

Your 2026 Medical Benefits Chart

PPO Plan 10L

Drexel University

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Doctor and hospital choice You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.		Higher costs may apply for out-of-network services.
Prior authorization* Benefit categories that include services that require prior authorization are marked with an asterisk (*). Additional information can be found on the last page of the medical benefits chart.		
Annual deductible The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	\$0 combined in-network and out-of-network	
Inpatient services		
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't limited to: - Semi-private room (or a private room if medically necessary) - Meals, including special diets - Regular nursing services - Costs of special care units (such as intensive or coronary care units) - Drugs and medications - Lab tests - X-rays and other radiology services	For Medicare-covered hospital stays: \$250 copay per day for days 1-5 per admission No limit to the number of days covered by the plan.	For Medicare-covered hospital stays: 20% coinsurance per admission No limit to the number of days covered by the plan.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical therapy, occupational therapy, and speech language therapy • Inpatient substance abuse services • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	\$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	20% coinsurance for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you'd pay at an in-network hospital.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. Our plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. For each travel and lodging reimbursement request, please submit a letter from the Medicare-approved transplant center with the dates you were treated as an outpatient and required to be near the Medicare-approved transplant center to receive treatment/ services related to the transplant care. Please also include documentation of any companion and the dates they traveled with you while you were receiving services related to the transplant care. Travel reimbursement forms can be requested from Member Services. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines on the date services are rendered. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) consistent with IRS guidelines for maximum lodging for that location. You can access current reimbursement on the US General Services Administration website www.gsa.gov. All requests for reimbursement must be submitted within one year (12 months) from the date incurred. For more information on how and where to submit a claim, please see the Asking us to pay our share of a bill for covered medical services chapter in your EOC.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood starts with the first pint. • Physician services In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center. Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient, you should ask the hospital staff. Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at https://Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-800-486-2048.		
Inpatient services in a psychiatric hospital* Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital. In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.	For Medicare-covered hospital stays: \$250 copay per day for days 1-5 per admission No limit to the number of days covered by the plan. \$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: 20% coinsurance per admission No limit to the number of days covered by the plan. 20% coinsurance for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care* (For a definition of skilled nursing facility, see the Definitions of important words chapter in your Evidence of coverage (EOC).) Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech language therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors) • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from plan facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	For Medicare-covered SNF stays: \$0 copay for days 1-20 and \$40 copay per day for days 21-100 per benefit period No prior hospital stay required.	For Medicare-covered SNF stays: 20% coinsurance for days 1-100 per benefit period No prior hospital stay required.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.		
Inpatient services you get when the hospital or SNF days are not covered or are no longer covered* If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or a skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetic and orthotic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back and neck braces, trusses and artificial legs, arms, and eyes including adjustments, repairs and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, occupational therapy, and speech language therapy		After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefits chart at the cost share amounts indicated.
Home health agency care* Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to:	\$0 copay for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	20% coinsurance for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech language therapy • Medical and social services • Medical equipment and supplies		
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be an in-network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice you have the right to stay in our plan; if you chose to stay in our plan you must continue to pay plan premiums. For hospice services and for services that are covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. For services covered by Medicare Part A or B not related to your terminal prognosis: If you need nonemergency, nonurgently needed services covered under Medicare Part A	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. \$40 copay for the one time only hospice consultation	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. 20% coinsurance for the one time only hospice consultation

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from an in-network provider and follow the plan rules for obtaining service, you only pay our plan cost-sharing amount for in-network services. • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare. For services that are covered by our plan but not covered by Medicare Part A or B: Our plan will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. If you have Part D prescription drug coverage, some drugs may be covered under your Part D benefit. Drugs are never covered by both hospice and your Part D plan at the same time. Note: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.		
Outpatient services		
Physician services, including doctor's office visits* Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Retail health clinics • Basic hearing and balance evaluations performed by your Primary Care Physician or specialist, if your doctor orders it to see if you need medical treatment, are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	\$10 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services \$40 copay per visit to an in-network specialist for Medicare-covered services \$10 copay per visit to an in-network retail health clinic for Medicare-covered services	20% coinsurance per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services 20% coinsurance per visit to an out-of-network specialist for Medicare-covered services 20% coinsurance per visit to an out-of-network retail health clinic for Medicare-covered services

