CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

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2020 COVID-19 Endorsement

This endorsement is an amendment to the existing Evidence of Coverage that outlines the Benefits of your Medicare Advantage Plan.

In response to medical conditions associated with COVID-19 (coronavirus), the Centers for Medicare & Medicaid Services (CMS) has issued this information to address the obligations and permissible flexibilities related to the state of emergency declared by the Governor of the State of Nevada and the President of the United States resulting from COVID-19. If you have been exposed to, or are experiencing symptoms of the virus, it is essential to know as soon as possible whether you have the virus to limit exposure to others and to obtain any needed medical attention or treatment.

Accordingly, this endorsement changes the terms of the plan in the following manner:

1. Telehealth visits with your Primary Care Provider / Specialist will be covered at the same Copay as an in-person office visit.
2. Services rendered at an Out-of-Network Medicare Facility or Provider will be covered with the same Cost-sharing that would apply if the service was rendered at an in network Facility or Provider.
3. Members who have been evacuated from a nursing home, discharged from the hospital so care can be provided to more serious ill patients, or who need Skilled Nursing Facility Care due to COVID-19 will have Skilled Nursing Facility Care covered without having a 3 day inpatient hospital stay before being admitted to the Skilled Nursing Facility.
4. For members who have had treatment delayed while in a Skilled Nursing Facility due to COVID-19, and who were not able to complete care during the first 100 day benefit period, Senior Care Plus will cover up to an additional 100 days of Skilled Nursing Facility Care.

The special requirements outlined above will remain in effect until March 5, 2021 or until the state of emergency is otherwise terminated or extended.

Please contact Customer Service at 775-982-3112 or toll-free at 888-775-7003 for additional information. (TTY users should call the State Relay Service at 711). (We are not open 7 days a week all year round). Hours are 8:00 a.m. to 8:00 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. You can also visit our website at www.SeniorCarePlus.com

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Senior Care Plus Essential (HMO) Plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Customer Service.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B or by our plan (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of Senior Care Plus Essential (HMO) Plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2021 is **$3,400.** The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your Part D late enrollment penalty and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount). If you reach the maximum out-of-pocket amount of **$3,400**, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan also limits your out-of-pocket costs for certain types of services

As a member of Senior Care Plus Essential (HMO) Plan, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the

provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a prior authorization.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a prior authorization.)
- If you believe a provider has "balance billed" you, contact Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services Senior Care Plus Essential (HMO) Plan, covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2021* Handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. *Maximum of 20 visits per plan year*	**$30** copayment per visit and a max of 20 visits.

Services that are covered for you	**What you must pay** when you get these services
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is 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. No*n-emergency transportation between facilities requires prior-authorization (approval in advance) to be covered*	**$250** copayment for each one-way Medicare-covered ambulance trip. **$0** copayment for transportation between inpatient facilities. According to Medicare guidelines, emergency and non-emergency ambulance services are covered based on medical necessity. If your condition qualifies for coverage, you will pay the copayment listed above. If your condition does not meet Medicare criteria and you utilize the ambulance service, you will then be responsible for the entire cost.
Annual Physical Exam The Annual Physical Exam is a more comprehensive examination than an annual wellness visit. Annual Physical Exam includes comprehensive physical examination and evaluation of status of chronic diseases. Services will include the following: bodily systems examinations, such as heart, lung, head and neck, and neurological system; measurement and recording of vital signs such as blood pressure, heart rate, and respiratory rate; a complete prescription medication review; and a review of any recent hospitalizations. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests or diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. *Annual Physical Exam visits do not need to be scheduled 12 months apart but are limited to one each calendar year.*	You pay **$0** for an annual physical. If you receive services that address a medical condition during the same office visit, additional cost-share may apply

Services that are covered for you	**What you must pay** when you get these services
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Doesn't include lab tests, radiological diagnostics tests or non-radiological diagnostic tests or diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. **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" visit to be covered for annual wellness visits after you've had Part B for 12 months. *Annual Wellness visits do not need to be scheduled 12 months apart but are limited to one each calendar year.*	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	**What you must pay** when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months A screening mammography is used for the early detection of breast cancer in women who have no signs or symptoms of the disease. Once a history of breast cancer has been established, and until there are no longer any signs or symptoms of breast cancer, ongoing mammograms are considered diagnostic and are subject to cost sharing as described under Outpatient Diagnostic Tests and Therapeutic Services and Supplies in this chart. Therefore, the screening mammography annual benefits is not available for members who have signs or symptoms of breast cancer. *You may get this service on your own, without a referral from your PCP as long as you get it from a Plan provider.*	There is no coinsurance, copayment, or deductible for covered screening mammograms. You are covered for an unlimited number of screening mammograms when medically necessary. **$10** office visit copay may apply if the service is not considered preventative or if the member is outside of the age limit (40+) or usage limit (1 per 12 months).
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 referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. *Requires prior-authorization (approval in advance) to be covered*	**$10** copayment for Medicare-covered Intensive Cardiac Rehabilitation Services. **$15** copayment for Medicare-covered Cardiac Rehabilitation Services.

