

2012 Summary of Benefits



R3444

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--medicaredrug-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:

- 7 days a week; and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- 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.

• 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/

• The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through

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:

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 guestions related to the Medicare Advantage Program. (TTY/TDD (711))

Current members should call locally (800)-204-1002 for guestions 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 guestions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-673-3563)

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.

Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,

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

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

Prospective members should call locally (800)-711-1656 for guestions 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.

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)
MPORTANT 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

Care Improvement Plus Gold Rx (Regional PPO SNP)

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 Medicareapproved 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-ofnetwork 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

have any cost-sharing Medicare services about cost sharing when network providers.

Care Improvement Plus Dual Advantage (Regional PPO SNP)

Care Improvement Plus Medicare Advantage (Regional PPO)

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 Medicareapproved 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-ofnetwork physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available

Medicaid eligibility, you may not responsibility for original ** Please consult with your plan receiving services from out-of-\$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

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Imp Dual (Region
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 yo out-of-netwo does NOT ac "assignment," can be based approved am additional an Medicare "lin are a membe charges a cop network phys higher Medic charge" does publications Your Medica on www.medica on www.medica on www.medicare, as explanations to "assignment charges" that type. To find out if DME supplie assignment o Medicare, vis www.medicare can also call or ask your p or supplier if 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 de \$6,700 out-o Medicare-cov However, in have no cost responsibility covered servi level of Medi

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t if physicians and liers accept t or participate in visit icare.gov/physician or icare.gov/supplier. You all 1-800-MEDICARE, r physician, provider, if they accept

deductible.*

t-of-pocket limit for covered services. in this plan you will ost sharing ity for Medicarervices, based on your edicaid eligibility.

Care Improvement Plus Medicare Advantage (Regional PPO)

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.

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Image: 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10	Important Information		\$6,700 out-of-pocket limit for	\$6,700 out-of-pocket limit for	 \$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 	Out-of-Network \$6,700 out-of-pocket limit for Medicare-covered services.
(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)specialist of hospital that accepts Medicare.Referral required for network specialists (for certain benefits)No referral required for network specialists.No referral required for network specialists.			In 2012 the annual Part B deductible amount is \$140. \$6,700 out-of-pocket limit for	\$6,700 out-of-pocket limit for	 \$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 	In and Out-of-Network \$6,700 out-of-pocket limit for Medicare-covered services.
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 In-Network Plan covers 90 days each benefit period. Plan covers 90 days each benefit period. In 2012 the amounts for each benefit period are: Days 91 - 150: \$578 per lifetime reserve day In-Network Plan covers 90 days each benefit period. Plan covers 90 days each benefit period. In 2012 the amounts for each benefit period are: Days 91 - 150: \$578 per lifetime reserve day In -Network Plan covers 90 days each benefit period. In 2012 the amounts for each benefit period are: Days 91 - 150: \$578 per lifetime reserve day In -Network Plan covers 90 days each benefit period. In 2012 the amounts for each benefit period are: Days 91 - 150: \$578 per lifetime reserve day. In 2012 the amounts for each benefit period are: Days 1 - 60: \$1156 deductible For Medicare-covered hospital stays: Days 1 - 50: \$578 per lifetime reserve day. In -Network Plan covers 90 days each benefit period. For Medicare-covered hospital stays: For Medicare-covered hospital stays: In -Network Plan covers 90 days each benefit Plan covers 90 days each benefit Plan covers 90 days each benefit In 400-MEDICARE Days 1 - 60: \$0 copay per day Days 1 - 90: \$0 copay per day Days 1 - 90: \$0 copay per day: In 400	(For more information, see Emergency Care - #15 and	specialist or hospital that accepts	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	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	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	 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
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	(includes Substance Abuse	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	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	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:		 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

Benefit 3. Inpatient Hospital Care (continued)	Original Medicare 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	Care Improvement Plus Silver Rx (Regional PPO SNP) Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Care Improvement Plus Gold Rx (Regional PPO SNP) Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO) Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
	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.	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	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.	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.	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 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.
	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 \$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. 	

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) 6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: \$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 Ceneral Authorization rules may apply. In-Network \$0 copay for each Medicare- covered home health visit. Out-of-Network \$0 copay for home health visits.	Out-of-Network For each SNF stay: Days 1 - 20: \$0 copay per SNF day Days 21 - 100: \$130 copay per SNF day General Authorization rules may apply. In-Network Ø% of the cost for each Medicare- covered home health visit. Out-of-Network 40% of the cost for home health visits.	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). 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.**	Out-of-Network For each SNF stay: Days 1 - 20: \$0 copay per SNF day Days 21 - 100: \$130 copay per
	18			19	

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.	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.
	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.	
OUTPATIENT CARE					
8. Doctor Office Visits	20% coinsurance	In-Network 20% of the cost for each primary care doctor visit for Medicare- covered benefits.	In-Network \$35 copay for each primary care doctor visit for Medicare-covered benefits.		In-Network \$35 copay for each primary care doctor visit for Medicare-covered benefits.
		20% of the cost for each in-area, network urgent care Medicare- covered visit.	\$35 copay for each in-area, network urgent care Medicare- covered visit.		\$35 copay for each in-area, network urgent care Medicare- covered visit.
		20% of the cost for each specialist visit for Medicare- covered benefits.	\$50 copay for each specialist visit for Medicare-covered benefits.		\$50 copay for each specialist visit for Medicare-covered benefits.
	0% coinsurance			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.	Out-of-Network \$35 copay for each primary care doctor visit.	Out-of-Network 20% of the cost for each primary care doctor visit.**	Out-of-Network \$35 copay for each primary care doctor visit.
		20% of the cost for each specialist visit.	\$50 copay for each specialist visit.	20% of the cost for each specialist visit.** See page 62 for information about Doctor Office Visits.	\$50 copay for each specialist visit.
	20			21	

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.	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.	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	
		Out-of-Network 20% of the cost for chiropractic benefits.	Out-of-Network \$20 copay for chiropractic benefits.	 qualified providers. Out-of-Network 20% of the cost for chiropractic benefits.** See page 62 for information about Chiropractic Services. 	Out-of-Network \$20 copay for chiropractic benefits.
covered. 20% coinsurance for medical necessary foot care, includir care for medical conditions affecting the lower limbs. Supplemental routine care in covered. 0% coinsurance for medical	 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 	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.	 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. 	In-Network \$0 copay for Medicare-covered podiatry benefits.* Medicare-covered podiatry benefits are for medically- necessary foot care.	 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.
	22	Out-of-Network 0% to 20% of the cost for podiatry benefits.	Out-of-Network \$0 to \$50 copay for podiatry benefits.	Out-of-Network 20% of the cost for podiatry benefits.** See page 62 for information about Podiatry Services. 23	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.	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	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	General Authorization rules may apply.	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
	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.	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	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	 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. 	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

