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## **Chapter 4. Medical benefits chart (what is covered and what you pay)**

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

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This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that gives a list of your covered services and tells how much you will pay for each covered service as a member of ODS Advantage PPORX. Later in this chapter, you can find information about medical services that are not covered.

<b>Section 1.1      What types of out-of-pocket costs do you pay for your covered services?</b>
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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”** means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service.
- **“Coinsurance”** means that you pay a percent of the total cost of a medical service. You pay a coinsurance at the time you get the medical service.

Some people qualify for programs to help them pay their out-of-pocket costs for Medicare. If you are enrolled in these programs, you may still have to pay the Medicaid copayment, depending on the rules in your state.

<b>Section 1.2      What is the maximum amount you will pay for certain covered medical services?</b>
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There is a limit to how much you have to pay out-of-pocket for certain covered health care services each year. After this level is reached, you will have 100% coverage and not have to pay any out of pocket costs for the remainder of the year for covered services. You will have to continue to pay your premium if your plan has a premium. All of your copayments and coinsurance amounts for in and out of network count towards your maximum out of pocket of \$2,500.

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

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<b>Section 2.1      Your medical benefits and costs as a member of the plan</b>
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The medical benefits chart on the following pages lists the services ODS Advantage PPORX covers and what you pay for each service. The services listed in the Medical Benefits Chart are covered only when all coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Except in the case of preventive services and screening tests, your services (including medical care, services, supplies, and equipment) *must* be medically necessary. Medically necessary means that the services are an accepted treatment for your medical condition.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other in network provider gets approval in advance (sometimes called “prior authorization”) from ODS Advantage PPORX. Covered services that need approval in advance are marked in the Medical Benefits Chart with the words “prior authorization required”.
- Prior authorization is only required for services obtained from a network provider. You never need prior authorization for out-of-network services from out-of-network providers.

Services that are covered for you

**What you must pay** when you get these services for both **In and Out of Network**

## Inpatient Care

### Inpatient hospital care

Covered services include:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- 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. If you are sent outside of your community for a transplant, 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 only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used.
- Physician Services

### **Prior Authorization required for in network services**

\$400 copayment per admission is applied each benefit period

\$0 copayment for additional days

No limit to the number of days covered by the plan each benefit period

If you get authorized inpatient care at a non-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services for both In and Out of Network
<p><b>Inpatient mental health care</b></p> <ul style="list-style-type: none"> <li>Covered services include mental health care services that require a hospital stay. 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.</li> </ul>	<p><b>Prior Authorization required for in network services</b></p> <p>\$400 copay per admission is applied each benefit period</p>
<p><b>Skilled nursing facility (SNF) care</b></p> <p>(For a definition of “skilled nursing facility,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>A 2-day inpatient hospital stay is required for each covered SNF stay. You are covered for 100 days each benefit period.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>Semiprivate room (or a private room if medically necessary)</li> <li>Meals, including special diets</li> <li>Regular nursing services</li> <li>Physical therapy, occupational therapy, and speech therapy</li> <li>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.)</li> <li>Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used.</li> <li>Medical and surgical supplies ordinarily provided by SNFs</li> <li>Laboratory tests ordinarily provided by SNFs</li> <li>X-rays and other radiology services ordinarily provided by SNFs</li> <li>Use of appliances such as wheelchairs ordinarily provided by SNFs</li> <li>Physician services</li> </ul>	<p><b>Prior Authorization required for in network services</b></p> <p>Days 1-20: \$0 copay for each day</p> <p>Days 21 – 100: \$50 copay for each day</p> <p>A 2-day prior inpatient hospital stay is required for each SNF stay.</p> <p>You are covered for 100 days each benefit period.</p>

Services that are covered for you	What you must pay when you get these services for both In and Out of Network
<p>Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> <li>• 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).</li> <li>• A SNF where your spouse is living at the time you leave the hospital.</li> </ul>	
<p><b>Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Physician services</li> <li>• Tests (like X-ray or lab tests)</li> <li>• X-ray, radium, and isotope therapy including technician materials and services</li> <li>• Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations</li> <li>• 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</li> <li>• 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</li> </ul>	<p>\$20 copay for PCP/\$30 copay for specialist</p> <p>\$10 copay for x-rays</p> <p>10% to \$100 maximum copay for MRI/CT/CAT/PET <b>(Prior auth required for in network services)</b></p> <p>\$30 copay for radiation therapy</p> <p>Prosthetics \$10 copay <b>(Prior auth required for in network services)</b></p> <p>DME 10% coinsurance <b>(Prior auth required for in network services)</b></p>

