Geisinger Gold Preferred (PPO) Summary of Benefits

Thank you for your interest in Geisinger Gold Preferred (PPO). Our plan is offered by GEISINGER INDEM-NITY INSURANCE COMPANY/Geisinger Gold, a Medicare Advantage Preferred (PPO) Provider Organization (PPO) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Geisinger Gold Preferred (PPO) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-forservice) Medicare Plan. Another option is a Medicare health plan, like Geisinger Gold Preferred (PPO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call Geisinger Gold Preferred (PPO) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Geisinger Gold Preferred (PPO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers. Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS GEISINGER GOLD Preferred (PPO) AVAILABLE?

There is more than one plan listed in this Summary of Benefits. Please refer to the chart in the back of this Summary for plan availability. If you move out of the state or county where you currently live, you must call Customer Service to update your information. If you don't, you may be disenrolled from Geisinger Gold. Please call Customer Service to find out if Geisinger Gold has a plan in your new state or county.

WHO IS ELIGIBLE TO JOIN GEISINGER GOLD PREFERRED (PPO)?

You can join Geisinger Gold Preferred (PPO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in Geisinger Gold Preferred (PPO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Geisinger Gold Preferred (PPO) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at www.GeisingerGold.com. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Geisinger Gold Preferred (PPO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.GeisingerGold.com. Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Geisinger Gold Preferred 1, Preferred 2 and Preferred 3 do cover Medicare Part B prescription drugs. Geisinger Gold Preferred 1, Preferred 2 and Preferred 3 do NOT cover Medicare Part D prescription drugs. Geisinger Gold Preferred 1 \$0 Deductible Rx, Preferred 2 \$0 Deductible Rx and Preferred 3 \$0 Deductible Rx do cover both Part B and Part D drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Geisinger Gold Preferred (PPO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at https://www.thehealthplan.com/Gold/Landing_Pages/Formulary/.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRE-SCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- •1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare You.
- •The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- •Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calen-

dar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Geisinger Gold Preferred (PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Geisinger Gold Preferred (PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-Preferred (PPO) drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of

Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGE-MENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Geisinger Gold Preferred (PPO) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Geisinger Gold Preferred (PPO) for more details.

- -- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- -- Osteoporosis Drugs: Injectable osteoporosis drugs for some women.
- -- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- -- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- -- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- -- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
- -- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- -- Oral Anti-Nausea Drugs: If you are part of an anticancer chemotherapeutic regimen.
- -- Inhalation and Infusion Drugs administered through Durable Medical Equipment.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans"

to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Geisinger Gold for more information about Geisinger Gold Preferred (PPO).

Visit us at www.GeisingerGold.com or, call us:

Customer Service Hours for October 1 – February 14:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern

Customer Service Hours for February 15 – September 30:

For information related to the Medicare Advantage Program, current members should call:

- Toll Free: (800)-498-9731
- Locally: (570)-271-8771
- TTY/TDD 711

For information related to the Medicare Part D Prescription Drug Program, current members should call:

- Toll Free: (800)-988-4861
- Locally: (570)-271-8771
- TTY/TDD 711

For information related to the Medicare Advantage Program or Medicare Part D Prescription Drug Program, prospective members should call:

- Toll Free: (800)-514-0138
- TTY/TDD 711

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

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amount. If you choose to

	Summary	of Benefits		If you have any questions about this plans benefits or costs, please contact Geisinger Gold for details.					
Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)		
IMPORTANT INFORMATION									
1 - Premium and Other Important Information	• In 2012 the monthly Part B Premium was \$99.90 and may change for 2013 and the annual Part B deductible amount was \$140 and may change for 2013. • If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. • Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDI-CARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	• Premiums range from \$33 to \$98 per month. Please refer to the Premium Table located after this section to find out what the premium is in your area. • You also must continue to pay your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers	• Premiums range from \$74 to \$150 per month. Please refer to the Premium Table located after this section to find out what the premium is in your area. • You also must continue to pay your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers	• Premiums range from \$20 to \$26 per month. Please refer to the Premium Table located after this section to find out what the premium is in your area. • You also must continue to pay your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers	• Premiums range from \$55 to \$61 per month. Please refer to the Premium Table located after this section to find out what the premium is in your area. • You also must continue to pay your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers	• \$96 monthly plan premium in addition to your monthly Medicare Part B premium. • Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., Out-of-Network) accept "assignment" from Medicare and will only charge	should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.		