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% coinsurance 0% coinsurance	In-Network40% of the cost for Medicare- covered individual visits.40% of the cost for Medicare- covered group visits.	In-Network \$40 copay for Medicare-covered individual visits. \$35 copay for Medicare-covered group visits.	In-Network \$0 copay for Medicare-covered visits *	In-Network\$40 copay for Medicare-covered individual visits.\$35 copay for Medicare-covered group visits.
	Out-of-Network 40% of the cost for outpatient substance abuse benefits.	Out-of-Network \$35 to \$40 copay for outpatient substance abuse benefits.	Out-of-Network 40% of the cost for outpatient substance abuse benefits.** See page 62 for information about	Out-of-Network \$35 to \$40 copay for outpatient substance abuse benefits.
 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 	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.	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.	General Authorization rules may apply.	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.
0% coinsurance for the doctor's services 0% coinsurance for ambulatory surgical center facility services	Out-of-Network 20% of the cost for outpatient hospital facility benefits. 20% of the cost for ambulatory surgical center benefits.	Out-of-Network \$150 copay for outpatient hospital facility benefits. \$150 copay for ambulatory surgical center benefits.	 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. 	Out-of-Network \$150 copay for outpatient hospital facility benefits. \$150 copay for ambulatory surgical center benefits.
	 20% coinsurance 0% coinsurance 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 	Original medicate Silver Rx (Regional PPO SNP) 20% coinsurance In-Network 40% of the cost for Medicare- covered individual visits. 40% of the cost for Medicare- covered group visits. 0% coinsurance Out-of-Network 40% of the cost for outpatient substance abuse benefits. 20% coinsurance for the doctor's services General Authorization rules may apply. In-Network 20% of the cost for each Medicare-covered ambulatory surgical center facility services 20% coinsurance for the doctor's services. Copay cannot exceed the Part A inpatient hospital deductible. 20% 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 facility services 0% coinsurance for the doctor's services Out-of-Network Out-of-Network 0% coinsurance for the doctor's services Out-of-Network Dow of the cost for each Medicare-covered outpatient hospital facility visit. 0% coinsurance for ambulatory surgical center facility services Out-of-Network 20% of the cost for outpatient hospital facility benefits. 20% of the cost for ambulatory	Consumance Silver Rx (Regional PPO SNP) 20% coinsurance In-Network 40% of the cost for Medicare- covered individual visits. 40% of the cost for Medicare- covered individual visits. 40% of the cost for outpatient substance abuse benefits. In-Network 540 copay for Medicare- covered individual visits. 535 copay for Medicare- covered group visits. 20% coinsurance Out-of-Network 40% of the cost for outpatient substance abuse benefits. Out-of-Network 535 to \$40 copay for outpatient substance abuse benefits. 20% coinsurance for the doctor's services General Authorization rules may apply. In-Network 20% of the cost for each Medicare-covered ambulatory surgical center facility services General Authorization rules may apply. In-Network 20% of the cost for each Medicare-covered outpatient hospital facility visit. General Authorization rules may apply. In-Network 20% of the cost for each Medicare-covered outpatient hospital facility visit. 0% coinsurance for the doctor's services Out-of-Network 20% of the cost for outpatient hospital facility visit. S150 copay for each Medicare- covered outpatient hospital facility visit. 0% coinsurance for ambulatory surgical center facility services Out-of-Network 20% of the cost for outpatient hospital facility benefits. 20% of the cost for outpatient hospital facility benefits. 20% of the cost for ambulatory Out-of-Network \$150 copay for ambulatory	Original modulation Silver Rx (Regional PPO SNP) 20% coinsurance In-Network 40% of the cost for Medicare- covered individual visits. 40% of the cost for Medicare- covered group visits. In-Network 40% of the cost for Medicare- covered group visits. S35 copay for Medicare-covered individual visit, S35 copay for Medicare-covered prop visits. In-Network 540 copay for Medicare-covered individual visit, S35 copay for Medicare-covered prop visits. In-Network 50 copay for Medicare-covered individual visit, S35 copay for Medicare-covered prop visits. In-Network 50 copay for Medicare-covered visit,** 20% coinsurance for the doctors services Ceneral Authorization rules may apply. In-Network In-Network S150 copay for each Medicare- covered ambulatory sugical center visit. Ceneral Authorization rules may apply. In-Network In-Network S150 copay for each Medicare- covered ambulatory sugical center visit. In-Network S150 copay for each Medicare- covered ambulatory sugical center facility versit. In-Network S150 copay for each Medicare- covered ambulatory sugical center benefits.** 0% coinsurance for he doctor's services Out-of-Network 20% of the cost for outpatient hospital facility 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	In-Network 20% of the cost for Medicare- covered ambulance benefits.	In-Network \$150 copay for Medicare- covered ambulance benefits.		In-Network \$150 copay for Medicare- covered ambulance benefits.
	0% coinsurance			In-Network \$0 copay for Medicare-covered ambulance benefits.*	
		Out-of-Network 20% of the cost for ambulance benefits.	Out-of-Network \$150 copay for ambulance benefits.	Out-of-Network 20% of the cost for ambulance benefits.** See page 62 for information about Ambulance Services.	Out-of-Network \$150 copay for ambulance benefits.
(You may go to any emergency room if you reasonably believe you need emergency care.)serve serve m Em care hose serve You em adr inp wit rooo No exce circe(You may go to any emergency care.)serve you need em adr inp wit rooo No exce circe(You may go to any emergency care.)serve you need em adr inp wit rooo No exce circe(You may go to any emergency care.)serve you need em adr inp wit rooo No exce circe(You may go to any emergency care.)serve you need em adr inp wit rooo No exce erve o% em No exce erve	 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 US. except under limited circumstances. 	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 \$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.
	0% coinsurance for the doctor's services. 0% outpatient hospital facility emergency services. Not covered outside the U.S. except under limited circumstances.			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.	

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Impro Dual A (Regiona
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 N urgently-neede
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% 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. 	<section-header></section-header>	General Authorization of In-Network There may be therapy, occup and speech an pathology serv may be except \$0 copay for N Occupational \$0 copay for N Physical and/o Language Ther