Services that are covered for you	What you must pay when you get these services for both In and Out of Network
<ul style="list-style-type: none"> <li>Physical therapy, speech therapy, and occupational therapy</li> </ul>	<p>PT/ST/OT \$20 copay  <b>(Prior Authorization required for in network services)</b></p>
<p><b>Home health agency care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>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)</li> <li>Physical therapy, occupational therapy, and speech therapy</li> <li>Medical social services</li> <li>Medical equipment and supplies</li> </ul>	<p><b>Prior authorization required for all services in this category in network</b></p> <p>No copay for home health services</p> <p>\$20 copay for PT/OT/ST</p> <p>10% coinsurance for DME supplies</p>
<p><b>Hospice care</b></p> <p>You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include:</p> <ul style="list-style-type: none"> <li>Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare</li> <li>Home care</li> </ul>	<p>When you enroll in a Medicare-certified hospice program, your hospice services are paid for by Original Medicare, not ODS Advantage PPORX</p>

Services that are covered for you	What you must pay when you get these services for both In and Out of Network
<b>Outpatient Services</b>	
<p><b>Physician services, including doctor's office visits</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center</li> <li>• Consultation, diagnosis, and treatment by a specialist</li> <li>• Hearing and balance exams, if your doctor orders it to see if you need medical treatment.</li> <li>• Telehealth office visits including consultation, diagnosis and treatment by a specialist</li> <li>• Second opinion prior to surgery</li> <li>• Outpatient hospital services</li> <li>• 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.</li> </ul>	<p>\$20 copay for PCP</p> <p>\$30 copay for specialist                  \$20 copay for Audiologist</p> <p>10% up to a maximum \$400 copay for outpatient or ASC services</p> <p>\$400 copay for inpatient services  <b>(Prior auth required in network services)</b></p>
<p><b>Chiropractic services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Manual manipulation of the spine to correct subluxation</li> </ul>	<p><b>Prior authorization required for in network services</b></p> <p>\$20 copay</p>
<p><b>Podiatry services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li> </ul>	<p>\$20 copay</p>

Services that are covered for you	What you must pay when you get these services for both In and Out of Network
<ul style="list-style-type: none"> <li>Routine foot care for members with certain medical conditions affecting the lower limbs.</li> </ul>	
<p><b>Outpatient mental health care</b></p> <p>Covered services include:</p> <p>Mental health services provided by a 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.</p>	<p>\$30 copay for each individual therapy visit</p> <p>\$20 copay for each group therapy visit</p>
<p><b>Partial hospitalization services</b></p> <p>“Partial hospitalization” is a structured program of active treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>\$20 copay</p>
<p><b>Outpatient substance abuse services</b></p>	<p>\$30 copay for each individual therapy visit</p> <p>\$20 copay for each group therapy visit</p>
<p><b>Outpatient surgery, including services provided at ambulatory surgical centers</b></p>	<p>10% up to a maximum \$400 for outpatient services and ambulatory surgical centers (ASC)</p>
<p><b>Ambulance services</b></p> <ul style="list-style-type: none"> <li>Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose</li> </ul>	<p>You pay \$50 copay for Medicare covered ambulance services</p>

Services that are covered for you	What you must pay when you get these services for both <b>In and Out of Network</b>
<p>medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.</p> <ul style="list-style-type: none"> <li>• Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.</li> </ul>	<p>\$50 copay applies to each one-way trip</p>
<p><b>Emergency care</b>                      Available Worldwide</p>	<p>\$50 copay</p> <p>Your copay is waived if your are admitted to the hospital within 24 hours of being seen for the same condition</p> <p>If you need inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost-sharing you would pay at a network hospital.</p>
<p><b>Urgently needed care</b></p>	<p>\$20 copay</p>