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Certain telehealth services for some physician or mental health services can be found in the section of this benefits chart titled, Video doctor visits ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within six months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while getting these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: ◦ You're not a new patient and ◦ The check-in isn't related to an office visit in the past seven days and ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	\$0 copay for Medicare-covered allergy testing \$0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.	20% coinsurance for Medicare-covered allergy testing 20% coinsurance for Medicare-covered allergy injections See antigen cost share in Part B drug section.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ◦ You're not a new patient and ◦ The evaluation isn't related to an office visit in the past seven days and ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another in-network provider prior to surgery • Physician services rendered in the home • Outpatient hospital services • In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. • Allergy testing and allergy injections		
Chiropractic services • We cover only manual manipulation of the spine to correct subluxation.	\$15 copay for each Medicare-covered visit	20% coinsurance for each Medicare-covered visit
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than three months). Services may include pain assessment, medication management, and care coordination and planning.	\$10 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered chronic pain management visit	20% coinsurance per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered chronic pain management visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
	\$40 copay per visit to an in-network specialist for Medicare-covered chronic pain management visit Cost sharing for this service will vary depending on individual services provided under the course of treatment	20% coinsurance per visit to an out-of-network specialist for Medicare-covered chronic pain management visit Cost sharing for this service will vary depending on individual services provided under the course of treatment
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:	\$10 copay for each Medicare-covered visit	20% coinsurance for each Medicare-covered visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• A master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.		
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and disease of the feet (such as hammer toe or heel spurs), in an office setting • Medicare-covered routine foot care for members with certain medical conditions affecting the lower limbs • A foot exam covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations	\$10 copay for each Medicare-covered visit	20% coinsurance for each Medicare-covered visit
Outpatient mental health care, including partial hospitalization services and intensive outpatient services* Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.	\$40 copay for each Medicare-covered professional individual therapy visit \$40 copay for each Medicare-covered professional group therapy visit \$40 copay for each Medicare-covered professional partial hospitalization and intensive outpatient services visit	20% coinsurance for each Medicare-covered professional individual therapy visit 20% coinsurance for each Medicare-covered professional group therapy visit 20% coinsurance for each Medicare-covered professional partial hospitalization and intensive outpatient services visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	\$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit \$0 copay for each Medicare-covered outpatient hospital facility group therapy visit \$0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit	20% coinsurance for each Medicare-covered outpatient hospital facility individual therapy visit 20% coinsurance for each Medicare-covered outpatient hospital facility group therapy visit 20% coinsurance for each Medicare-covered partial hospitalization facility and intensive outpatient services visit
Outpatient substance use disorder services, including partial hospitalization services and intensive outpatient services* Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	\$40 copay for each Medicare-covered professional individual therapy visit \$40 copay for each Medicare-covered professional group therapy visit \$40 copay for each Medicare-covered professional partial hospitalization and intensive outpatient services visit	20% coinsurance for each Medicare-covered professional individual therapy visit 20% coinsurance for each Medicare-covered professional group therapy visit 20% coinsurance for each Medicare-covered professional partial hospitalization and intensive outpatient services visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
	\$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit \$0 copay for each Medicare-covered outpatient hospital facility group therapy visit \$0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit	20% coinsurance for each Medicare-covered outpatient hospital facility individual therapy visit 20% coinsurance for each Medicare-covered outpatient hospital facility group therapy visit 20% coinsurance for each Medicare-covered partial hospitalization facility and intensive outpatient services visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* Facilities where surgical procedures are performed and the patient is released the same day. Note: If you're having surgery in a hospital, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at https://Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	\$100 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery \$100 copay for each Medicare-covered outpatient observation room visit	20% coinsurance for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery 20% coinsurance for each Medicare-covered outpatient observation room visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient hospital observation, non-surgical Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	\$10 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services \$40 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services \$100 copay for each Medicare-covered outpatient observation room visit	20% coinsurance for a visit to an out-of-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services 20% coinsurance for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services 20% coinsurance for each Medicare-covered outpatient observation room visit
Ambulance services • Covered ambulance services, whether for an emergency or nonemergency situation, include fixed wing, rotary wing, water, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. • If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. • Ambulance service is not covered for physician office visits.	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. \$75 copay per one-way trip for Medicare-covered ambulance services	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. Emergency outpatient copay is waived if the member is admitted to the hospital within 72 hours for the same condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. This coverage is worldwide and is limited to what's allowed under the Medicare fee schedule for the services performed/ received in the United States. Please refer to the Foreign travel emergency and urgently needed services benefit section for cost sharing and limits outside of the United States or its territories. Cost sharing for necessary emergency services you get out-of-network is the same when you get these services in-network. If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at an in-network hospital.		\$100 copay for each Medicare-covered emergency room visit
Urgently needed services • Urgently needed services are available on a worldwide basis. The urgently needed services copay is waived if the member is admitted to the hospital within 72 hours for the same condition. A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing.		\$50 copay for each Medicare-covered urgently needed care visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits, (like annual checkups) aren't considered urgently needed even if you're outside the service area or our plan network is temporarily unavailable. This coverage is worldwide and is limited to what's allowed under the Medicare fee schedule for the services performed/ received in the United States. Please refer to the Foreign travel emergency and urgently needed services benefit section for cost sharing and limits outside of the United States or its territories.		
Outpatient rehabilitation services* Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	\$40 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits	20% coinsurance for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits
Cardiac rehabilitation services* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	\$0 copay for Medicare-covered cardiac rehabilitation therapy visits	20% coinsurance for Medicare-covered cardiac rehabilitation therapy visits
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	\$35 copay for Medicare-covered pulmonary rehabilitation therapy visits	20% coinsurance for Medicare-covered pulmonary rehabilitation therapy visits
Supervised exercise therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must:	\$25 copay for Medicare-covered supervised exercise therapy visits	20% coinsurance for Medicare-covered supervised exercise therapy visits

