
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

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 PERS ODS Advantage PPORX. Later in this chapter, you can find information about medical services that are not covered.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services
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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”** 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.)

Some people qualify for State Medicaid programs to help them pay their out-of-pocket costs for Medicare. (These “Medicare Savings Programs” include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs.) If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending on the rules in your state.

Section 1.2 What is the most you will pay for covered medical services?

Under our plan, there is one limit on what you have to pay out-of-pocket for covered medical services:

- Your **combined maximum out-of-pocket amount** is \$2500. This is the most you pay during the calendar year for covered plan services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount.) If you have paid \$2500 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered plan 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 does not allow providers to “balance bill” you
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As a member of PERS ODS Advantage PPORX, an important protection for you is that, after you meet any deductibles, you only have to pay the plan’s cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges such as “balance billing.” This protection (that you never pay more than the plan 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 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 obtain 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 obtain 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.

SECTION 2	Use the <i>Medical Benefits Chart</i> to find out what is covered for you and how much you will pay
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Section 2.1	Your medical benefits and costs as a member of the plan
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The Medical Benefits Chart on the following pages lists the services PERS ODS Advantage PPORX 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.

- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from PERS ODS Advantage PPORX.
 - Covered services that need approval in advance to be covered as in-network services are marked in bold “**Prior Authorization is required for in-network services**” in the Medical Benefits Chart.
 - You never need approval in advance for out-of-network services from out-of-network providers.
 - While you don’t need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
 - If you receive the covered services from a network provider, you will pay the coinsurance percentage multiplied by the total provider rate in the provider’s contract,
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you will pay the coinsurance percentage times the Medicare allowable,
- 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.

Medical Benefits Chart

Services that are covered for you

What you must pay when you get these services 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 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. If PERS ODS Advantage PPORX provides transplant services at a distant location (farther away than the normal community patterns of care) and you chose to obtain transplants at this distant 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 only with the fourth pint of blood that you need - you pay for the first 3 pints of

Prior Authorization is required for all in-network services

Days 1 – 3 \$100.00 copayment each day for in and out-of-network services

Days 4 and beyond \$0 copayment per day

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

A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.