Services that are covered for you	What you must pay when you get these services for both In and Out of Network
<p>inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease. Coverage includes fitting.</p> <ul style="list-style-type: none"> <li>• Self-management training is covered under certain conditions</li> <li>• For persons at risk of diabetes: Fasting plasma glucose tests. Up to 2 tests per year not less than 6 months apart.</li> </ul>	<p>\$10 copay for self management training                      \$0 copay for fasting glucose tests (office visit copay may apply)</p>
<p><b>Medical nutrition therapy</b></p> <p>For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.</p>	<p>\$10 copay</p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation therapy</li> <li>• Surgical supplies, such as dressings</li> <li>• Supplies, such as splints and casts</li> <li>• Laboratory tests</li> <li>• Blood. Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need.</li> <li>• Other outpatient diagnostic tests</li> </ul>	<p>office visit, in or out patient copays apply to all of the following services:</p> <p>\$10 copay for each x-ray</p> <p>\$30 copay for Radiation therapy</p> <p>\$0 copay for lab tests                      \$0 copay for blood</p> <p><b>Prior authorization required for in network MRI/CT/CAT/SPECT and Nuclear Cardiology studies 10% up to a maximum \$100 copay per procedure</b></p>

Services that are covered for you	What you must pay when you get these services for both In and Out of Network
<p><b>Vision care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Outpatient physician services for eye care.</li> <li>• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year</li> <li>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</li> <li>• One routine vision exam every two years</li> </ul>	
	<p>\$30 copay for specialist office visit</p> <p>\$0 copayment for glaucoma screening test</p> <p>\$0 copay for corrective lenses/frames</p> <p>\$30 copay for routine vision exam</p>
<p><b>Preventive Care and Screening Tests</b></p>	
<p><b>Abdominal aortic aneurysm screening</b></p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your physical exam.</p>	
	<p>\$0 copay</p>
<p><b>Bone mass measurement</b></p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years 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.</p>	
	<p>\$20 copay</p>
<p><b>Colorectal screening</b></p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</li> </ul>	
	<p>\$0 copay for each lab or colorectal screening</p> <p>office visit copay may apply</p>

Services that are covered for you	What you must pay when you get these services for both In and Out of Network
<ul style="list-style-type: none"> <li>Fecal occult blood test, every 12 months</li> </ul> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>Screening colonoscopy (or screening barium enema as an alternative) every 24 months</li> </ul> <p>For people not at high risk of colorectal cancer, we cover:</p> <p>Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy</p>	<p>10% up to \$400 maximum copay for procedures in an outpatient hospital or ASC</p>
<p><b>Immunizations</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>Pneumonia vaccine</li> <li>Flu shots, once a year in the fall or winter</li> <li>Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li> <li>Other vaccines if you are at risk</li> </ul> <p>We also cover some vaccines under our outpatient prescription drug benefit.</p>	<p>\$0 copay for flu and pneumonia vaccines</p> <p>10% coinsurance for Hepatitis B and other vaccines</p>
<p><b>Mammography screening</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>One baseline exam between the ages of 35 and 39</li> <li>One screening every 12 months for women age 40 and older</li> </ul>	<p>\$20 copay</p>
<p><b>Pap test, pelvic exams, and clinical breast exams</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 12 months</li> <li>If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age:one Pap test every 12 months</li> </ul>	<p>\$0 copay for tests and exams</p> <p>PCP or specialist office visit copay may apply</p>

Services that are covered for you	What you must pay when you get these services for both In and Out of Network
<p><b>Prostate cancer screening exams</b></p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> <li>• Digital rectal exam</li> <li>• Prostate Specific Antigen (PSA) test</li> </ul>	<p>\$0 copay for tests and exams</p> <p>PCP or specialist office visit copay may apply</p>
<p><b>Cardiovascular disease testing</b></p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Covered once every five years.</p>	<p>\$0 copay for tests and exams</p> <p>PCP or specialist office visit copay may apply</p>
<p><b>Physician exams</b></p> <p>One Routine physical exam per year. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests.</p>	<p>\$0 copay</p> <p>Limited to one routine exam per year</p>
<p><b>Other Services</b></p>	
<p><b>Dialysis (kidney)</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)</li> <li>• Inpatient dialysis treatments (if you are admitted to a hospital for special care)</li> <li>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li> </ul>	<p><b>Prior authorization is required for all in network services in this category</b></p> <p>10% coinsurance for outpatient dialysis</p> <p>\$400 copay for in patient services per benefit period</p> <p>\$20 copay for self dialysis training</p>