rovement Plus Advantage nal PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
	General \$40 copay for Medicare-covered urgently-needed-care visits.
Medicare-covered ded-care 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.
n rules may apply. e limits on physical upational therapy, and language rvices. If so, there ptions to these limits. Medicare-covered al Therapy visits.* Medicare-covered /or Speech and erapy 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. 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.
DUTPATIENT MEDICAL SERVICE	es and supplies				
8. 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.	General Authorization rules may apply. In-Network 20% of the cost for Medicare- covered items.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items.*	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.	Out-of-Network 40% of the cost for durable medical equipment.	Out-of-Network 20% of the cost for durable medical equipment.** See page 62 for information about Durable Medical Equipment.	Out-of-Network 30% of the cost for durable medical equipment.
9. 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.	General Authorization rules may apply. In-Network 20% of the cost for Medicare- covered items.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered	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.	Out-of-Network 20% of the cost for prosthetic devices.	items.* Out-of-Network 20% of the cost for prosthetic devices.** See page 62 for information about Prosthetic Devices.	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 	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	 In-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*	 In-Network \$0 copay for Diabetes self- management training \$0 copay for Diabetes monitoring supplies \$0 copay for Therapeutic shoes or inserts
	supplies 0% coinsurance for Diabetic 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	Out-of-Network \$0 copay for Diabetes self- management training \$0 copay for Diabetes monitoring supplies \$0 copay for Therapeutic shoes or inserts	 \$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. 	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	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 thorapoutic radiology	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-		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-
	illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and	covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and		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	20% coinsurance for digital rectal exam and other related services. Covered once a year for all men	Lab Services, separate cost sharing of 20% of the cost may apply If the doctor provides you	Lab Services, separate cost sharing of \$35 to \$50 may apply If the doctor provides you		Lab Services, separate cost sharing of \$35 to \$50 may apply If the doctor provides you
(continued)	with Medicare over age 50.	services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of 20% of the cost may apply	services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$35 to \$50 may apply		services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$35 to \$50 may apply
	0% coinsurance for diagnostic tests and X-rays			General Authorization rules may apply.	
	\$0 copay for Medicare-covered lab services Lab Services: Medicare covers			In-Network \$0 copay for Medicare covered: - lab services*	
	medically necessary diagnostic lab services that are ordered by			 diagnostic procedures and tests* X-rays* 	
	your treating doctor when they are provided by a Clinical Laboratory Improvement			 diagnostic radiology services (not including X-rays)* therapeutic radiology services* 	
	Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected	Out-of-Network 20% of the cost for therapeutic radiology services 20% of the cost for outpatient	Out-of-Network 20% of the cost for therapeutic radiology services 20% of the cost for outpatient	Out-of-Network 20% of the cost for therapeutic radiology services** 20% of the cost for outpatient	Out-of-Network 20% of the cost for therapeutic radiology services 20% of the cost for outpatient
	illness or condition. Medicare does not cover most supplemental routine screening	X-rays 20% of the cost for diagnostic radiology services	X-rays 20% of the cost for diagnostic radiology services	X-rays** 20% of the cost for diagnostic radiology services**	X-rays 20% of the cost for diagnostic radiology services
	tests, like checking your cholesterol.	20% of the cost for diagnostic procedures, tests, and lab services	20% of the cost for diagnostic procedures, tests, and lab services	20% of the cost for diagnostic procedures, tests, and lab services**	20% of the cost for diagnostic procedures, tests, and lab services
	0% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.			See page 62 for information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services.	
22. Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services 20% coinsurance for Pulmonary	General Authorization rules may apply. In-Network	General Authorization rules may apply. In-Network		General Authorization rules may apply. In-Network \$50 copay for Medicare-covered
	Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services	20% of the cost for Medicare- covered Cardiac RehabilitationServices20% of the cost for Medicare- covered Intensive Cardiac	\$50 copay for Medicare-covered Cardiac Rehabilitation Services \$50 copay for Medicare-covered Intensive Cardiac Rehabilitation Services		 \$50 copay for Medicare-covered Cardiac Rehabilitation Services \$50 copay for Medicare-covered Intensive Cardiac Rehabilitation Services
	provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	Rehabilitation Services 20% of the cost for Medicare- covered Pulmonary Rehabilitation Services	\$50 copay for Medicare-covered Pulmonary 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 Impro Dual A (Regiona
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 In-Network \$0 copay for: - Medicare-cor Rehabilitation - Medicare-cor Cardiac Reha - Medicare-cor Rehabilitation 20% of the co Rehabilitation 20% of the co Cardiac Rehab 20% of the co Rehabilitation
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 - Hepatitis B Vaccine - HIV Screening - Breast Cancer Screening (Mammogram) - Medical Nutrition Therapy Services - Personalized Prevention Plan Services (Annual Wellness Visits)	General \$0 copay for a services covery Medicare at zer - Abdominal A Screening - Bone Mass M - Cardiovascul - Cervical and Screening (Pa Exam) - Colorectal Ca - Diabetes Screening - Influenza Va - Hepatitis B V - HIV Screening - Breast Cancel (Mammogram - Medical Nuttor Services - Personalized Services (Anno Visits)

Care Improvement Plus Medicare Advantage (Regional PPO)

on rules may apply.

vered under Original zero cost sharing: l Aortic Aneurysm

s Measurement cular Screening

nd Vaginal Cancer (Pap Test and Pelvic

Cancer Screening

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utrition Therapy

ed Prevention Plan Annual Wellness \$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 Impr Dual A (Regiona
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 	 Pneumococo Prostate Can (Prostate Spettest only) Smoking Cesto stop smoke Welcome to Exam (Initial Physical Examination Physical Examination Physical Examination Pregnant and risk for the infranyone who a Medicare covery 12 monitimes during a contact plan for In-Network The plan coversion Supplementation programs: Written healting materials, information (So copay for Night) Out-of-Network Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain Strain

Care Improvement Plus Dual Advantage (Regional PPO SNP)

Pneumococcal Vaccine

Prostate Cancer Screening (Prostate Specific Antigen (PSA)

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 isk 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.

The plan covers the following upplemental education/wellness

Written health education

materials, including Newsletters

Additional Smoking Cessation

Nursing Hotline

Out-of-Network

\$0 copay for Medicare-covered preventive services**

50 copay for supplemental education/wellness programs

Care Improvement Plus Medicare Advantage (Regional PPO)

- 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 Impr Dual A (Regiona
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	In-Network 20% of the cost for renal dialysis \$0 copay for kidney disease education services	In-Network \$0 copay for \$0 copay for
		Out-of-Network \$0 copay for kidney disease education services 20% of the cost for renal dialysis	Out-of-Network \$0 copay for kidney disease education services 20% of the cost for renal dialysis	education serv Out-of-Netwo \$0 copay for l education serv 20% of the co dialysis** See page 62 for Kidney Diseas

Care Improvement Plus Medicare Advantage (Regional PPO)

In-Network

20% of the cost for renal dialysis \$0 copay for kidney disease education services

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cost for renal

Out-of-Network \$0 copay for kidney disease education services 20% of the cost for renal dialysis

? for information about ease and Conditions.

Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Impr Dual <i>A</i> (Regiona
25. Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add	Drugs covered under Medicare Part B	Drugs covered under Medicare Part B	Drugs covere Part B
J	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	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.	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	General \$0 annual dec covered drugs \$0 copay for chemotherapy Part-B covered 20% of the co out-of-networ
	prescription drug coverage.	Drugs Covered under Medicare Part D	Drugs Covered under Medicare Part D	Drugs Covere 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	GeneralThis 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	General This plan uses plan will send You can also http://www.ca com/members medicare-drug on the web. Different out- apply for peop - have limited - live in long to or - have access Indian/Triba Health Servi The plan offer in-network pr (i.e., this wou and the Distri This means th same cost-sha your prescript them at an in- outside of the (for instance w Total yearly d total drug cos plan, and Mee
		try one drug to treat your condition before it will cover another drug for that condition.	try one drug to treat your condition before it will cover another drug for that condition.	try one drug t condition before another drug

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offers national k prescription coverage vould include 50 states istrict of Columbia). is that you will pay the sharing amount for ription drugs if you get in-network pharmacy the plan's service area ce when you travel).

y drug costs are the costs paid by you, the Medicare.

may require you to first ug to treat your before it will cover rug for that condition.