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.		
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, see the Definitions of important words chapter in your EOC.) Covered items include, but aren't limited to wheelchairs, crutches, powered mattress systems, diabetic supplies, continuous blood glucose monitors, hospital bed ordered by a provider for use at home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. For additional information on the ownership of DME and the rental of oxygen supplies and oxygen, please see Chapter 3. Copay or coinsurance only applies when you are not currently receiving inpatient care. If you are receiving inpatient care your DME will be included in the copay or coinsurance for those services. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you can ask them if they can special order it for you. Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there isn't NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. This plan only covers FreeStyle Libre® (made by Abbott) and Dexcom Continuous Glucose Monitors (CGMs). We will not	10% coinsurance for Medicare-covered DME including oxygen supplies and oxygen The rental period for oxygen equipment and oxygen is 36 months. For the remaining 24 months you will be responsible for the oxygen. After the five-year period, the cost-sharing responsibility for both oxygen supplies and oxygen resumes. \$0 copay for Medicare-covered CGMs and related supplies	10% coinsurance for Medicare-covered DME including oxygen supplies and oxygen The rental period for oxygen equipment and oxygen is 36 months. For the remaining 24 months you will be responsible for the oxygen. After the five-year period, the cost-sharing responsibility for both oxygen supplies and oxygen resumes. 20% coinsurance for Medicare-covered CGMs and related supplies

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
cover other brands unless your provider tells us it is medically necessary. Coverage is limited to two to three sensors per month, depending on the receiver, and one receiver every two years. This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids (HA). Other brands are covered if deemed medically necessary by the provider. The review of medical necessity for use of HA and any non-preferred brands is part of the plan's prior authorization process.	See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.	See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.
Prosthetic and orthotic devices and related supplies* Devices (other than dental) that replace all or a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery - go to Vision care later in this benefits chart for more detail.	10% coinsurance for Medicare-covered prosthetic and orthotic devices	10% coinsurance for Medicare-covered prosthetic and orthotic devices
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefits • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Separately from the home infusion therapy professional services, home infusion requires a durable medical equipment component:	\$0 copay for Medicare-covered professional services provided by a qualified home infusion supplier in the patient's home 10% coinsurance for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)	20% coinsurance for Medicare-covered professional services provided by a qualified home infusion supplier in the patient's home 10% coinsurance for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Durable medical equipment – the external infusion pump, the related supplies and the infusion drug(s), pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items		
 Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users) Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors • Blood glucose monitors are limited to one every year • Up to 200 blood glucose test strips and lancets for a 30-day supply • For people with diabetes who have severe diabetic foot disease: one pair per year of therapeutic custom molded shoes (including inserts provided with such shoes) and two additional pairs of inserts or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting of shoes or inserts • Diabetes self-management training is covered under certain conditions	If purchased through a pharmacy: \$0 copay for a 30-day supply on each Medicare-covered purchase of FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) blood glucose test strips, lancets, lancet devices, and glucose control solutions or a \$10 copay for all other brands when purchased through the pharmacy If purchased through a pharmacy: \$0 copay for Medicare-covered FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) blood glucose monitors or a \$10 copay for all other brands when purchased through the pharmacy	If purchased through a pharmacy: 10% coinsurance for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions when purchased through the pharmacy If purchased through a pharmacy: 10% coinsurance for Medicare-covered blood glucose monitors when purchased through the pharmacy