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of a plan's network (i.e.,

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care and will only charge

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Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
		see an <i>Out-of-Network</i> physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for <i>Out-of-Network</i> physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare Benefits available on www. medicare.gov for a full list- ing of benefits under Origi- nal Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that ap- ply by benefit type. • To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www. medicare.gov/physician or www.medicare.gov/ supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. In-Network • \$3,400 out-of-pocket limit for Medicare-covered services and select Non- Medicare Supplemental Services. Contact plan for	see an <i>Out-of-Network</i> physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for <i>Out-of-Network</i> physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare You or Your Medicare Benefits available on www. medicare.gov for a full list- ing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that ap- ply by benefit type. • To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www. medicare.gov/physician or www.medicare.gov/ supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. 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See the publications Medicare You or Your Medicare Benefits available on www. medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. • To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www. medicare.gov/physician or www.medicare.gov/supplier. You can also call	care-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for <i>Out-of-Network</i> physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare You or Your Medicare Benefits available on www. medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. • To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www. medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. In-Network • \$3,400 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.
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Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
		Medicare Supplemental Services covered under this limit. In and Out-of-Network • \$195 annual deductible. Contact the plan for services that apply. • Any annual service category deductible may count towards the plan level deductible, if there is one. • \$5,100 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	Medicare Supplemental Services covered under this limit. In and Out-of-Network • \$195 annual deduct- ible. Contact the plan for services that apply. • Any annual service category deductible may count towards the plan level deductible, if there is one. • \$5,100 out-of-pocket limit for Medicare-covered services and select Non- Medicare Supplemental Services. Contact plan for details regarding Non- Medicare Supplemental Services covered under this limit.	Medicare Supplemental Services covered under this limit. In and Out-of-Network • \$100 annual deductible. Contact the plan for services that apply. • Any annual service category deductible may count towards the plan level deductible, if there is one. • \$5,100 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	Medicare Supplemental Services covered under this limit. In and Out-of-Network • \$100 annual deductible. Contact the plan for services that apply. • Any annual service category deductible may count towards the plan level deductible, if there is one. • \$5,100 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	In and Out-of-Network • \$120 annual deductible. Contact the plan for services that apply. • Any annual service category deductible may count towards the plan level deductible, if there is one. • \$5,100 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	In and Out-of-Network • \$120 annual deductible. Contact the plan for services that apply. • Any annual service category deductible may count towards the plan level deductible, if there is one. • \$5,100 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.
2 - Doctor and Hospital Choice (For more information, see Emergen- cy Care - #15 and Urgent- ly Needed Care - #16.)	• You may go to any doctor, specialist or hospital that accepts Medicare.	 In-Network No referral required for network doctors, specialists, and hospitals. In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. 	In-Network • No referral required for network doctors, specialists, and hospitals. In and Out-of-Network • You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.	 In-Network No referral required for network doctors, specialists, and hospitals. In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. 	 In-Network No referral required for network doctors, specialists, and hospitals. In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. 	In-Network • No referral required for network doctors, specialists, and hospitals. In and Out-of-Network • You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.	 In-Network No referral required for network doctors, specialists, and hospitals. In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.
INPATIENT CARE 3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	• In 2012 the amounts for each benefit period were: • Days 1 - 60: \$1156 deductible • Days 61 - 90: \$289 per day • Days 91 - 150: \$578 per	 In-Network No limit to the number of days covered by the plan each hospital stay. \$295 copay for each Medicare-covered hospital stay 	 In-Network No limit to the number of days covered by the plan each hospital stay. \$295 copay for each Medicare-covered hospital stay 	 In-Network No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1 - 5: \$225 copay 	 In-Network No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1 - 5: \$225 copay 	 In-Network No limit to the number of days covered by the plan each hospital stay. \$275 copay for each Medicare-covered hospital stay 	 In-Network No limit to the number of days covered by the plan each hospital stay. \$275 copay for each Medicare-covered hospital stay

are met. This limitation

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Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
	lifetime reserve day • These amounts may change for 2013. • Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. • Lifetime reserve days can only be used once. • A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit periods you can have.	• \$0 copay for additional hospital days • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network • 20% of the cost for each hospital stay.	• \$0 copay for additional hospital days • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network • 20% of the cost for each hospital stay.	per day • Days 6 - 90: \$0 copay per day • \$0 copay for additional hospital days • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. <i>Out-of-Network</i> • 25% of the cost for each hospital stay.	per day	• \$0 copay for additional hospital days • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. <i>Out-of-Network</i> • 20% of the cost for each hospital stay.	• \$0 copay for additional hospital days • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. <i>Out-of-Network</i> • 20% of the cost for each hospital stay.
4 - Inpatient Mental Health Care	 In 2012 the amounts for each benefit period were: Days 1 - 60: \$1156 deductible Days 61 - 90: \$289 per day Days 91 - 150: \$578 per lifetime reserve day These amounts may change for 2013. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions 	services count toward the	In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a General hospital. • \$295 copay for each Medicare-covered hospital stay. • Except in an emergency,	In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a General hospital. • For Medicare-covered hospital stays: • Days 1 - 5: \$225 copay per day	In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a General hospital. • For Medicare-covered hospital stays: • Days 1 - 5: \$225 copay per day	In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a General hospital. • \$275 copay for each Medicare-covered hospital stay. • Except in an emergency,	In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a General hospital. • \$275 copay for each Medicare-covered hospital stay. • Except in an emergency,