Care Improvement Plus Medicare Advantage (Regional PPO)

Drugs covered under Medicare Part B

General

20% of the cost for Part Bcovered 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. also see the formulary at You can also see the formulary at w.careimprovementplus. http://www.careimprovementplus. com/members/formulary--

drug-plan-coverage.aspx 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 Impro Dual A (Regiona
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 	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	Some drugs ha Your provider authorization Improvement Advantage (Re for certain dru You must go to pharmacies fo number of dru handling, prov or patient edu requirements to by most pharm network. Thes
		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	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	on the plan's of printed materi the Medicare Plan Finder or If the actual co than the norm
		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	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	amount for tha pay the actual higher cost-sha If you request exception for a
		Improvement Plus Silver Rx (Regional PPO SNP) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.	Improvement Plus Gold Rx (Regional PPO SNP) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.	Improvement Advantage (Re approves the e pay the generi generic drugs share for bran
		In-Network \$150 annual deductible.	In-Network \$0 deductible.	In-Network You pay a \$0 a
		Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,930:	Initial Coverage You pay the following until total yearly drug costs reach \$2,930:	Initial Coverage Depending on institutional sta following: For generic dr
		Retail Pharmacy Tier 1: Generic Drugs	Retail Pharmacy Tier 1: Generic Drugs	brand drugs tr either:
		- \$10 copay for a one-month (30-day) supply of drugs in this tier	- \$8 copay for a one-month (30-day) supply of drugs in this tier	- A \$0 copay; - A \$1.10 copa - A \$2.60 copa For all other d
	46	- \$30 copay for a three-month (90-day) supply of drugs in this tier	- \$24 copay for a three-month (90-day) supply of drugs in this tier	- A \$0 copay; - A \$3.30 cop - A \$6.50 cop

Improvement Plus ual Advantage gional PPO SNP)

ugs have quantity limits. wider must get prior ation from Care ment Plus Dual ge (Regional PPO SNP) in drugs.

t go to certain ties for a very limited of drugs, due to special provider coordination, at education

ents that cannot be met pharmacies in your These drugs are listed lan's website, formulary, naterials, as well as on icare Prescription Drug der on Medicare.gov.

tual cost of a drug is less normal cost-sharing for that drug, you will actual cost, not the pst-sharing amount.

quest a formulary n for a drug and Care ment Plus Dual ge (Regional PPO SNP) s the exception, you will generic cost share for drugs and the brand cost brand drugs.

a \$0 annual deductible.

overage

ng on your income and nal status, you pay the

ric drugs (including ugs treated as generic),

opay; or O copay; or O copay ther drugs, either: opay; or O copay; or O copay.

Care Improvement Plus Medicare Advantage (Regional PPO)

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

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

rovement Plus Advantage al PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
	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)	
25. Outpatient Prescription Drugs (continued)		- \$25 copay for a three-month (90-day) supply of drugs in this tier	- \$20 copay for a three-month (90-day) supply of drugs in this tier	
		Tier 2: Preferred Brand Drugs	Tier 2: Preferred Brand Drugs	
		- \$45 copay for a one-month (30-day) supply of drugs in this tier	- \$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	- \$112.50 copay for a three- month (90-day) supply of drugs in this tier	
		Tier 3: Non-Preferred Brand Drugs	Tier 3: Non-Preferred Brand Drugs	
		- \$95 copay for a one-month (30-day) supply of drugs in this tier	- \$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	- \$237.50 copay for a three- month (90-day) supply of drugs in this tier	
		Tier 4: Specialty Tier Drugs	Tier 4: Specialty Tier Drugs	
		- 29% coinsurance for a one- month (30-day) supply of drugs in this tier	- 33% 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	- 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.	 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. 	

Care Improvement Plus Dual Advantage (Regional PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
	- \$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.

Drugs (continued) After your yearly out-of-pocket drug costs reach 54,700, you pay the greater of. After your yearly out-of-pocket drug costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay a St official costs reach 54,700, you pay the greater of. You pay the following the greater of. You pay following in this the following	Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Imp Dual (Region
Including brand drugs treated as generic) and a 56.50 copay for all other drugs.Out-of-Network Plan drugs may be covered in special circumstances, for unstance, Illnes while traveling outside of the plan's service area where there is no network plarmacy. You may have to pay more then your normal cost- sharing amount if you get your drugs at an out-of-network plarmacy. You may have to pay more then your normal cost- sharing amount if you get your drugs at an out-of-network plarmacy. You may have to pay more then your normal cost- sharing amount if you get your drugs at an out-of-network plarmacy. You may have to pay more then your normal cost- sharing amount if you get your drugs at an out-of-network plarmacy. In addition, you will plarmacy. In addition, you will plarmacy. In addition, you will plarmacy is full charge for the drug and submit documentation to receive reinbursement from Care Improvement PIDs Silver Rx (Regional PPO SNP).Out-of-Network Plan drugs restrice area outside of the drugs and submit documentation to receive reinbursement from Care Improvement PIDs Silver Rx (Regional PPO SNP).Out-of-Network drug costs reach \$2,930: Tier 1: Generic Drugs - \$80 copay for a one-month (30-day) supply of drugs in this tierOut-of-Network drug costs reach \$2,930: Tier 1: Generic Drugs - \$81 copay for a one-month (30-day) supply of drugs in this tierOut-of-Network drug costs reach \$2,930: Tier 1: Generic Drugs - \$81 copay for a one-month (30-day) supply of drugs in this tierOut-of-Network drug costs reach \$2,930: Tier 1: Generic Drugs - \$85 copay for a one-month (30-day) supply of drugs in this tierOut-of-Network drug costs reach \$2,930: Tier 3: Non-Prefered Brand Drugs - \$85 copay for a one-month <td>Drugs</td> <td></td> <td>After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of: - 5% coinsurance, or</td> <td>After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of: - 5% coinsurance, or</td> <td>Catastrophic You pay a \$0</td>	Drugs		After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of: - 5% coinsurance, or	After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of: - 5% coinsurance, or	Catastrophic You pay a \$0
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 you 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. 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).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 drug at an out-of-network pharmacy. In addition, you will likely have to pay the 			(including brand drugs treated as generic) and a \$6.50 copay	(including brand drugs treated as generic) and a \$6.50 copay	
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 total yearly drug costs reach \$2,930:Depending c institutional s reimbursed up tot the plan's cost of the drug minus the following for drugs purchased out-of- drug costs reach \$2,930:Depending c institutional s reimbursed up tot the plan's cost of the drug minus the following for drugs purchased out-of- drug costs reach \$2,930:Depending c institutional s reimbursed up tot the plan's cost of the drug minus the following for drugs purchased out-of- drug costs reach \$2,930:Depending c institutional s reimbursed up the plan's cost of the drug minus the following for drugs purchased out-of- drug costs reach \$2,930:Depending c institutional s reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of- drug costs reach \$2,930:Depending c institutional s reimbursed up to the plan's cost of the drug minus the following for drugs one-month (30- day) supply of drugs in this tierDepending c institutional s reimbursed up to the plan's cost of the drug minus the following for a one-month (30-day) supply of drugs in this tierDepending c plan's cost of the drug minus the following for drugs one-month (30-day) supply of drugs in this tierDepending c plan's cost of the drug minus the following for drugs one-month (30-day) supply of drugs in this tierDepending c for a one-month (30-day) supp			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	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	Out-of-Netw Plan drugs m special circui instance, illne outside of the where there i pharmacy. Ye more than yo sharing amou drugs at an o pharmacy. In likely have to pharmacy's f drug and sub to receive im Care Improve Advantage (R
			 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 	 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 	Out-of-Netw Depending of institutional s reimbursed b Improvement Advantage (R up to the plat minus the fol For generic d of-network (if drugs treated - A \$0 copay - A \$1.10 cop - A \$2.60 co For all other out-of-netwo drugs treated - A \$0 copay - A \$3.30 cop

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ic Coverage \$0 copay.