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
	If purchased through a DME provider: \$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions when purchased through a DME provider	If purchased through a DME provider: 10% coinsurance for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions when purchased through a DME provider
	If purchased through a DME provider: \$0 copay for Medicare-covered blood glucose monitors when purchased through a DME provider	If purchased through a DME provider: 10% coinsurance for Medicare-covered blood glucose monitors when purchased through a DME provider
	\$0 copay for Medicare-covered therapeutic shoes and inserts	10% coinsurance for Medicare-covered therapeutic shoes and inserts
	\$0 copay for Medicare-covered diabetes self-management training	20% coinsurance for Medicare-covered diabetes self-management training

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
	See the Durable Medical Equipment (DME) benefit section for continuous glucose monitors (CGMs) cost sharing.	See the Durable Medical Equipment (DME) benefit section for continuous glucose monitors (CGMs) cost sharing.
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but aren't limited to: • X-rays • Complex diagnostic tests and radiology services • Radiation (radium and isotope) therapy, including technician materials and supplies • Testing to confirm chronic obstructive pulmonary disease (COPD) • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem • Other outpatient diagnostic tests Certain diagnostic tests and radiology services are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans.	\$10 copay for each Medicare-covered X-ray visit and/or simple diagnostic test \$80 copay for Medicare-covered complex diagnostic test and/or radiology visit \$40 copay for each Medicare-covered radiation therapy treatment \$0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease 10% coinsurance for Medicare-covered supplies \$0 copay for each Medicare-covered clinical/diagnostic lab test	20% coinsurance for each Medicare-covered X-ray visit and/or simple diagnostic test 20% coinsurance for Medicare-covered complex diagnostic test and/or radiology visit 20% coinsurance for each Medicare-covered radiation therapy treatment 20% coinsurance for Medicare-covered testing to confirm chronic obstructive pulmonary disease 10% coinsurance for Medicare-covered supplies \$0 copay for each Medicare-covered clinical/diagnostic lab test

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
	\$0 copay for each Medicare-covered hemoglobin A1c or urine tests to check albumin levels \$0 copay per Medicare-covered pint of blood	\$0 copay for each Medicare-covered hemoglobin A1c or urine tests to check albumin levels \$0 copay per Medicare-covered pint of blood
Opioid treatment program services* Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA) approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	\$40 copay per visit for Medicare-covered opioid treatment program services	20% coinsurance per visit for Medicare-covered opioid treatment program services
 Vision care (non-routine) Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are age 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year.	\$10 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye \$40 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye	20% coinsurance for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye 20% coinsurance for visits to an out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have two separate cataract operations, you can't reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.	\$0 copay for Medicare-covered glaucoma screening \$0 copay for Medicare-covered diabetic retinopathy screening 20% coinsurance for glasses/contacts following Medicare-covered cataract surgery	20% coinsurance for Medicare-covered glaucoma screening 20% coinsurance for Medicare-covered diabetic retinopathy screening 20% coinsurance for glasses/contacts following Medicare-covered cataract surgery

Preventive services care and screening tests



You will see this apple next to preventive services throughout this chart. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you in-network. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received. In addition, if an office visit is billed for the existing medical condition care or an additional non-preventive service received, the applicable in-network primary care physician or in-network specialist copay or coinsurance will apply.

