Services					
Yes	$2/day			Cost based payment	CN & MN
Inpatient Hospital Services, other than in an Institution for Mental Diseases					
Yes	$10/admission, except emergencies and transfers	Admissions for specified surgical procedures	LOS limited to 75th percentile of published guidelines for region or days certified by state's Utilization Review authority, special schedule for rehab services	Prospective cost based per diem or reasonable charge	CN & MN
Outpatient Hospital Services					
Yes	$3/day	Specified services	Selected elective surgeries require second opinion	Percentage of charge	CN & MN
Rehabilitation Services: Mental Health and Substance Abuse					
Yes			Services limited to the severely mentally ill	Fee for service	CN & MN
Rural Health Clinic Services					
Yes	$2/day			Prospective cost based rate/visit or certified cost/encounter	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Practitioner Services					
Certified Registered Nurse Anesthetist Services					
Yes	$.50/day			Fee for service	CN & MN
Chiropractor Services					
No					
Dental Services					
Yes	$.50-$3/ service depending on payment	Specified services	Exam and cleaning 2/year except adults who are not pregnant, blind or residing in nursing facilities are limited to trauma care related to facial injury or treatment of health-impacting disease or medical condition	Fee for service	CN & MN
Medical and Remedial Care - Other Practitioners					
Medical/Surgical Services of a Dentist					
Yes	$.50-$3/service depending on payment			Fee for service	CN & MN
Nurse Midwife Services					
Yes	$1/day		Services limited to women age 15 and older and infants up to 2 months	Fee for service	CN & MN
Nurse Practitioner Services					
Yes	$1/day			Fee for service	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Optometrist Services					
Yes	$.50-$3/service, depending on payment		1 vision exam/year with or without refraction except adults who are not pregnant, blind or residing in nursing facilities are limited to 1 exam/2 years	Fee for service	CN & MN
Physician Services					
Yes	$1/day		Specified procedures require a second opinion	Fee for service	CN & MN
Podiatrist Services					
Yes	$.50-$3/service, depending on payment		Specified services are no longer covered for adults who are not pregnant, blind or residing in nursing facilities	Fee for service	CN & MN
Psychologist Services					
Yes	$2/day	Yes		Fee for service	CN & MN
Prescription Drugs					
Prescription Drugs					
Yes	$.50-$2/Rx depending on drug cost			Lower of AWP-10.43% or WAC+10%, plus $4.09 dispensing fee	CN & MN
Physical Therapy and Other Services					
Occupational Therapy Services					
Yes			Adult coverage limited to those who are pregnant, blind or residing in nursing facilities	Fee for service	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Physical Therapy Services					
Yes			Adult coverage limited to those who are pregnant, blind or residing in nursing facilities	Fee for service	CN & MN
Services for Speech, Hearing and Language Disorders					
Yes			Adult coverage limited to those who are pregnant, blind or residing in nursing facilities	Fee for service	CN & MN
Products and Devices					
Dentures					
Yes	5% of payment for denture and related services	Yes	1 full upper and/or lower denture or 1 partial denture/lifetime, reline after 1 year, adult coverage limited to those who are pregnant, blind or residing in nursing facilities	Fee for service	CN & MN
Eyeglasses					
Yes	$.50-$3/item or service, depending on payment		1 pair eyeglasses/2 years, replacement of lenses only if specified diopter criteria met	Fee for service	CN & MN
Hearing Aids					
Yes	$.50-$3/service, depending on payment	New or replacement hearing aid	1 hearing aid/4 years, adult coverage limited to those who are pregnant, blind or residing in nursing facilities	Fee for service	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Medical Equipment and Supplies					
Yes		Yes	Adult coverage other than for pregnant or blind limited to specified items unless provided through home health plan of care	Fee for service	CN & MN
Prosthetic and Orthotic Devices					
Yes		Specified services	Adult coverage other than for pregnant or blind does not include orthotics unless provided through home health plan of care	Fee for service	CN & MN
Transportation Services					
Ambulance Services					
Yes				Fee for service	CN & MN
Non-Emergency Medical Transportation Services					
Yes	$2/day			See service-specific FN	CN & MN
Other Services					
Diagnostic, Screening and Preventive Services					
Yes				Fee for service	CN & MN
Early and Periodic Screening, Diagnosis and Treatment					
See service-specific FN.					
Extended Services for Pregnant Women					
Family Planning Services					
See service-specific FN.					
Laboratory and X-Ray Services, outside Hospital or Clinic					
Yes	$1/day			Fee for service	CN & MN
Targeted Case Management					
Yes	$1/day			Fee for service	CN & MN

Long-Term Care Services

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Community Based Care					
Home and Community Based Services Waiver					
Yes			Services for the following populations: 2, 4, 5, 7 & 8 - See service-specific FN	Dependent upon the services provided	CN & MN
Home Health Services, includes nursing services, home health aides, and medical supplies/equipment					
Yes			100 nursing and home health aide visits/year, adult coverage for therapies limited to those who are pregnant or blind	Fee for service	CN & MN
Hospice Care					
Yes			Two 90-day periods and one 60-day period with additional periods as necessary	Prospective rates based on Medicare methodology	CN & MN
Personal Care Services					
Yes			Care must be supervised by RN, alternative to institutional placement	Fee for service with payment ceiling at monthly nursing facility cost cap	CN & MN
Private Duty Nursing Services					
No					
Program of All-Inclusive Care for the Elderly					
Yes			See service-specific FN	Capitated payment	CN
Institutional Care					
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services In Institutions for Mental Diseases, age 65 and older					
Yes			12 therapeutic leave days/6 months	Prospective cost based per diem	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Inpatient Psychiatric Services, under age 21					
Yes				Prospective cost based per diem, some facilities receive standard rate	CN & MN
Intermediate Care Facility Services for the Mentally Retarded					
Yes			12 therapeutic leave days/6 months	Prospective cost based per diem with limits for private facilities, cost based payment for public facilities	CN & MN
Nursing Facility Services, other than in an Institution for Mental Diseases					
Yes			12 therapeutic leave days/6 months	Prospective per diem based on cost	CN & MN
Religious Non-Medical Health Care Institution and Practitioner Services					
No					

CARE IMPROVEMENT PLUS

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