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may be covered in umstances, for ness while traveling he plan's service area e is no network You may have to pay your normal costount if you get your out-of-network In addition, you will to pay the full charge for the ubmit documentation mbursement from vement Plus Dual (Regional PPO SNP). work Initial Coverage on your income and status, you will be by Care nt Plus Dual (Regional PPO SNP) lan's cost of the drug ollowing: drugs purchased out-(including brand ed as generic), either: ay; or opay; or copay

er drugs purchased vork, (including brand ed as generic),either:

- ay; or
- opay; or
- opay

Care Improvement Plus Medicare Advantage (Regional PPO)

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 costsharing 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-ofnetwork 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

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Benefit	Original Medicare	Care Improvement Plus Silver Rx (Regional PPO SNP)	Care Improvement Plus Gold Rx (Regional PPO SNP)	Care Impro Dual Ac (Regiona
25. Outpatient Prescription		Tier 4: Specialty Tier Drugs	Tier 4: Specialty Tier Drugs	
Drugs (continued)		- 29% coinsurance for a one- month (30-day) supply of drugs in this tier	- 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.	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	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 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 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.	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	Out-of-Network Catastrophic	Out-of-Networ
		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:	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:	Coverage You will be rei drugs purchase
		- 5% coinsurance, or	- 5% coinsurance, or	
		- \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.	- \$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.	You will not be reimbursed for the difference between the Out- of-Network Pharmacy charge and the plan's In-Network allowable amount.	<i>See page 62 fo about Prescript</i>

rovement Plus Advantage 1al PPO SNP)	Care Improvement Plus Medicare Advantage (Regional PPO)
	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.
ork Catastrophic	Out-of-Network Catastrophic
reimbursed in full for ased out-of-network.	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.
for information iption 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.		General Authorization rules may apply.	
	0,	In-Network	In-Network	In-Network	In-Network
		20% of the cost for Medicare- covered dental benefits	\$0 copay for Medicare-covered dental benefits	\$0 copay for Medicare-covered dental benefits*	\$0 copay for Medicare-covered dental benefits
		\$15 copay for an office visit that includes:	\$10 copay for an office visit that includes:	\$0 copay for an office visit that includes:	\$10 copay for an office visit tha includes:
		- up to 1 oral exam(s) every year	- up to 1 oral exam(s) every year	- up to 1 oral exam(s) every year	- up to 1 oral exam(s) every yea
		- up to 1 cleaning(s) every year	- up to 1 cleaning(s) every year	- up to 1 cleaning(s) every year	- up to 1 cleaning(s) every year
		- up to 1 dental X-ray(s) every year	- up to 1 dental X-ray(s) every year	- up to 1 dental X-ray(s) every year	- up to 1 dental X-ray(s) every year
		Out-of-Network \$15 copay for preventive dental benefits	Out-of-Network \$10 copay for preventive dental benefits	Out-of-Network \$0 copay for preventive dental benefits	Out-of-Network \$0 copay for comprehensive dental benefits
		20% of the cost for comprehensive dental benefits	\$0 to \$10 copay for comprehensive dental benefits	20% of the cost for comprehensive dental benefits**	\$10 copay for preventive dental benefits
		In and Out-of-Network Contact the plan for availability of additional in-network and out- of-network 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 and Out-of-Network Contact the plan for availability of additional in-network and out- of-network comprehensive dental benefits.	
27. Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic	In-Network In general, supplemental routine hearing exams and hearing aids not covered. - 20% of the cost for Medicare-	In-Network In general, supplemental routine hearing exams and hearing aids not covered.		In-Network In general, supplemental routine hearing exams and hearing aids not covered. - \$50 copay for Medicare-
	hearing exams.	covered diagnostic hearing exams	 \$50 copay for Medicare- covered diagnostic hearing exams 		covered diagnostic hearing exams
	Supplemental routine hearing exams and hearing aids not covered. 0% coinsurance for diagnostic hearing exams.		CAUTIS	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.	Out-of-Network \$50 copay for hearing exams.	Out-of-Network 20% of the cost for hearing exams.** See page 62 for information	Out-of-Network \$50 copay for hearing exams.
				about Hearing Services.	

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% coinsurance for diagnosis	In-Network	In-Network		In-Network
and treatment of diseases and conditions of the eye. Supplemental routine eye exams	- 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery.	- \$50 copay for one pair of eyeglasses or contact lenses after cataract surgery.		- \$50 copay for one pair of eyeglasses or contact lenses after cataract surgery.
Medicare pays for one pair of eyeglasses or contact lenses after	- 20% of the cost for exams to diagnose and treat diseases and conditions of the eye.	 \$50 copay for exams to diagnose and treat diseases and conditions of the eye. 		- \$50 copay for exams to diagnose and treat diseases and conditions of the eye.
cataract surgery. Annual glaucoma screenings covered for people at risk.	- 0% of the cost for up to 1 supplemental routine eye exam(s) every year.	- \$30 copay for up to 1 supplemental routine eye exam(s) every year.		 \$30 copay for up to 1 supplemental routine eye exam(s) every year.
	- 0% of the cost for glasses.	- \$0 copay for glasses.		- \$0 copay for glasses.
	- 0% of the cost for contacts.	- \$0 copay for contacts.		- \$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.	 0% to 20% of the cost for eye wear.** 20% of the cost for eye 	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.
	 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. 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 	 Silver Rx (Regional PPO SNP) 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. O% coinsurance for diagnosis and treatment of diseases and conditions of the eye. O% coinsurance for diagnosis and reatment 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. O% coinsurance for diagnosis and treat 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. Ott-of-Network % to 20% of the cost for eye wear. 20% of the cost 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 	Original metucate Silver Bx (Regional PPO SNP) 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. In-Network Supplemental routine eye exams and glasses not covered. In-Network Medicare pays for one pair of eyeglasses or contact lenses and conditions of the eye. -20% of the cost for ore pair of eyeglasses or contact lenses after cataract surgery. -20% of the cost for up to 1 supplemental routine eye exam(s) every year. -50 copay for one pair of eyeglasses or contact lenses and conditions of the eye. 0% of onsurance for diagnosis and treatment of diseases and conditions of the eye. -0% of the cost for contacts. -50 copay for contacts. 0% of the cost for contacts. -0% of the cost for contacts. -50 copay for glasses. 0% of the cost for contacts. -0% of the cost for contacts. -50 copay for glasses. 0% of the cost for contacts. -0% of the cost for contacts. -50 copay for glasses. 0% to the cost for contacts. -50 copay for eye wear. 0% to the cost for contacts. -50 copay for eye wear. 0% to the cost for eye wear. -50 copay for eye wear. 0% to to zowered for people at risk. -50 copay for eye wear. 0% to to zowered for people at risk. -50 copay for eye wear. 0% to to zowered for people at risk. -50 copay for eye wear. <td>Original method by Silver Rx (Regional PPO SNP) Dual Advantage (Regional PPO SNP) 20% coinsurance for diagnosi and treatment of diseases and conditions of the eye. - 20%, of the cost for one pair of eyeglases on convert. - 20%, of the cost for exams to diagnose and treat diseases and conditions of the eye. - 20% of the cost for icp to 1 supplemental routine eye exams to every eyar. - 50 copay for one pair of eyeglases or contact. - 50 copay for expans to diagnose and treat diseases and conditions of the eye. - 50 copay for glasses. - 50 copay for glasses. 0% of the cost for glasses. - 0% of the cost for contacts. - 50 copay for glasses. - 50 copay for contacts. 0% of the cost for contacts. - 0% of the cost for contacts. - 50 copay for contacts. 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Network 0% of the cost for experts. - 0% of the cost for experts. - 50 copay for experts. - 0% of the cost for eye exams) every year. - 0% of the cost for eye exams. 0% of the cost for eye exams. - 0% of the cost for eye exams. - 0% of the cost for eye exams. - 0% of the cost for eye exams. - 0% of the cost for eye exams. 00ttof-Network Still plan coverage</td>	Original method by Silver Rx (Regional PPO SNP) Dual Advantage (Regional PPO SNP) 20% coinsurance for diagnosi and treatment of diseases and conditions of the eye. - 20%, of the cost for one pair of eyeglases on convert. - 20%, of the cost for exams to diagnose and treat diseases and conditions of the eye. - 20% of the cost for icp to 1 supplemental routine eye exams to every eyar. - 50 copay for one pair of eyeglases or contact. - 50 copay for expans to diagnose and treat diseases and conditions of the eye. - 50 copay for glasses. - 50 copay for glasses. 0% of the cost for glasses. - 0% of the cost for contacts. - 50 copay for glasses. - 50 copay for contacts. 0% of the cost for contacts. - 0% of the cost for contacts. - 50 copay for contacts. Network 0% of the cost for contacts. - 0% of the cost for contacts. - 50 copay for contacts. Network 0% of the cost for contacts. - 0% of the cost for experts. - 50 copay for contacts. Network 0% of the cost for experts. - 0% of the cost for experts. - 50 copay for experts. - 0% of the cost for eye exams) every year. - 0% of the cost for eye exams. 0% of the cost for eye exams. - 0% of the cost for eye exams. - 0% of the cost for eye exams. - 0% of the cost for eye exams. - 0% of the cost for eye exams. 00ttof-Network Still plan coverage