 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.	20% coinsurance for members eligible for this Medicare-covered preventive screening.
 Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months, or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.	20% coinsurance for the Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
In addition, we cover a bone mass measurement post fracture. Recommendation is to get a bone mass measurement within six months of fracture, which may help reduce risk of additional fractures in the future.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement or a bone mass measurement after a fracture.	20% coinsurance for the Medicare-covered bone mass measurement or a bone mass measurement after a fracture.
 Colorectal cancer screening and colorectal services The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high-risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.	20% coinsurance for the Medicare-covered colorectal cancer screening exam and services.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every three years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every three years. • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.		
 HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.	20% coinsurance for members eligible for the Medicare-covered preventive HIV screening.
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to eight HIV screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered PrEP benefit.	20% coinsurance for the Medicare-covered PrEP benefit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
A one-time hepatitis B virus screening.		
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	20% coinsurance for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
 Medicare Part B immunizations Covered services include: • Pneumonia vaccines • Flu/influenza shots, (or vaccines), including H1N1, once each flu season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules If you have Part D prescription drug coverage, some vaccines are covered under your Part D benefit (for example, the shingles vaccine). Please refer to your Part D prescription drug benefits.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.
 Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.	20% coinsurance for Medicare-covered screening mammograms.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
 Cervical and vaginal cancer screening Covered services include: • For all women, Pap tests and pelvic exams are covered once every 24 months. • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	20% coinsurance for Medicare-covered preventive Pap and pelvic exams.
 Prostate cancer screening exams For men aged 50 and older, the following are covered once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.	20% coinsurance for a Medicare-covered annual PSA test.
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.	20% coinsurance for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.
 Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.	20% coinsurance for Medicare-covered cardiovascular disease testing that is covered once every five years.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
 Welcome to Medicare preventive visit Our plan covers a one-time Welcome to Medicare preventive visit. The visit includes a review of your health, measurements of height, weight, body mass index, blood pressure, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. Important: We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your Welcome to Medicare preventive visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered Welcome to Medicare preventive visit.	20% coinsurance for the Medicare-covered Welcome to Medicare preventive visit.
 Annual wellness visit If you've had Medicare Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare preventive visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.	20% coinsurance for the Medicare-covered annual wellness visit.
 Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.	20% coinsurance for a Medicare-covered annual depression screening visit.
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.	20% coinsurance for Medicare-covered diabetes screening tests.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	20% coinsurance for the MDPP benefit.
 Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.	20% coinsurance for Medicare-covered preventive obesity screening and therapy.
 Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	20% coinsurance for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
 Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.	20% coinsurance for Medicare-covered screening for the Hepatitis C Virus.

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

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with the patient getting up to eight sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Other services		
Services to treat outpatient kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area or when your provider for this service is temporarily unavailable or inaccessible) • Home dialysis or certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home and outpatient dialysis equipment and supplies Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B drugs, go to Medicare Part B drugs in this benefits chart.	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. \$0 copay for each Medicare-covered kidney disease education session \$10 copay for Medicare-covered outpatient dialysis \$0 copay for Medicare-covered home dialysis or home support services	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. 20% coinsurance for each Medicare-covered kidney disease education session \$10 copay for Medicare-covered outpatient dialysis 20% coinsurance for Medicare-covered home dialysis or home support services

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
	\$0 copay for Medicare-covered self-dialysis training 10% coinsurance for Medicare-covered home dialysis equipment and supplies 10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies	10% coinsurance for Medicare-covered self-dialysis training 10% coinsurance for Medicare-covered home dialysis equipment and supplies 10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies
Medicare Part B drugs* These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs include substances that are naturally present in the body, such as blood clotting factors • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia	20% coinsurance for Medicare-covered Part B drugs 20% coinsurance for Medicare-covered Part B drug administration Certain rebatable drugs may be subject to a lower coinsurance. 20% coinsurance with a maximum out-of-pocket of \$35 for a Medicare-covered one-month supply of insulin 20% coinsurance for Medicare-covered Part B chemotherapy drugs	20% coinsurance for Medicare-covered Part B drugs 20% coinsurance for Medicare-covered Part B drug administration Certain rebatable drugs may be subject to a lower coinsurance. 20% coinsurance with a maximum out-of-pocket of \$35 for a Medicare-covered one-month supply of insulin 20% coinsurance for Medicare-covered Part B chemotherapy drugs

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home and outpatient dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, or Methoxy polyethylene glycol-epoetin beta Mircera®)	20% coinsurance for Medicare-covered Part B chemotherapy drug administration	20% coinsurance for Medicare-covered Part B chemotherapy drug administration