There is no limit to

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>unreplaced blood. All other components of blood are covered beginning with the first pint used.</p> <ul style="list-style-type: none">• Physician services <p>Note: To be an inpatient, your provider must write an order to admit you to 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, you should ask the hospital staff.</p> <p>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 http://www.medicare.gov/Publications/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.</p>	<p>the number of benefit periods you can have.</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>Inpatient mental health care</p> <ul style="list-style-type: none">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.	<p>Prior Authorization is required for all in-network services</p> <p>Days 1 – 3 \$100.00 copayment each day for in and out-of-network services</p> <p>Days 4 and beyond \$0 copayment per day</p> <p>A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.</p> <p>There is no limit to the number of benefit periods you can have.</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of “skilled nursing facility care,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Semiprivate room (or a private room if medically necessary)• Meals, including special diets• Regular 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 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.• 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 services <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">• 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.	<p>Prior Authorization is required for all in-network services</p> <p>Days 1-20 \$0 copayment for each day</p> <p>Days 21-100 \$40.00 copayment for each day</p> <p>No prior hospital stay required</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>Inpatient services covered during a non-covered inpatient stay</p> <p>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) stay. Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • 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 • Physical therapy, speech therapy, and occupational therapy 	<p>Prior Authorization is required for all in-network services</p> <p>\$15.00 copayment for PCP/\$20.00 copayment for specialist</p> <p>\$0 copayment for Medicare covered lab services</p> <p>You pay 10% of the total cost for x-ray, diagnostic radiology and therapeutic radiology services</p> <p>You pay 10% of the total cost for prosthetics, orthotic devices and durable medical equipment</p> <p>\$20.00 copayment for physical therapy, speech therapy and occupational therapy</p>
<p>Home health agency care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 	<p>Prior Authorization is required for all in-network services</p> <p>\$0 copayment for</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>total fewer than 8 hours per day and 35 hours per week)</p> <ul style="list-style-type: none"> • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies 	<p>Medicare covered home health visits</p> <p>\$20.00 copayment for physical therapy, speech therapy and occupational therapy</p> <p>You pay 10% of the total cost for prosthetics, orthotic devices and durable medical equipment.</p>
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:</p> <ul style="list-style-type: none"> • You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing • --or-- You can get your care covered by Original Medicare. In 	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not PERS ODS Advantage PPORX.</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	
<p>Outpatient Services</p>	
<p>Physician services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical or surgical 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. • Telehealth office visits including consultation, diagnosis and treatment by a specialist • 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) 	<p>\$15.00 copayment for PCP office visits</p> <p>\$20.00 copayment for specialist office visits</p> <p>\$20.00 copayment for non-routine dental care office visits</p> <p>\$20.00 copayment for Medicare covered basic hearing and balance exams</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>Outpatient hospital services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Services in an emergency department or outpatient clinic, including same-day surgery• Laboratory 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 screenings and preventive services• Certain drugs and biologicals that you can't give yourself <p>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.</p> <p>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 http://www.medicare.gov/Publications/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.</p>	<p>\$0 copayment for laboratory tests, screening and preventive services</p> <p>10% of the total cost for Part B drugs and biologicals</p> <p>10% of the total cost for x-rays</p> <p>Prior Authorization is required for all in-network services listed below:</p> <p>\$125.00 copayment for each Medicare covered outpatient service in a hospital or Ambulatory Surgical Center (ASC)</p> <p>You pay 10% of the total cost for MRI/CT/CAT/SPECT/PET and Nuclear Cardiology and radiation therapy</p> <p>You pay 10% of the total cost for Medicare covered diagnostic radiology services</p> <p>\$20.00 copayment per day for partial hospitalization</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> We cover only manual manipulation of the spine to correct subluxation 	<p>Prior Authorization is required for all in-network services</p> <p>\$20.00 copayment</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> 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 	<p>\$20.00 copayment</p>
<p>Outpatient mental health care</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>\$20.00 copayment for Medicare covered group therapy visits</p> <p>\$20.00 copayment for Medicare covered individual visits</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting 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.</p>	<p>Prior Authorization is required for all in-network services</p> <p>\$20.00 copayment per day</p>
<p>Outpatient substance abuse services</p>	<p>\$20.00 copayment for Medicare covered group therapy visits</p> <p>\$20.00 copayment for Medicare covered individual visits</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital, 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.”</p>	<p>Prior Authorization is required for all in-network services</p> <p>\$125.00 copayment for each Medicare covered outpatient service in a hospital or Ambulatory Surgical Center (ASC)</p>
<p>Ambulance services</p> <ul style="list-style-type: none"> • 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 medical condition is such that other means of transportation are contraindicated (could endanger the person’s health) or if authorized by the plan. 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. • 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. 	<p>\$50.00 copayment for each Medicare covered trip</p> <p>\$50.00 copayment applies to each one-way trip</p>
<p>Emergency care</p> <p>Emergency care is care that is needed to evaluate or stabilize an emergency medical condition.</p> <p>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</p>	<p>\$50.00 copayment</p> <p>Your copayment is waived if you are admitted to the hospital within 24-hours for the same condition; you pay \$0</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>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.</p> <p>Worldwide coverage</p>	<p>copayment for the emergency room visit.</p>
<p>Urgently needed care</p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.</p> <p>Worldwide coverage</p>	<p>\$20.00 copayment</p> <p>Your copayment is waived if you are admitted to the hospital within 24-hours for the same condition; you pay \$0 copayment for the urgent care visit.</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>Prior Authorization is required for all in-network services</p> <p>\$20.00 copayment</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>Prior Authorization is required for all in-network services</p> <p>\$20.00 copayment</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for</p>	<p>Prior Authorization is required for all in-network</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.</p>	<p>services \$20.00 copayment</p>
<p>Durable medical equipment 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, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p>Prior Authorization is required for all in-network services You pay 10% of the total cost</p>
<p>Prosthetic devices and related supplies Devices (other than dental) that replace 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.</p>	<p>Prior Authorization is required for all in-network services You pay 10% of the total cost</p>
<p>Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • 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: 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 	<p>\$0 copayment for diabetic supplies</p> <p>\$0 copayment for self management training.</p> <p>\$0 copayment for Medicare covered lab services</p> <p>Prior Authorization is required for the below in-network service: You pay 10% of the</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
conditions	total cost for therapeutic custom molded shoes and inserts for custom molded shoes.
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 • Laboratory tests • 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. • Other outpatient diagnostic tests 	<p>\$0 copayment for Medicare covered lab services, diagnostic procedures and tests.</p> <p>You pay 10% of the total cost for x-rays</p> <p>Prior Authorization is required for all in-network services for the following services:</p> <p>You pay 10% of the total cost for MRI/CT/CAT/SPECT/PET and Nuclear Cardiology and radiation therapy</p> <p>You pay 10% of the total cost for Medicare covered diagnostic radiology services</p>
<p>Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for 	<p>\$0 copayment for exams to diagnose and treat diseases and conditions of the eye</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>eyeglasses/contacts.</p> <ul style="list-style-type: none"> • 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. • 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.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. 	<p>\$0 copayment for one pair of eyeglasses or contact lenses after cataract surgery</p>
<p>Preventive Services</p>	
<p>Note: 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 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.</p>	
<p>Abdominal aortic aneurysm screening</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 “Welcome to Medicare” physical exam.</p>	<p>\$0 copayment</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>Bone mass measurement</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 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.</p>	<p>\$0 copayment</p>
<p>Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>\$0 copayment</p>
<p>HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>\$0 copayment</p>
<p>Immunizations</p> <p>Covered Medicare Part B services include:</p>	<p>\$0 copayment</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter • 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 <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	
<p>Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 	<p>\$0 copayment</p>
<p>Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 12 months • 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 	<p>\$0 copayment</p>
<p>Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>\$0 copayment</p>
<p>Cardiovascular disease testing</p>	<p>\$0 copayment</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	
<p>“Welcome to Medicare” physical exam</p> <p>The plan covers a one-time “Welcome to Medicare” physical exam, which 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.</p> <p>Important: You must have the physical exam 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” physical exam.</p>	<p>There is no copayment for the Welcome to Medicare exam.</p>
<p>Annual wellness visit</p> <p>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.</p> <p>Note: Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” exam. However, you don’t need to have had a “Welcome to Medicare” exam to be covered for annual wellness visits after you’ve had Part B for 12 months.</p>	<p>There is no copayment for the annual wellness visit.</p>
<p>Diabetes screening</p> <p>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.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>\$0 copayment</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when ordered by your doctor.</p> <p>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 order. A physician must prescribe these services and renew their order yearly if your treatment is needed into another calendar year.</p>	<p>\$0 copayment</p>
<p>Smoking and tobacco use cessation (counseling to stop smoking)</p> <p>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. Each counseling attempt includes up to four face-to-face visits.</p> <p>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. Each counseling attempt includes up to four face-to-face visits, however, you will pay the applicable inpatient or outpatient cost sharing</p>	<p>If you haven’t been diagnosed with an illness caused or complicated by tobacco use: \$0 copayment</p> <p>If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco: \$0 copayment</p>
<p>Other Services</p>	
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 	<p>Prior Authorization is required for all in-network services</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network
<p>their doctor, we cover up to six sessions of kidney disease education services per lifetime.</p> <ul style="list-style-type: none"> • 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) <p>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 below, “Medicare Part B prescription drugs.”</p>	<p>Days 1 – 3 \$100.00 copayment per days for Inpatient dialysis in a hospital</p> <p>You pay 10% of the total cost for renal dialysis</p> <p>\$0 copayment for nutritional therapy for end stage renal disease</p> <p>You pay 10% of the total cost for home dialysis equipment and supplies</p>
<p>Medicare Part B prescription drugs</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"> • 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 was 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 	<p>You pay 10% of the total cost for Part B covered drugs and chemotherapy drugs</p>