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.
	60			61	

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				
	y an organized fac oulatory Surgery C	cility or clinic not Center	part of a hospital:		
Yes		Specified surgical procedures		Fee for service	CN & MN
	y an organized fac d Mental Health C	cility or clinic not Clinics	part of a hospital:		
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
	ed Health Center S	Services			
Yes			12 ambulatory encounters/year irrespective of setting	Greater of prospective rate/encounter or allowable cost	CN & MN
Inpatient Hospital	Services, other th	nan in an Institutio	n for Mental Disea	ases	
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		Reimbursement Methodology	Populations Covered	Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Outpatient Hospita	al Services					Rural Health Clin	ic Services				
Yes		Specified surgical procedures	12 non- emergency visits/year	payment for pediatric, teaching and critical access hospitals; fee for	CN & MN				12 visits/year irrespective of setting included in limits for other specified practitioners	Prospective cost based rate/encounter	CN & MN
				service for other hospitals		Practitioner Serv					
Rehabilitation Serv	vices: Mental He	alth and Substance	e Abuse	1103011113		Certified Registere	ed Nurse Anesthet	tist Services			
Yes		Specified services	Substance abuse services require	Fee for service	CN & MN					Fee for service at 80% of physician fee	CN & MN
			mental health			Chiropractor Servi	ces				
			primary diagnosis						12 visits/year	Fee for service	CN & MN
			Medicaid			Dental Services					
			Beneficiaries will								
			be limited to a			Medical and Rem	edial Care - Othe	er Practitioners			
			maximum of								
			eight hours per 24 hour day of			Medical/Surgical	Services of a Den	tist			
		outpatient services with the exception of Crisis Intervention, Crisis	butpatient services with the exception of Crisis ntervention,					12 visits/year irrespective of setting included in limits for other specified practitioners	Fee for service	CN & MN	
			Stabilization			Nurse Midwife Se	ervices				
			Intervention by Mental Health Professional and Crisis Stabilization Intervention by Mental Health	ıd ,		Nurse Practitione	r Services		12 visits/year irrespective of setting included in limits for other specified practitioners	Fee for service at 80% of physician fee	CN & MN
			Paraprofessional.				i Scivices		12 visits/year	Fee for service at	
			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						irrespective of	80% of physician fee	
		entity									