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
	does not apply to inpatient psychiatric services furnished in a <i>General</i> hospital.	your doctor must tell the plan that you are going to be admitted to the hospital. <i>Out-of-Network</i> • 20% of the cost for each hospital stay.	your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network • 20% of the cost for each hospital stay.	 Days 6 - 90: \$0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network 25% of the cost for each hospital stay. 	 Days 6 - 90: \$0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. <i>Out-of-Network</i> 25% of the cost for each hospital stay. 	your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network • 20% of the cost for each hospital stay.	your doctor must tell the plan that you are going to be admitted to the hospital. <i>Out-of-Network</i> • 20% of the cost for each hospital stay.
5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	 In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day Days 21 - 100: \$144.50 per day These amounts may change for 2013. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. 	 General Authorization rules may apply. In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 8: \$0 copay per day Days 9 - 42: \$65 copay per day Days 43 - 100: \$0 copay per day Out-of-Network 20% of the cost for each SNF stay. 	 General Authorization rules may apply. In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 8: \$0 copay per day Days 9 - 42: \$65 copay per day Days 43 - 100: \$0 copay per day Out-of-Network 20% of the cost for each SNF stay. 	 General Authorization rules may apply. In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 3: \$0 copay per day Days 4 - 45: \$65 copay per day Days 46 - 100: \$0 copay per day Out-of-Network 25% of the cost for each SNF stay. 	 General Authorization rules may apply. In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 3: \$0 copay per day Days 4 - 45: \$65 copay per day Days 46 - 100: \$0 copay per day Out-of-Network 25% of the cost for each SNF stay. 	 General Authorization rules may apply. In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 8: \$0 copay per day Days 9 - 42: \$65 copay per day Days 43 - 100: \$0 copay per day Out-of-Network 20% of the cost for each SNF stay. 	 General Authorization rules may apply. In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 8: \$0 copay per day Days 9 - 42: \$65 copay per day Days 43 - 100: \$0 copay per day Out-of-Network 20% of the cost for each SNF stay.
6 - Home Health Care (includes medically neces- sary intermittent skilled nursing care, home health aide services, and rehabilita- tion services, etc.)	• \$0 copay.	 General Authorization rules may apply. In-Network \$0 copay for Medicarecovered home health visits Out-of-Network 20% of the cost for 	 General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits Out-of-Network 20% of the cost for 	 General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits Out-of-Network 25% of the cost for 	 General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits Out-of-Network 25% of the cost for 	 General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits Out-of-Network 20% of the cost for 	 General Authorization rules may apply. In-Network \$0 copay for Medicarecovered home health visits Out-of-Network 20% of the cost for