Services that are covered for you	What you must pay when you get these services in and out-of-network		
<p>bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug</p> <ul style="list-style-type: none"> • Antigens • 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 <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>			
<p>Additional Benefits</p>			
<p>Vision care</p> <table border="0"> <tr> <td data-bbox="159 1262 1055 1293">One non-Medicare covered routine eye exam every 12 months</td> <td data-bbox="1101 1262 1341 1293">\$20.00 copayment</td> </tr> </table>		One non-Medicare covered routine eye exam every 12 months	\$20.00 copayment
One non-Medicare covered routine eye exam every 12 months	\$20.00 copayment		

Section 2.2 Getting care using our plan’s optional visitor/traveler benefit

When you are continuously absent from our plan’s service area for more than six months, we usually must disenroll you from our plan. However, we offer as a supplemental benefit a visitor/traveler program in the entire United States, which will allow you to remain enrolled in our plan when you are outside of our service area for up to 12 months. This program is available to all PERS ODS Advantage PPORX members who are temporarily in the visitor/traveler area. Under our visitor/traveler program you may receive all plan covered services at in-network cost sharing as long as you use Medicare providers. Please contact the plan for assistance in locating a Medicare provider when using the visitor/traveler benefit.

If you are in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you have not returned to the plan’s service area within 12 months, you will be disenrolled from the plan.

SECTION 3 What benefits are not covered by the plan?

Section 3.1 Benefits we do <i>not</i> cover (exclusions)
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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 excluded 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 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 covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information on clinical research studies.) 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.
- 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.

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- 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, unless 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, fillings or dentures. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
 - 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.
 - Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
 - Routine hearing exams, hearing aids, or exams to fit hearing aids.
 - Eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
 - 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.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.