Optometrist Services I refractive exam2 years, 12 visits/year irrespective of setting included in limits for other specified practitioners, 2 in limits for other specified procedures Fee for service CN & MN Physician Services Specified surgical procedures 12 visits/year irrespective of setting included in limits for other specified practitioners, 2 in limits for other specified practitioners, 2 it leaves of the setting included in limits for other specified practitioners, 2 in limits for other specified procedures CN & MN Podiatrist Services Visits/year Fee for service, lab services reimbursed up to Medicare payment ceilings CN & MN Psychologist Services Image: Specified services reimbursed up to Medicare payment ceilings CN & MN MN Prescription Drugs Prescription Drugs Image: Specifical services reimbursed up to Medicare payment ceilings in HCBS waives in nursing facilities or participating in HCBS waives in a dispensing fee for generic Rx, with no FUL or state MAC CN & MN	YesI refractive exam2 years, 12 visits/year irrespective of setting included in limits for other specified practitionersFee for serviceCN & MNPhysician ServicesSpecified surgical procedures12 visits/year irrespective of setting included in limits for other specified practitioners, 2Fee for serviceCN & MNPediatrist ServicesSpecified procedures12 visits/year irrespective of setting included in limits for other specified practitioners, 2Fee for serviceCN & MNPodiatrist Services12 visits/year index or observice proceduresFee for service secrified practitioners, 2Fee for service secrified practitioners, 2CN & MNPodiatrist Services2Visits/year index or observice proceduresFee for service, lab services reimbursed up to proceduredCN & MNPrescription DrugsMore than 3 prescription DrugsS.50-\$3/Rx depending on drug costMore than 3 prescriptions per institutionalized beneficiaries6 Rxs/month except for persons in nursing facilities or participating in HCBS waiversAWP-14% for brand Rx, AWP- 20% for generic Rx with no FUL orCN & MN	Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Physician ServicesSpecified surgical proceduresI 2 visits/year irrespective of setting included in limits for other specified practitionersFee for serviceCN & MNYesSpecified surgical procedures12 visits/year irrespective of setting included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/yearFee for service setting included 	exam2 years, 12 visits/year inspective of setting included in limits for other specified practitionersexam2 years, 12 visits/year inspective of setting included in limits for other specified practitionersEvent Setting included in limits for other specified in limits for other specified in limits for other specified in limits for other specified practitioners, 2 in-person and 2 telemedicineFee for service setting included in limits for other specified practitioners, 2 in-person and 2 telemedicineCN & MNPodiatrist Services2 visits/year in-person and 2 telemedicine consultations/yearFee for service, lab servicesCN & MNPodiatrist ServicesCN & MNPodiatrist Services </td <td>Optometrist Servi</td> <td>ces</td> <td></td> <td></td> <td></td> <td></td>	Optometrist Servi	ces				
YesSpecified surgical procedures12 visits/year irrespective of setting included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/yearFee for service setsing included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/yearFee for service setsing included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/yearFee for service setsing included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/yearFee for service, setsing included in limits for other setsing included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/yearFee for service, setsing included in limits for other setsing facilities or participating in HCBS waiversFee for service, for generic Rx, plus \$5.51 dispensing fee for generic Rx with no FUL orCN & MN	YesSpecified surgical procedures12 visits/year irrespective of setting included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/yearFee for serviceCN & MNPodiatrist ServicesYesImage: Service service service setting included practitioners, 2 in-person and 2 telemedicine consultations/yearFee for service, lab services reimbursed up to Medicare payment ceilingsCN & MNPodiatrist ServicesImage: Service service servicesFee for service, lab services reimbursed up to Medicare payment ceilingsCN & MNPsychologist ServicesImage: Service service serviceFee for service, lab services reimbursed up to Medicare payment ceilingsCN & MNPrescription DrugsImage: Service service serviceImage: Service service serviceCN & MNYes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month except for persons in nursing facilities or participating in HCBS waiversCN & MNCN & MNS.50-\$3/Rx depending on dispensing fee for generic Rx with no FUL orCN & MN				exam/2 years, 12 visits/year irrespective of setting included in limits for other specified		CN & MN
surgical proceduresirrespective of setting included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/yearInternational wavePodiatrist Services2 visits/yearFee for service, lab services reimbursed up to Medicare payment ceilingsCN & MNPostchologist Services2 visits/yearFee for service, 	surgical proceduresirrespective of setting included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/yearIn a number setting included in limits for other specified practitioners, 2 in-person and 2 telemedicine consultations/yearCN & MN advector A MN advectorPodiatrist ServicesImage: Service and the service and	,	S				
YesImage: Service of the s	YesImage: Service of the s	Yes		surgical	irrespective of setting included in limits for other specified practitioners, 2 in-person and 2 telemedicine		CN & MN
Psychologist ServicesIab servicesNoImage: servicesNoImage: servicesPrescription DrugsPrescription DrugsYes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month except for persons in nursing facilities or participating in HCBS waiversAWP-14% for brand Rx, AWP- 20% for generic Rx, plus \$5.51 dispensing fee for each, additional \$2.00 dispensing fee 	Psychologist ServicesIab servicesNoImage: servicesPrescription DrugsPrescription DrugsYes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month except for persons in nursing facilities or participating in HCBS waiversAWP-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 orCN & MN		S				
NoImage: NoImage: NoImage: NoImage: NoPrescription DrugsYes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month except for persons in nursing facilities or participating in HCBS waiversAWP-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 orCN & MN	NoImage: NoImage: NoImage: NoPrescription DrugsYes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month except for persons in nursing facilities or participating in HCBS waiversAWP-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 orCN & MN	Yes			2 visits/year	lab services reimbursed up to Medicare	
Prescription DrugsYes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month 	Prescription DrugsYes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month except for persons in nursing facilities or participating in HCBS waiversAWP-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 orCN & MN	Psychologist Serv	ices				
Prescription DrugsYes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month except for persons in nursing facilities or participating in HCBS waiversAWP-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 orCN & MN	Prescription DrugsYes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month except for persons in nursing facilities or participating in HCBS waiversAWP-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 orCN & MN	No					
Yes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month except for persons in nursing facilities or participating in HCBS waiversAWP-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 orCN & MN	Yes\$.50-\$3/Rx depending on drug costMore than 3 prescriptions per month for non- institutionalized beneficiaries6 Rxs/month except for persons in nursing facilitiesAWP-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 orCN & MN	Prescription Dru	Igs				
depending on drug cost prescriptions per institutionalized beneficiaries prescriptions per institutionalized beneficiaries prescriptions per month for non- institutionalized beneficiaries prescriptions per nursing facilities or participating in HCBS waivers per for each, additional \$2.00 dispensing fee for generic Rx with no FUL or	depending on drug cost	Prescription Drug	S				
		Yes	depending on	prescriptions per month for non- institutionalized	except for persons in nursing facilities or participating	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	CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approv Requiremer
Physical Therap	y and Other Serv	ices
Occupational Th	erapy Services	
No		
Physical Therapy	Services	
No		
Services for Spee	ch, Hearing and L	anguage Disor
No		
Products and De	evices	
Dentures		
No		
Eyeglasses		
Yes	\$2/dispensing service	2 pair eyeglas rather than bifocals
Hearing Aids		
No		
Medical Equipme	ent and Supplies	
Yes		Specified mec equipment an med supply items
Prosthetic and O	rthotic Devices	
Yes		Augmentative communicatio devices
Transportation S		
Ambulance Servi	ces	
Yes		
	Medical Transport	tation Services
Yes		

rders	;		
sses	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
d nd	Med supplies limited to \$250/month	Fee for service for med equipment, med supplies paid up to Medicare payment ceilings	CN & MN
e ion	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
		Fee for service	CN & MN
		See service- specific FN	CN & MN
6	7		

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered		Is the Benefit Covered?	Copayment Requirement	Prior Appro Requireme
Other Services							Hospice Care		
Diagnostic, Scree	ening and Prevent	ive Services				_	Yes		
No						_			
Early and Periodi	c Screening, Diag	nosis and Treatme	ent			_			
See service- specific FN.									
Extended Service	s for Pregnant Wo	omen				_	Personal Care Ser	rvices	_
						_	Yes		
Family Planning S	Services					_			
See service- specific FN.						_	Private Duty Nur	sing Services	N/
•	- Rav Services, ou	tside Hospital or C	Clinic			_	Yes		Yes
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 Ma	anagement					_			
Yes				Fee for service, negotiated rate or cost based payment	CN & MN	_			
Long-Term C	Care Services					_			
Community Base									
Home and Comn		vices Waiver				-	Program of All-In	clusive Care for t	he Elderly
Yes	7		Services for the following	Dependent upon the services	CN & MN	_	Yes		Yes
			populations: 2, 4				Institutional Care	<u>ــــــــــــــــــــــــــــــــــــ</u>	
			& 8 - See service-specific				Inpatient Hospita Mental Diseases,	l, Nursing Facility	
			FN			_	No		
	rvices, includes n	-		nd medical supplie		_	Inpatient Psychia	tric Services, und	er age 21
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		Yes		Yes
			58			_			