Services that are covered for you	What you must pay when you get these services for both In and Out of Network
<ul style="list-style-type: none"> <li>• Home dialysis equipment and supplies</li> <li>• 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)</li> </ul>	<p>10% coinsurance for home dialysis equipment                  \$0 copay for support services</p>
<p><b>Medicare Part B prescription drugs</b></p> <p>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:</p> <ul style="list-style-type: none"> <li>• Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>• 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</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> <li>• 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)</li> <li>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p>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 listed in Chapter 6.</p>	

**Prior authorization required for in network services**

20% coinsurance for Part B drugs

Services that are covered for you	<b>What you must pay</b> when you get these services for both <b>In and Out of Network</b>
<b>Additional Benefits</b>	
<b>Health and wellness education programs</b> These are programs focused on clinical health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members.	
	Free programs

**Section 2.2      Extra “optional supplemental” benefit you can buy**

Our Plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called “**Optional Supplemental Benefits.**” If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits included in this section are subject to the same appeals process as any other benefits.

ODS Advantage EXTRA CARE combines services you may need from time to time that are not covered under your ODS Advantage PPORX plan, like Vision Services, Routine Chiropractic Services, Acupuncture and Naturopathic services, Hearing tests and aids. ODS Advantage EXTRA CARE will pay 50% of the charges for services listed up to the annual maximum of \$500. The annual maximum applies toward the combined cost of ODS Advantage EXTRA CARE services rendered for the year, not to each individual service.

OPTIONAL BENEFIT	PREMIUM	COINSURANCE
Vision Services including frames, glasses and contacts		50% of the cost of the services
Routine Chiropractic services		50% of the cost of the services
Acupuncture and naturopathic services, including treatments, vitamins or dietary supplements		50% of the cost of the services
Hearing tests and aids		50% of the cost of the services
Combined annual maximum for all services		\$25 per month

You may enroll in the ODS Advantage EXTRA CARE when you enroll into ODS Advantage PPORX. You also have until 30 days after your enrollment effective date to decide if you would

like to enroll into ODS Advantage EXTRA CARE. You may also enroll into ODS Advantage EXTRA CARE during the annual plan election period (November 15<sup>th</sup> through December 31<sup>st</sup> of each year). Call Member Services at 1-877-299-9062 or TTY 1-800-433-6313 Monday through Friday from 7am to 8 pm Pacific time if you would like to enroll.

You will have to pay an additional monthly premium of \$25 per month along with your Part B premium and the ODS Advantage PPORX premium.

You may disenroll from ODS Advantage EXTRA CARE any time or at the time you disenroll from the ODS Advantage PPORX plan. Once you disenroll from ODS Advantage EXTRA CARE you must wait until the next annual enrollment period to enroll again. You cannot retain coverage under ODS Advantage EXTRA CARE once you disenroll from the ODS Advantage PPORX plan. A refund of overpayment of premium will be issued upon confirmation of disenrollment by CMS.

The ODS Advantage EXTRA CARE benefits are subject to the same grievance and appeal process as your Medicare Advantage benefits.

### **Section 2.3      Getting care using our plan’s traveler benefit**

You may get care when you are outside the service area for up to 12 months. Please make sure you see Medicare providers and those providers are willing to bill ODS Advantage PPORX for your care. You may need to pay higher cost sharing for routine care from non-network providers, but you won’t pay extra in a medical emergency or if your care is urgently needed. If you have questions about your medical costs when you travel, please call Member Services.

## **SECTION 3      What types of benefits are not covered by the plan?**

### **Section 3.1      Types of benefits we do *not* cover (exclusions)**

This section tells you what kinds of benefits are “excluded.” Excluded means that the plan doesn’t cover these benefits.

The list below describes some services and items that aren’t covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won’t pay for the medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit 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.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in

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this *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as a covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. See Chapter 3, Section 5 for more information on clinical research studies.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- 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.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, filings or dentures. However, non-routine dental care received at a hospital may be covered.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the 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.

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- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
  - Hearing aids and routine hearing examinations.
  - Eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
  - Outpatient prescription drugs including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
  - Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
  - Acupuncture.
  - Naturopath services (uses natural or alternative treatments).
  - Services provided to veterans in Veterans Affairs (VA) facilities. However, 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.
  - Any services listed above that aren't covered will remain not covered even if received at an emergency facility.