Services that are covered for you	**What you must pay** when you get these services
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 intensive behavioral therapy cardiovascular disease preventive benefit, preventive medicine counseling / risk factor reduction interventions for cardiovascular disease. **$10** office visit copay may apply if the services are not considered preventative.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. **$10** office visit copay may apply if the services are not considered preventative or if the member goes over the usage limit (once every 5 years).
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months *You may get these routine women's health services on your own, without a referral from your PCP as long as you get the services from a Plan provider*	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **$10** office visit copay may apply if the services are not considered preventative or if the member goes over the usage limit (once every 24 months).
Chiropractic services Covered services include: We cover only manual manipulation of the spine to correct subluxation.	**$20** copayment for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).

Services that are covered for you	**What you must pay** when you get these services
Colorectal cancer screening For people 45 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If you have a prior history of colon cancer, or have had polyps removed during a previous colonoscopy, ongoing colonoscopies are considered diagnostic and are subject to cost sharing as described under the outpatient surgery cost sharing in this chart. Therefore, the screening colonoscopy benefit is not available for members who have signs or symptoms prior to the colonoscopy. A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the outpatient surgery cost sharing described later in this chart.

Services that are covered for you	**What you must pay** when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: • Preventive dental services including 2 exams, 2 cleanings, and 2 set of bitewing x-rays per year. • Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. **Diagnostic and Preventive Services** are not subject to a calendar year deductible. **For additional information, please see the end of this section.** Delta Dental administers dental benefits on behalf of Senior Care Plus. *Refer to exclusions section and the end of Section 3 for more information on Preventive Dental.*	There is no copayment for diagnostic and preventive dental services (maximum of 2 visits per year). **$45** copayment for each visit for Medicare-covered dental services.
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 an annual depression screening visit. **$10** office visit copay may apply if the service is not considered preventative or if the member goes over the usage limit (one screening per year).

Services that are covered for you	**What you must pay** when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
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 • For people with diabetes who have severe diabetic foot disease: Orthopedic and Orthotic Devices o One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions *Orthopedic and Orthotic devices require prior-authorization (approval in advance) to be covered.*	There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self- management training preventive benefit. There is no cost for blood glucose monitors. **20%** coinsurance of the cost for each Medicare-covered Diabetes supply item received in a retail setting or through mail order.

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. 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 may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.SeniorCarePlus.com. Generally, the Senior Care Plus Essential (HMO) Plan covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to the Senior Care Plus Essential (HMO) Plan and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.) If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*) *Requires prior-authorization (approval in advance) to be covered if the cost is over $100.*	**20%** coinsurance of the cost for each Medicare-covered item.

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Coverage is available worldwide.	**$120** copayment for each Medicare-covered emergency room visit. You do not pay this amount if you are immediately admitted to the hospital within 24 hours. If you are admitted to a hospital, you will pay cost sharing as described in the "Inpatient Hospital Care" section in this benefit chart. If you are held for observation, the **Outpatient Observation** copayment applies. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the same cost sharing you would pay at a network hospital. In some cases, you may have to pay an additional copayment for the services provided by certain providers in the emergency room **$120** copayment for each Medicare-covered worldwide emergency room visit.
Fitness Benefit Senior Care Plus offers a gym membership at select gym facilities in our service area for active members enrolled in the Senior Care Plus Essential (HMO) Plan. Please visit www.SeniorCarePlus.com for information on signing up for this benefit or contact Customer Service at 775-982-3112. Participating facilities may change throughout the plan year.	There is no coinsurance, copayment, or deductible for members eligible for the fitness benefit.

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs Senior Care Plus offers written health education materials, including newsletters, as well as services of a certified health educator or other qualified health professional. We offer a number of educational and support programs for members to overcome the challenges presented through health conditions such as asthma or diabetes and to aid them in creating and adopting a healthy lifestyle. Nutrition and weight management services are offered by registered dieticians in the form of nutrition counseling (non-diabetes) and weight management courses. Nutrition education has no limit to the number of visits as long as medical necessity is met. Services may be in a group or individual setting, but generally one-on-one counseling	There is no coinsurance, copayment, or deductible for Medicare-covered health and wellness programs.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. We also cover one (1) routine hearing exam per year. You must see a TruHearing provider to use this benefit. Call 1-844-341-9614 to schedule an appointment.	**$45** for Medicare-covered diagnostic hearing and balance exams when medically necessary. **$45** copay for routine hearing exam (limit 1 per year) *Routine hearing exam copayments do not apply to the maximum out-of-pocket*.