val nt	Coverage Limitations	Reimbursement Methodology	Populations Covered
	Two 90-day periods with additional 60- day periods as necessary	Prospective rate using Medicare wage index	CN & MN
	64 hours/month	Fee for service using hourly	CN
		rates	
	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
		Capitated	CN
		payment	
ate	Care Facility Servi	ces In Institutions 1	for
		-	
	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	Section IV Is the Benefit	- Medicaid Copayment	d Benefits Prior Approv
ntermediate Care	e Facility Services	for the Mentally R	etarded			Covered?	Requirement	Requiremen
Yes			5 hosp leave days/ hospitalization, facility must	Prospective cost based class rate for facilities with	CN	Clinic Services,	d Clinic Services by an organized fa nbulatory Surgery (cility or clinic r
			have 85% occupancy rate to be paid, unlimited	fewer than 16 beds, prospective cost based per diem for larger private facilities, cost		Yes		
			consecutive days	for public		Clinic Services, Public Health a	by an organized fa nd Mental Health (cility or clinic r Clinics
		• • • • •		facilities		Yes	\$.50/day	
<u> </u>	ervices, other thai	n in an Institution				· · ·	fied Health Center	Services
Yes			hospitalization,	Prospective cost based per diem	CN	Yes	\$2/day	
			facility must have 85%			Inpatient Hospi	tal Services, other tl	nan in an Institu
Poligious Non M	odical Hoalth Car	e Institution and P	occupancy rate to be paid, unlimited therapeutic leave days up to 14 days consecutively	e paid, mited apeutic leave up to 14 secutively		Yes	\$10/admission, except emergencies and transfers	Admissions fo specified surgical procedures
No				5				
						Outpatient Hos	pital Services	
						Yes	\$3/day	Specified services
						Rehabilitation S	ervices: Mental He	alth and Substa
				Yes				
						Rural Health Cl	inic Services	
						Yes	\$2/day	

Benefits (Missouri)

oval ent	Coverage Limitations	Reimbursement Methodology	Populations Covered
not	part of a hospital:		
	Coverage limited to specified procedures	Fee for service, using an all- inclusive payment per episode of care	CN & MN
not	part of a hospital:		
		Fee for service	CN & MN
		Cost based payment	CN & MN
tutio	n for Mental Disea	ises	
or	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
	Selected elective surgeries require second opinion	Percentage of charge	CN & MN
ance	Abuse		
	Services limited to the severely mentally ill	Fee for service	CN & MN
		Prospective cost based rate/visit or certified cost/encounter	CN & MN

Is the Bene Covered		Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered	Is the Bene Covered?	• <i>'</i>	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Population Covered
Practitioner	Services					Optometrist S	Services				
Certified Reg	gistered Nurse Anesthe	tist Services				Yes	\$.50-\$3/service,		1 vision	Fee for service	CN & MN
'es	\$.50/day			Fee for service	CN & MN		depending on		exam/year with		
hiropractor	Services						payment		or without refraction except		
No									adults who are		
Dental Servio	ces								not pregnant,		
Yes	\$.50-\$3/ service depending on payment	payment except adults who are not pregnant, blind			blind or residing in nursing facilities are limited to 1 exam/2 years						
			nursing facilities			Physician Ser			Specified	Fee for service	CN & MN
	are limited to trauma care related to facial		Yes	Tes	\$1/day		procedures require a second opinion	ree for service			
			injury or treatment of			Podiatrist Serv	vices				
Medical and	health-impacting disease or medical condition nd Remedial Care - Other Practitioners	Yes	\$.50-\$3/service, depending on payment		Specified services are no longer covered for adults who are not pregnant,		CN & MN				
									blind or residing		
Medical/Surg	gical Services of a Den	tict							in nursing facilities		
Yes	\$.50-\$3/service					Psychologist	Services		lacinues		
	depending on			Fee for service	CN & MN	Yes	\$2/day	Yes		Fee for service	CN & MN
	payment					Prescription	,	103		Tee IOI service	
lurse Midw	ife Services					Prescription	0				
/es	\$1/day		Services limited to women age 15 and older and infants up to 2 months		CN & MN	Yes	\$.50-\$2/Rx depending on drug cost			Lower of AWP- 10.43% or WAC+10%, plus \$4.09 dispensing fee	
	tioner Services					Physical The	rapy and Other Serv	ices			
'es	\$1/day			Fee for service	CN & MN	Occupational	I Therapy Services				
					Yes			Adult coverage limited to those who are pregnant, blind or residing in nursing facilities	Fee for service	CN & MN	
			72					7	3		

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 Speed	ch, Hearing and L	anguage Disorders			
Yes			Adult coverage limited to those who are pregnant, blind or residing in nursing facilities	Fee for service	CN & MN
Products and De	vices				
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		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		CN & MN

Is the Benefit Covered?	Copayment Requirement	Prior Approv Requirement
Medical Equipme	ent and Supplies	
Yes		Yes
Prosthetic and Or	rthotic Devices	
Yes		Specified services
Transportation Se	ervices	
Ambulance Servi	ces	
Yes		
Non-Emergency	Medical Transport	ation Services
Yes	\$2/day	
Other Services		
Diagnostic, Scree	ening and Preventiv	ve Services
Yes		
Early and Periodi	c Screening, Diagr	nosis and Treat
See service- specific FN.		
Extended Service	s for Pregnant Wo	men
Family Planning S	Services	
See service- specific FN.		
Laboratory and X	-Ray Services, out	side Hospital c
Yes	\$1/day	
Targeted Case Ma	anagement	
Yes	\$1/day	

val nt	Coverage Limitations	Reimbursement Methodology	Populations Covered
	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
	Adult coverage	Fee for service	CN & MN
	other than for pregnant or blind does not include orthotics unless provided through home health plan of care		
		Fee for service	CN & MN
		See service- specific FN	CN & MN
		Fee for service	CN & MN
tme	nt		
or C	linic		
		Fee for service	CN & MN
		F	
		Fee for service	CN & MN

Copayment Prior Approval Requirement Requirement Is the Benefit **Covered?**

Coverage Limitations

Reimbursement Populations Methodology Covered

Long-Term Care Services

Community Based Care

Community Based Care	е			
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	
Home Health Services,	includes nursing services, ho	me health aides, ai	nd medical supplie	es/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 Se	ervices			
No				

Program of All-Inclusive Care for the Elderly Yes

See service- Capitated CN specific FN payment

Institutional Care

Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services In Institutions for Mental Diseases, age 65 and older

Yes	12 therapeutic	Prospective cost	CN & MN
	leave days/6	based per diem	
	months		

Is the Benefit Covered?	Copayment Requirement	Prior Approv Requirement
Inpatient Psychia	tric Services, unde	r age 21
Yes		
Intermediate Car	e Facility Services	for the Montall
Yes	e raciity Services	
Nursing Eacility 9	Services, other thar	n in an Instituti
Yes	ervices, outer that	
Polizious Non M	odical Health Car	Institution on
No	edical Health Care	e institution an

val nt	Coverage Limitations	Reimbursement Methodology	Populations Covered			
		Prospective cost based per diem, some facilities receive standard rate	CN & MN			
ly R	ly Retarded					
	12 therapeutic leave days/6 months	Prospective cost based per diem with limits for private facilities, cost based payment for public facilities	CN & MN			
ion	for Mental Disease	es				
	12 therapeutic leave days/6 months	Prospective per diem based on cost	CN & MN			
nd Pi	ractitioner Service	s				
7	7					



CARE IMPROVEMENT PLUS

Specialized Care for Medicare Beneficiaries

351 W Camden Street, Suite 100 Baltimore, MD 21201

For Full information on Care Improvement Plus benefits, call:

Current Members 7 days a week, 8 am – 8 pm 1-800-204-1002 (TTY: 1-800-713-1603)

Prospective Members 7 days a week, 8 am – 8 pm 1-800-711-1656 (TTY: 1-800-713-1603)

Visit us on the web www.careimprovementplus.com