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) We also cover some vaccines under our Part B prescription drug benefit. Some of Part B covered drugs listed above may be subject to step therapy. You may log into your secure member portal to find the list of Part B drugs that may be subject to step therapy. This list is located with your Plan Documents under your Benefits section. If you have Part D prescription drug coverage, please refer to your Evidence of Coverage for information on our Part D prescription drug and vaccine benefits.		
Additional supplemental benefits, services, and discounts		
Routine hearing services This plan provides additional hearing coverage not covered by Original Medicare. • Routine hearing exams are limited to one every calendar year • Hearing aid fitting evaluations are limited to one per covered hearing aid Routine hearing exams and fitting evaluations are limited to a \$70 maximum benefit every calendar year combined in-network and out-of-network. • Hearing aids Hearing aids are limited to one per ear every calendar year through TruHearing. The hearing aid benefit applies to covered, prescribed hearing aids. Includes digital hearing aid technology and inner ear, outer ear, and over the ear models. Fitting adjustment after hearing aid is received, if necessary. This benefit is limited to two devices. The hearing aid benefit does not provide coverage for over-the-counter hearing aids, amplifiers, internet purchases, over the phone purchases, assistive listening devices (ALDs), disposable hearing aids, earmolds or accessories. We have partnered with TruHearing to bring you these discounts and services. Although you can see an out-of-	Must use a TruHearing participating provider. \$0 copay for routine hearing exams \$0 copay for hearing aid fitting evaluations \$699 copay for advanced digital hearing aids \$999 copay for premium digital hearing aids	Out-of-network providers must order hearing aids through TruHearing. \$0 copay for routine hearing exams \$0 copay for hearing aid fitting evaluations \$699 copay for advanced digital hearing aids \$999 copay for premium digital hearing aids

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
network provider for your exam, you must select a hearing aid from the list available through TruHearing. They will send the hearing aid(s) directly to your provider. Hearing Aids must be supplied by the plan's hearing network vendor, TruHearing. The plan does not reimburse for devices received from other vendors or providers under this supplemental benefit. For more information on your benefit, covered devices or to locate a TruHearing provider please contact TruHearing at 1-855-312-2545. Hearing benefit management administered by TruHearing, an independent company.	Members receive a free battery supply for non-rechargeable hearing aids during the first three years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.	Hearing aid must be ordered through TruHearing and selected from the list of available devices. TruHearing will send the device directly to your provider. Members receive a free battery supply for non-rechargeable hearing aids during the first three years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.
Routine vision services This plan provides additional vision coverage not covered by Original Medicare. • Routine vision exams Routine vision exams, including a refraction, are limited to one every calendar year combined in-network and out-of-network. • Eyewear Eyewear is limited to a \$100 maximum benefit* every two calendar years combined in-network and out-of-network. Covered eyewear includes prescription glasses, lenses, frames, and elective contacts.	Must use a Blue View Vision provider. \$0 copay for routine vision exams \$0 copay for eyewear	Up to a \$70 reimbursement for routine vision exams Up to a \$100 reimbursement for eyewear

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Non-elective contacts are covered every two years combined in-network and out-of-network. This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. This information is intended to be a brief outline of coverage. For additional benefit information, including exclusions and limitations or to locate a participating Blue View Vision provider, please contact Member Services. If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a Blue View Vision Out-of-Network Claim Form for reimbursement up to your maximum out-of-network allowance. In-network benefits and discounts will not apply. * Any remaining unused eyewear benefit amount must be used in the same calendar year of the first eyewear purchase. Unused amounts cannot carry over to the following calendar year or benefit period.	\$0 copay for non-elective contact lenses After the plan pays benefits for routine vision exams and eyewear, you are responsible for any remaining cost. Any in-store promotions or discounts cannot be combined with your Blue View Vision benefit and discount.	Non-elective contact lenses reimbursed in full After the plan pays benefits for routine vision exams and eyewear, you are responsible for any remaining cost.
Routine foot care This plan provides additional foot care coverage not covered by Original Medicare. Up to 12 covered visits per year combined in-network and out-of-network Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails, and other hygienic and preventive maintenance care.	\$10 copay for each routine foot care visit After the plan pays benefits for routine foot care, you are responsible for any remaining cost.	20% coinsurance for each routine foot care visit After the plan pays benefits for routine foot care, you are responsible for any remaining cost.
Annual routine physical exam The annual routine physical exam benefit covers a standard physical exam in addition to the Medicare-covered Welcome to Medicare or Annual Wellness Visit.	\$0 copay for an annual physical exam	20% coinsurance for an annual physical exam