Services that are covered for you	**What you must pay** when you get these services
Hearing Aids Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. Benefit is combined in and out-of-network. You must see a TruHearing provider to use this benefit. Call 1-844-341-9614 to schedule an appointment. Hearing aid purchases includes: • 3 provider visits within first year of hearing aid purchase • 45 day trial period • 3-year extended warranty • 48 batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries • Hearing aids that are not the TruHearing Advanced or Premium hearing aids • Hearing aid return fees • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan.	**$699** copayment per aid for Advanced hearing aids **$999** copayment per aid for Premium hearing aids *Hearing aid copayments do not apply to the maximum out-of-pocket.*
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.

Services that are covered for you	**What you must pay** when you get these services
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	There is no coinsurance, copayment, or deductible for each Medicare-covered home health visit.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services included, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	You pay **20%** coinsurance for Medicare-covered Home Infusion Therapy services.

Services that are covered for you	**What you must pay** when you get these services
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Senior Care Plus Essential (HMO) Plan. **$50** copayment for each specialist visit for hospice consultation services

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) For services that are covered by Senior Care Plus Essential (HMO) Plan but are not covered by Medicare Part A or B: Senior Care Plus Essential (HMO) Plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules • Shingles vaccine is covered under Part B if done during an office visit**.** We also cover some vaccines under our Part D prescription drug benefit. *Other vaccines require prior-authorization (approval in advance).*	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.

Inpatient hospital care

Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, observation and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.

Covered services include but are not limited to:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If the Senior Care Plus Essential (HMO) Plan provides transplant services at a location outside the pattern of care for transplants in your community, and you are approved to obtain transplants at this location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.

Preferred:

$275 per day for day(s) 1–5

$0 each day for day(s) 6-90 for a Medicare-covered stay at a network hospital.

Preferred facilities are facilities that provide inpatient, outpatient, and ambulatory services to members for a lower copayment than other in-network facilities.

Please refer to the online Provider Directory at www.SeniorCarePlus.com for a list of Preferred Facilities, please note that our providers may change. You may also contact Customer Service at 775-982-3112.

Non-Preferred:

$440 per day for day(s) 1–5

$0 each day for day(s) 6-90 for a Medicare-covered stay at a network hospital.

Non-Preferred facilities are in-network facilities that provide these services at a higher copayment amount.

For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

There are no additional copayments for inpatient

Services that are covered for you	**What you must pay** when you get these services
• Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. *Except in an emergency, your provider must obtain prior-authorization (approval in advance) to be covered.* *Transplant services to include the evaluation process requires prior-authorization (approval in advance) to be covered.*	hospital-acute services when readmitted to a contracted facility during a benefit period or within 60 days of last discharge. A benefit period begins on the first day you go to a Medicare covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. You may pay up to the maximum inpatient copayment for each benefit period If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the same cost-sharing you would pay at a network hospital.

Inpatient mental health care • Covered services include mental health care services that require a hospital stay. • There is a 190-day lifetime limit for inpatient services in a free-standing psychiatric hospital • The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. There is a 190-day lifetime limit for mental health care and substance abuse services provided in a free standing psychiatric hospital. The benefit is limited by prior partial or complete use of a 190-day lifetime treatment in a psychiatric hospital. The 190-day limit does not apply to mental health and substance abuse services provided in a psychiatric unit of a general hospital *Except in an emergency, your provider must obtain prior-authorization (approval in advance) to be covered.* *Transplant services to include the evaluation process requires prior-authorization (approval in advance) to be covered*	**Preferred:** **$275** per day for day(s) 1–5 **$0** each day for day(s) 6–90 for a Medicare-covered stay at a network hospital. Preferred facilities are facilities that provide inpatient, outpatient, and ambulatory services to members for a lower copayment than other in-network facilities. Please refer to the online Provider Directory at www.SeniorCarePlus.com for a list of Preferred Facilities, please note that our providers may change. You may also contact Customer Service at 775-982-3112. **Non-Preferred:** **$440** per day for day(s) 1–5 **$0** each day for day(s) 6–90 for a Medicare-covered stay at a network hospital. Non-Preferred facilities are in-network facilities that provide these services at a higher copayment amount. The 190-day lifetime limit does not apply to stays in a general acute care hospital. There are no additional copayments for inpatient hospital-acute services when readmitted to a contracted facility during a benefit period or within 60 days of last discharge. A benefit period begins on the first day you go to a Medicare covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any

Services that are covered for you	**What you must pay** when you get these services
	hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. You may pay up to the maximum inpatient copayment for each benefit period.

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:	When your stay is no longer covered, these services will be covered as described in the following sections:
• Physician services	Please refer below to Physician/ Practitioner Services, Including Doctor's Office Visits.
• 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	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	Please refer below to Prosthetic Devices and Related Supplies.
• Physical therapy, speech therapy, and occupational therapy *Physical therapy, speech therapy and occupational therapy over 20 visits per year requires prior-authorization (approval in advance) to be covered*	Please refer below to Outpatient Rehabilitation Services.

Services that are covered for you	**What you must pay** when you get these services
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 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Medicare Part B prescription drugs

These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens (for allergy shots)
- Chemotherapy Drugs
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

The drug that is prescribed for you under this Part B Prescription Drug Benefit may have a requirement for **"step therapy."** This requirement encourages you and your provider to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**step therapy**."

Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.

20% coinsurance for all drugs covered under Original Medicare.

There is no benefit limit on drugs covered under original Medicare.

Additionally, for the administration of that drug, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/ Practitioner Services, Including Doctor's Office Visits" or "Outpatient Hospital Services" in this benefit chart) depending on where you received drug administration or infusion services. You pay these amounts until you reach the Medical out-of-pocket maximum

<u>These prescription drugs are covered under Part B and not covered under the Medicare Prescription Drug Program (Part D) and therefore do not apply to your Medicare Part D out- of-pocket maximum.</u>

Services that are covered for you	**What you must pay** when you get these services
Requires prior-authorization (approval in advance) to be covered.	
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 preventive obesity screening and therapy.
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing *Requires prior-authorization (approval in advance) to be covered.*	**$50** copayment for each Medicare-covered Opioid Treatment Program Service

Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Bone Marrow Services • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests – Non-radiological diagnostic services including but not limited to, Sleep Studies, EKG, Vascular Studies, Stress Tests, and Breathing Capacity Tests. • Other outpatient diagnostic tests – Radiological diagnostic services, not including x-rays, including but not limited to, Ultrasounds, Nuclear Cardiac Imaging, PET, MRI and CT Scans. **Note:** There is no separate charge for medical supplies routinely used in the course of an office visit (such as bandages, cotton swabs and other routine supplies.) However, supplies for which an appropriate separate charge is made by providers (such as, chemical agents used in certain diagnostic procedures) are subject to cost-sharing as shown. If diagnostic services are performed in the office, the greater of an office visit copayment or diagnostic service copayment will apply. If multiple diagnostic tests are performed on the same day by the same provider, only the highest copayment will be charged. Facility copayment applies for diagnostic tests performed in a Same-Day Surgery (SDS) facility or Ambulatory Surgery Center (ASC) *Radiation Therapy requires prior-authorization (approval in advance) to be covered.*	You pay a **$70** copayment for Medicare-covered X-rays. You will only pay one copayment per day even if multiple X-rays are performed. You pay a **$60** copayment for Medicare-covered Radiation Therapy visits. You pay **$0** for Medicare-covered surgical supplies. Your copayments for Bone Marrow Services will vary depending on the type and site of service. You pay **$0** for Medicare-covered laboratory services. This copayment does not apply to blood draws or INR testing (anti-coagulant testing). You pay a **$275** copayment for Medicare-covered Sleep Studies and Stress Tests. You pay a **$100** copayment for Medicare-covered CT Scans, Vascular Studies and Breathing Capacity Tests. You pay a **$135** copayment for MRI's, PET Scans, and Nuclear Medicine. You pay a **$120** copayment for INR Test Strips and Specialty Genetic Testing. You pay **$0** for Medicare-covered blood services. You pay **$0** for EKGs, including Pre-Operative EKGs. You will only pay one copayment per day even if multiple tests are performed. If you have multiple services

Services that are covered for you	**What you must pay** when you get these services
	performed by different providers, separate cost-sharing will apply. You pay a **$275** copayment for non-preventative flexible sigmoidoscopies that are performed during an outpatient visit.
Outpatient Hospital Observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**Preferred:** **$275** copayment for each Medicare-covered Outpatient Hospital Observation services. Preferred facilities are facilities that provide inpatient, outpatient, and ambulatory services to members for a lower copayment than other in-network facilities. Please refer to the online Provider Directory at www.SeniorCarePlus.com for a list of Preferred Facilities, please note that our providers may change. You may also contact Customer Service at 775-982-3112. **Non-Preferred:** **$440** copayment for each Medicare-covered Outpatient Hospital Observation services. Non-Preferred facilities are in-network facilities that provide these services at a higher copayment amount.

Outpatient hospital services

We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Covered services include, but are not limited to:

- Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery
- Laboratory and diagnostic tests billed by the hospital
- Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Certain drugs and biologicals that you can't give yourself
- Outpatient Infusion Therapy, does not include the cost of drugs

For the drug that is infused, you will pay the cost-sharing as described in "Medicare Part B Prescription Drugs" in this benefit chart. In addition, for the administration of infusion therapy drugs, you will pay the cost-sharing that applied to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" or "Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers" in this benefit chart) depending on where you received drug administration or infusion services.

Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at

Preferred:

$275 copayment for each Medicare-covered visit to an ambulatory surgical center or outpatient hospital facility for hospital services.

Preferred facilities are facilities that provide inpatient, outpatient, and ambulatory services to members for a lower copayment than other in-network facilities.

Please refer to the online Provider Directory at www.SeniorCarePlus.com for a list of Preferred Facilities, please note that our providers may change. You may also contact Customer Service at 775-982-3112.

Non-Preferred:

$440 copayment for each Medicare-covered visit to an ambulatory surgical center or outpatient hospital facility for hospital services.

Non-Preferred facilities are in-network facilities that provide these services at a higher copayment amount.

Biopsy, exploration and removal of foreign bodies and or polyps when undergoing a preventative colonoscopy have a copayment of **$0**. Copayment for outpatient surgery or procedures done in a SDS facility will take the Preferred or Non-Preferred copay. If non preventive Colonoscopies and endoscopies are performed during visit, the corresponding Preferred or Non-Preferred Outpatient Services copayment applies.

Services that are covered for you	**What you must pay** when you get these services
https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. *Requires prior-authorization (approval in advance) to be covered.*	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**$40** copayment for each Medicare-covered individual/group therapy visit.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). *Requires prior-authorization (approval in advance) to be covered over 20 visits per calendar year or if provided at an inpatient or skilled facility if skilled benefits have been exhausted.*	**$20** copayment for each Medicare-covered physical therapy, occupational therapy, and speech language therapy visit. **$20** copayment for each CORF visit.

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance abuse services Covered services include: Substance abuse services provided from a Medicare-participating provider or facility as allowed under applicable state laws for treatment of alcoholism and drug abuse in an outpatient setting if services are medically necessary. Coverage under Medicare Part B is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.	**$50** copayment for each Medicare-covered individual/group therapy visit.

Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an outpatient, you should ask your doctor of the hospital staff. If you receive any services or item other than surgery, including but not limited to diagnostic tests, therapeutic services, prosthetics, orthotics, supplies or Part B drugs, there may be additional cost sharing for those services or items. Please refer to the appropriate service or item you received for the specific cost sharing required. *Requires prior-authorization (approval in advance) to be covered.*	**Preferred:** You pay **$275** per visit for outpatient procedures and services, including but not limited to diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital or ambulatory surgical center. Preferred facilities are facilities that provide inpatient, outpatient, and ambulatory services to members for a lower copayment than other in-network facilities. Please refer to the online Provider Directory at www.SeniorCarePlus.com for a list of Preferred Facilities, please note that our providers may change. You may also contact Customer Service at 775-982-3112. **Non-Preferred:** You pay **$440** per visit for outpatient procedures and services, including but not limited to diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital or ambulatory surgical center. Non-Preferred facilities are in-network facilities that provide these services at a higher copayment amount. Refer to "Colorectal Screening" in this chart for cost-sharing you pay for colorectal screening procedures. You pay no outpatient surgery copayment if you are admitted as an inpatient to the hospital for the same condition within 24

Services that are covered for you	**What you must pay** when you get these services
	hours after an outpatient procedure or surgery (refer to "Inpatient Hospital Care" in this chart for the hospital cost-share that applies instead). If you are held for observation, the copayment still applies. You pay these amounts until you reach the out-of-pocket maximum.
Over the counter (OTC) drugs Items as a supplement benefit under Part C. Over-the-counter drugs, medications and other substances, which do not require a prescription, even if ordered by a physician are included. Service specific Maximum Plan benefit coverage amount. Covers all of the OTC list which is found in chapter 4 of the Medicare Managed care Manual.	Max plan benefit coverage amount **$25** per quarter.
Partial hospitalization 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 is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. *Requires prior-authorization (approval in advance) to be covered.*	**$45** copayment for each Medicare-covered visit.

Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare. Specific Part B service(s) the plan has identified as clinically appropriate to furnish through electronic exchange when the provider is not in the same location as the enrollee. • Certain additional telehealth services, including for: Dermatology and Urgent Care are provided through Senior Care Plus' Preferred Virtual Visit vendor, Teladoc. o You have the option of getting through 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. • Telehealth services for monthly ESRD-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 for diagnosis, evaluation or treatment of symptoms of an acute stroke o Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o You're not a new patient and o The check-in isn't related to an office visit in the past 7 days and o The Check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Evaluation video and/or images send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: o You're not a new patient and	**$0** copayment per visit to a preferred PCPs Medicare covered services. **$10** copayment per visit to all non-preferred PCPs for Medicare covered services. **$10** copayment per visit to Convenient Care Facilities. **$50** copayment for each specialist visit for Medicare-covered services. **$0** copayment for Dermatology Services provided Senior Care Plus's preferred Virtual Visit vendor, Teladoc. No referral is required from your PCP to visit a specialist on the plan. If diagnostic services are performed in the office, the greater of an office visit copay or diagnostic service copay will apply

Services that are covered for you	**What you must pay** when you get these services
o The evaluation isn't related to an office visit in the past 7 days and o 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 **if** you're not a new patient • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) covered by Medicare Covered Guidance • Teladoc is Senior Care Plus preferred Virtual Visit vendor. To access the platform, please navigate to the following website, member.teladoc.com/signin to register your account. You may also contact Customer Service or Teladoc directly, 1-800-835-2362, for more information on how to use these services. No prior authorization required for Teladoc.	