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Video doctor visits LiveHealth Online lets you see board-certified doctors and licensed therapists, psychologists, and psychiatrists through live, two-way video on your smartphone, tablet or computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your health plan ID card ready – you'll need it to answer some questions. Sign up for Free: - You must enter your health insurance information during enrollment, so have your ID card ready when you sign up. Benefits of a video doctor visit: - The visit is just like seeing your regular doctor face-to-face, but just by web camera. - It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye, and more. - The doctor can send prescriptions to the pharmacy of your choice, if needed.¹ - If you're feeling stressed, worried, or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road. In most cases, you can make an appointment and talk with a therapist² or make an appointment and talk with a psychiatrist³ from the privacy of your home. Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan. 1. Prescription is prescribed based on physician recommendations and state regulations (rules). 2. Appointments are typically scheduled within seven days but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. 3. Appointments are typically scheduled within 28 days but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.		\$0 copay for video doctor visits using LiveHealth Online

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
 Health and wellness education programs SilverSneakers® Membership SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers online and at participating locations¹. You have access to a nationwide network of participating locations where you can take classes² and use exercise equipment and other amenities. Enroll in as many locations as you like, at any time. You also have access to instructors who lead specially designed group exercise classes in-person and online, seven days a week. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks, and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers LIVE classes, SilverSneakers On Demand videos and the SilverSneakers GO mobile app. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-855-741-4985 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. 1. Participating locations (PL) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers is a registered trademark of Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.		\$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine As a member, you have access to a 24-hour nurse line, seven days a week, 365 days a year. When you call our nurse line, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the nurse line at 1-844-916-3650. TTY users should call 711.		\$0 copay for 24/7 NurseLine

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Only 24/7 NurseLine is included in our plan. All other nurse access programs are excluded.		
Foreign travel emergency and urgently needed services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. • Emergency outpatient care • Urgently needed services • Inpatient care (60 days per lifetime) This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/ received in the United States. If you are in need of emergency care outside of the United States or its territories, you should call the Blue Cross Blue Shield Global Core Program at 800-810-BLUE or collect at 804-673-1177. Representatives are available 24 hours a day, seven days a week, 365 days a year to assist you. When you are outside the United States or its territories, this plan provides coverage for emergency/urgent services only. This is a Supplemental Benefit and not a benefit covered under the federal Medicare program. For more coverage, you may have the option of purchasing additional travel insurance through an authorized agency.		\$100 copay for emergency care \$50 copay for urgently needed services \$250 copay per day for days 1-5 per admission for emergency inpatient care
Medicare Community Resource Support Need help with a specific issue? While your plan includes Medicare benefits along with the extra benefits outlined in this benefits chart, you may sometimes require more support. As a member, you have access to our Medicare Community Resource Support team. They are here to help you find community-based services and support programs in your area. To use this benefit, contact Member Services at the number on the back of your member ID card, and ask for the Medicare Community Resource Support team.		\$0 copay for Medicare Community Resource Support

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Healthy Meals* Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total). A portion of this benefit may be used to obtain meal replacement shakes. • A qualifying event includes when you are in a hospital or a skilled nursing facility and are discharged home. • This benefit also qualifies as a Special Supplemental Benefit for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. • For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in your plan's Evidence of Coverage. • Chronic condition meals, must be ordered or approved by a healthcare provider, and you must be part of a supervised program designed to transition you to a healthier lifestyle. You, or your provider can contact Member Services on the back of your member ID card and a representative will help with the process to validate you qualify for the benefit. If you qualify, we or an approved vendor acting on our behalf may contact you at the number you provided, to confirm shipping details and any nutritional requirements. We are unable to initiate your chronic condition meals without speaking to you. By requesting this benefit you are expressly authorizing us to contact you by telephone.		\$0 copay for Healthy Meals
Medicare-approved clinical research studies A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.		After Original Medicare has paid its share of the Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's cost sharing for like services. Any remaining plan cost sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Maximum out-of-pocket amount All copays, coinsurance, and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of routine hearing services, routine vision services, and the foreign travel emergency and urgently needed services copay or coinsurance amounts. The annual deductible and in-network copay and coinsurance amounts apply to both, the in-network and out-of-network medical plan out-of-pocket maximums. The out-of-network copay and coinsurance amounts apply only to the out-of-network medical plan out-of-pocket maximum. Part D prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.	\$6,700	\$10,000

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

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