Services that are covered for you	**What you must pay** when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	**$50** copayment for each Medicare-covered visit in an office or home setting. For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for each Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test. Diagnostic PSA exams are subject to cost sharing as described under Outpatient Diagnostic Tests and Therapeutic Services and Supplies in this chart. **$10** office visit copay may apply if the services are not considered preventative or if the member goes over the usage limit (once every 12 months).

Services that are covered for you	**What you must pay** when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. **Medical Supplies** Medically necessary items or other materials that are used once, and thrown away, or somehow used up. Includes but not limited to: catheters, gauze, surgical dressing supplies, bandages, sterile water, and tracheostomy supplies. *Prosthetic devices require prior-authorization (approval in advance) to be covered.*	**20%** coinsurance for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies. You pay **20%** coinsurance for Medicare-covered medical supplies.
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 the chronic respiratory disease. Medicare covers up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of pulmonary rehabilitation services.	**$15** copayment for each Medicare-covered Pulmonary Rehabilitation visit.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 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.

Services that are covered for you	**What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.
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 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Services to treat 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, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs." *Dialysis services require prior-authorization (approval in advance) to be covered.*	**20%** coinsurance of the cost for Medicare-covered renal dialysis services. Dialysis treatments while you are an inpatient are included in your inpatient hospital care copayment.

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • 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 will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital *Requires prior-authorization (approval in advance) to be covered.*	**$20** copayment each day for day(s) 1–20 for a stay at a Skilled Nursing Facility. **$150** copayment each day for day(s) 21–34 for a stay at a Skilled Nursing Facility. **$0** copayment each day for days 35–100 for a stay at a Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. A benefit period begins on the first day you go to a Medicare covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Services that are covered for you	**What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. *Requires prior-authorization (approval in advance) to be covered.*	**$15** copayment for Medicare-covered Supervised Exercise Therapy (SET).

Services that are covered for you	**What you must pay** when you get these services
Tele-monitoring Services Tele-monitoring includes remote patient monitoring, equipment to track vital signs at home or ambulatory healthcare that allows members to use a mobile medical device to perform a routine test and send the test data to a healthcare professional in real time. Tele-monitoring services are provided for patients with a diagnosis of Congestive Heart Failure and services are tracked daily.	There is no coinsurance, copayment, or deductible for Medicare-covered tele-monitoring services.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Covered services include urgently needed services obtained at a retail walk-in clinic or an urgent care center. Worldwide coverage for 'urgently needed services' when medical services are needed right away because of an illness, injury, or condition that you did not expect or anticipate, and you can't wait until you are back in our plans service area to obtain services. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. This coverage is available worldwide.	**$30** copayment for each Medicare-covered urgently needed care visit at a "preferred facility." **$65** copayment for each Medicare-covered urgently needed care visit at a "non-preferred" facility. **$65** copayment for Worldwide coverage of urgently needed services received outside of the United States.
Teladoc is Senior Care Plus' preferred Virtual Visit vendor. To access the platform, please navigate to the following website to register your account, https://member.teladoc.com/signin. You may also contact Customer Service or Teladoc directly, 1-800-835-2362, for more information on how to use these services. No prior authorization required for Teladoc. Dispatch Health is a Senior Care Plus preferred at home urgent care vendor. Dispatch Health can be reached by calling 775-419-2710 8AM to 8PM every day. You can learn more about Dispatch Health at www.dispatchhealth.com	**$0** copayment for Virtual Urgent Care visits through Senior Care Plus's preferred Virtual Visit vendor, Teladoc. **$30** copayment for each Medicare-covered urgently needed care visit at a "preferred facility."

Services that are covered for you	**What you must pay** when you get these services
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • One (1) routine eye exam per year. Yearly allowance towards the purchase of a complete set of eyeglasses or contact lenses.	**$20** for each Medicare-covered eye exam (diagnosis and treatment for disease and conditions of the eye). **20%** coinsurance of the Medicare-approved amount for one pair of eyeglasses or one set of contact lenses after each cataract surgery with an intraocular lens. **$25** for each yearly routine eye exam. Up to a **$150** yearly allowance towards the purchase of a complete set of eyeglasses or contact lenses.
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests or diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. There is no coinsurance, copayment, or deductible for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit. Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies for other EKG's.

Services that are covered for you	**What you must pay** when you get these services
Wound Therapy Requires prior-authorization (approval in advance) to be covered to be covered over 12 visits per calendar year. All Biological Skin Therapies and Hyperbaric Therapy wound therapy requires prior-authorization to be covered.	**$20** copayment for each Medicare-covered wound therapy visit.

Delta Dental administers your preventive dental benefit on behalf of Senior Care Plus.

Delta Dental contracts with licensed dentists who participate in other dental plans offered by Delta Dental. Not all of these dentists agree or contract with Delta Dental to be a Participating Provider in this Plan. We therefore highly recommend that you verify that the dentist you select is a Participating Provider in this dental Plan before each appointment. The dentist may be under contract for another Delta Dental benefits plan but not necessarily this Plan for Hometown Health's Medicare Advantage beneficiaries.

Covered services include -

1. Diagnostic: Procedures to aid the Provider in determining required dental treatment.
2. Preventive: Regular cleanings.

The Plan will pay Benefits only for covered services. The Plan covers several categories of dental services when a Participating Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with Delta Dental's standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. Delta Dental may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and Exclusions will be applied for the period during which you are a Member of the Plan.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Plan. Even if the dentist bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Coinsurance

The Plan will pay a percentage of the Maximum Plan Allowance for covered services, as shown in Attachment A and you are responsible for paying the remaining percentage of Maximum Plan Allowance as well as any additional Cost-sharing. The percentage of the Maximum Plan Allowance you are required to pay is called the coinsurance ("Coinsurance"). The Co-insurance

is part of your out- of-pocket cost. You pay these even after a Deductible, if any, has been met. In addition to the Coinsurance, and any remaining Deductible, you may be required to pay any amount in excess of your Maximum Amount and the cost of any non-covered services. This is what we mean by Cost-sharing.

The amount of your Coinsurance will depend on the type of service you receive. Participating Providers are required to collect Coinsurance for covered services. Coinsurance is a method of sharing the costs of providing dental Benefits. If the Participating Provider discounts, waives or rebates any portion of the Coinsurance to you, the Plan will be obligated to provide as Benefits only the applicable percentages of the Maximum Plan Allowance reduced by the amount of the fees or allowances that are discounted, waived or rebated.

Maximum Amount

Most dental programs have a maximum amount. A maximum amount ("Maximum Amount" or "Maximum") is the total dollar amount the Plan will pay toward the cost of dental care. You are responsible for paying costs above this amount. The Maximum Amount payable, if any, is shown in Attachment A. The Maximum Amount may apply on a yearly basis, a per services basis, or a lifetime basis.

Pre-Treatment Estimate

Pre-Treatment Estimate requests are not required; however, your Participating Provider may file a Claim Form with Delta Dental before beginning treatment, showing the services to be provided to you. Delta Dental will estimate the amount of Benefits payable under the Plan for the listed services. By asking your dentist for a Pre-Treatment Estimate from Delta Dental before you agree to receive any prescribed treatment, you will have an estimate up front of what the Plan will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Plan when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date the Plan terminates;
- the date Benefits under the Plan are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage ends; or
- the date the Participating Provider's agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount the Plan will pay if you are enrolled and meet all the requirements of the Plan program at the time the treatment you have planned is completed. It may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

SELECTING YOUR PROVIDER

Free Choice of Dentist within Network

We recognize that many factors affect the choice of dentist and therefore support your right to freely choose your treating dentist within your network. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Participating Provider for your covered treatment. In addition, you can see different Participating Providers within your network.

Remember, you may only receive benefits for covered services provided by a Participating Provider. In order to receive Benefits under this Plan, the dental care you receive must be covered services and they must be provided by a Participating Provider. The Plan does not pay Benefits for dental care that are not covered services and to be entitled to Benefits for covered services they must be provided by a Participating Provider, unless the services are provided in an emergency. We highly recommend you verify that the dentist is a Participating Provider in this dental before each appointment. Review the section titled "How Claims Are Paid" for an explanation of payment procedures to understand the method of payments applicable to your Participating Provider selection.

Locating a Delta Dental Participating Provider

There are two ways in which you can locate a Participating Provider near you:

- You may access information through Hometown Health website; or
- You may also call Delta Dental's Customer Service Center toll-free at (855) 643-8513 and a representative will assist you. Delta Dental can provide you with information regarding a Delta Dental Participating Provider's specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — Participating Provider

Selecting a Participating Provider allows the Member to obtain Benefits for covered services performed for you. Payment to a Participating Provider is calculated based on the Maximum Plan Allowance. Participating Providers agree to accept Delta Dental's Maximum Plan Allowance as payment in full for covered services which means you will only be responsible for any applicable Cost Sharing for the covered service.

The portion of the Maximum Plan Allowance payable by the Plan is limited to the applicable Plan Benefit Level shown in Attachment A. The Plan's payment is sent directly to the Participating Provider who submitted the claim. Delta Dental will advise you of any charges not payable by the Plan for which you are responsible. These Cost Sharing charges are generally your share of the Maximum Plan Allowance (Coinsurance), as well as any Deductibles, charges where the Maximum Amount has been exceeded, and/or charges for non-covered services.

Payment for Services – Non Participating Provider

Except in the case of an emergency where a Participating Provider is not available to provide you with care you need, the Plan does not pay any Benefits for dental services (regardless of whether

they are covered services) if the services are provided by a Non Participating Provider. You will be solely responsible for any dental care provided by a Non Participating Provider.

Delta Dental contracts with licensed dentists who participate in other dental plans offered by Delta Dental. Not all of these dentists agree or contract with Delta Dental to be a Participating Provider in this Plan. We therefore highly recommend that you verify that the dentist you select is a Participating Provider in this dental Plan before each appointment. The dentist may be under contract for another Delta Dental benefits plan but not necessarily this Plan for Hometown Health's Medicare Advantage beneficiaries.

How to Submit a Claim

Delta Dental does not require special claim forms. However, most dental offices have Claim Forms available. Participating Providers, PPO Providers and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and send it to:

Delta Dental Insurance Company
P.O. Box 1809 Alpharetta, GA 30023

CLAIMS APPEAL

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Participating Providers to the courtesy extended you by Delta Dental's telephone representatives. If you have any question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Participating Provider, you have the right to file a grievance or appeal with Hometown Health at (888) 775-7003

SECTION 3 What services are not covered by the plan?

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

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	**Not covered under any condition**	**Covered only under specific conditions**
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Surgical treatment for morbid obesity.		✓ Covered only when medically necessary.
Private room in a hospital.		✓ Covered only when medically necessary.
Private duty nurses.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic and reconstructive surgery or procedures		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Elective hysterectomy, tubal ligation, or vasectomy, if the primary indication for these procedures is sterilization. Reversal of sterilization procedures, penile vacuum erection devices, or nonprescription contraceptive supplies.	✓	
Radial keratotomy, LASIK surgery, other low vision aids and custom Cataract lenses	Radial keratotomy, LASIK surgery, other low vision aids and Custom Cataract lenses are not covered under the plan	✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Replacements for broken, lost or stolen lenses, contact lenses or frames. Any additional service required outside basic vision analyses for contact lenses, except fitting fees. Regardless of Optical Necessity, benefits are not available more frequently than that which is specified in the Master Application. Allowances are one-time use benefits; no remaining balance. Discounts do not apply for benefits provided by other group benefit plans.	✓	
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Naturopath services (uses natural or alternative treatments).	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including but not limited to home and car remodeling or modification, and exercise equipment.	✓	
Immunizations for foreign travel purposes.	✓	
Substance abuse detoxification and rehabilitation.		✓ May be covered with Case Review
Requests for payment (asking the plan to pay its share of the costs) for covered drugs sent after 36 months of getting your prescription filled.	✓	
Equipment or supplies that condition the air, heating pads, hot water bottles, wigs, and their care, support stockings and other primarily non-medical equipment.	✓	
Services provided to veterans in Veterans Affairs (VA) facilities.		✓ When emergency services are received at VA hospital and the VA (cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services that you get from non-plan providers		✓ Care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, and care from non-plan providers that is arranged or approved by a plan provider is covered.
Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service. You do not need a referral to make an office visit appointment with a Specialist who participates in the plan in the plans service area.	✓	
Services that you get without prior authorization, when prior authorization is required for getting that service (this booklet gives a definition of prior authorization and tells which services require prior authorization).	✓	Services that you get without prior authorization, when prior authorization is required for getting that service (this booklet gives a definition of prior authorization and tells which services require prior authorization).
Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See previous sections for more information about getting care for a medical emergency).	✓	
Counseling or referral services that our Plan objects to base on moral or religious grounds. In the case of our Plan, we won't give counseling or referral services related to advance directives related to withholding nutrition/treatment, etc.		✓ To the extent these services are covered by Medicare, they will be covered under the Original Medicare Plan.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Prescription medications, including but not limited to, compound medications		✓ These prescriptions will only be covered if they are covered under Medicare Part A or B.
Transplants unless specifically designated as a Medicare benefit, and services rendered to an organ donor. Transplant services are subject to all of Original Medicare's coverage policies.		✓ If a member of the plan is the recipient of the organ, the transplant or service will be covered.
Equipment or supplies that condition the air, heating pads, hot water bottles, wigs, and their care, support stockings and other primarily non-medical equipment.	✓	
Routine hearing exams, hearing aids, or exams to fit hearing aids.	✓	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Naturopath services (uses natural or alternative treatments).	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.