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
		Medicare-covered home health visits	Medicare-covered home health visits	Medicare-covered home health visits	Medicare-covered home health visits	Medicare-covered home health visits	Medicare-covered home health visits
7 - Hospice	 You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice. 	General • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	General • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	General • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	General • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	General • You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	General • You must get care from a Medicare-certified hospical Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE							
8 - Doctor Office Visits	• 20% coinsurance	In-Network • \$10 copay for each Medicare-covered primary care doctor visit. • \$25 copay for each Medicare-covered specialist visit. Out-of-Network • \$20 copay for each Medicare-covered primary care doctor visit • \$35 copay for each Medicare-covered specialist visit	In-Network • \$10 copay for each Medicare-covered primary care doctor visit. • \$25 copay for each Medicare-covered specialist visit. Out-of-Network • \$20 copay for each Medicare-covered primary care doctor visit • \$35 copay for each Medicare-covered specialist visit	 In-Network \$20 copay for each Medicare-covered primary care doctor visit. \$35 copay for each Medicare-covered specialist visit. Out-of-Network \$30 copay for each Medicare-covered primary care doctor visit \$45 copay for each Medicare-covered specialist visit 	In-Network • \$20 copay for each Medicare-covered primary care doctor visit. • \$35 copay for each Medicare-covered specialist visit. Out-of-Network • \$30 copay for each Medicare-covered primary care doctor visit • \$45 copay for each Medicare-covered specialist visit	In-Network • \$10 copay for each Medicare-covered primary care doctor visit. • \$25 copay for each Medicare-covered specialist visit. Out-of-Network • \$20 copay for each Medicare-covered primary care doctor visit • \$35 copay for each Medicare-covered specialist visit	In-Network • \$10 copay for each Medicare-covered primary care doctor visit. • \$25 copay for each Medicare-covered speciality visit. Out-of-Network • \$20 copay for each Medicare-covered primary care doctor visit • \$35 copay for each Medicare-covered speciality visit
9 - Chiropractic Services	• Supplemental routine care not covered • 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	In-Network • \$20 copay for each Medicare-covered chiro- practic visit • Medicare-covered chiro- practic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalign- ment of a joint or body part) if you get it from a chiropractor. Out-of-Network • \$35 copay for Medicare- covered chiropractic visits.	In-Network • \$20 copay for each Medicare-covered chiro- practic visit • Medicare-covered chiro- practic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalign- ment of a joint or body part) if you get it from a chiropractor. Out-of-Network • \$35 copay for Medicare- covered chiropractic visits.	 In-Network \$20 copay for each Medicare-covered chiro-practic visit Medicare-covered chiro-practic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor. Out-of-Network \$45 copay for Medicare-covered chiropractic visits. 	In-Network • \$20 copay for each Medicare-covered chiro- practic visit • Medicare-covered chiro- practic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalign- ment of a joint or body part) if you get it from a chiropractor. Out-of-Network • \$45 copay for Medicare- covered chiropractic visits.	In-Network • \$20 copay for each Medicare-covered chiro- practic visit • Medicare-covered chiro- practic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalign- ment of a joint or body part) if you get it from a chiropractor. Out-of-Network • \$35 copay for Medicare- covered chiropractic visits.	In-Network • \$20 copay for each Medicare-covered chiro- practic visit • Medicare-covered chiro- practic visits are for manumanipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor. Out-of-Network • \$35 copay for Medicare covered chiropractic visits

	Summar y	of Deffettis					
Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
10 - Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	In-Network • \$25 copay for each Medicare-covered podiatry visit • \$0 copay for up to 4 sup- plemental routine podiatry visit(s) every year • Medicare-covered podia- try visits are for medically- necessary foot care. Out-of-Network • \$35 copay for Medicare- covered podiatry visits • \$35 copay for supplemen- tal routine podiatry visits	In-Network • \$25 copay for each Medicare-covered podiatry visit • \$0 copay for up to 4 sup- plemental routine podiatry visit(s) every year • Medicare-covered podia- try visits are for medically- necessary foot care. Out-of-Network • \$35 copay for Medicare- covered podiatry visits • \$35 copay for supplemental routine podiatry visits	 In-Network up to 4 supplemental routine podiatry visit(s) every year \$35 copay for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medicallynecessary foot care. Out-of-Network \$45 copay for Medicare-covered podiatry visits \$45 copay for supplemental routine podiatry visits 	 In-Network up to 4 supplemental routine podiatry visit(s) every year \$35 copay for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medicallynecessary foot care. Out-of-Network \$45 copay for Medicare-covered podiatry visits \$45 copay for supplemental routine podiatry visits 	Medicare-covered podiatry visit • \$0 copay for up to 4 supplemental routine podiatry visit(s) every year • Medicare-covered podiatry visits are for medicallynecessary foot care. Out-of-Network • \$35 copay for Medicare-covered podiatry visits	In-Network • \$25 copay for each Medicare-covered podiatry visit • \$0 copay for up to 4 sup- plemental routine podiatry visit(s) every year • Medicare-covered podia- try visits are for medically- necessary foot care. Out-of-Network • \$35 copay for Medicare- covered podiatry visits • \$35 copay for supplemental routine podiatry visits
11 - Outpatient Mental Health Care	 • 35% coinsurance for most outpatient mental health services • Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. • "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. 	care-covered Mental Health	• Authorization rules may apply. In-Network • \$25 copay for each Medicare-covered individual therapy visit • \$10 copay for each Medicare-covered group therapy visit • \$25 copay for each Medicare-covered individual therapy visit • \$25 copay for each Medicare-covered individual therapy visit with a psychiatrist • \$10 copay for each Medicare-covered group therapy visit with a psychiatrist • \$25 copay for Medicare-covered partial hospitalization program services Out-of-Network • 20% of the cost for Medicare-covered Mental Health	• Authorization rules may apply. In-Network • \$25 copay for each Medicare-covered individual therapy visit • \$10 copay for each Medicare-covered group therapy visit • \$25 copay for each Medicare-covered individual therapy visit with a psychiatrist • \$10 copay for each Medicare-covered group therapy visit with a psychiatrist • \$10 copay for each Medicare-covered group therapy visit with a psychiatrist • 20% of the cost for Medicare-covered partial hospitalization program services Out-of-Network • 25% of the cost for Medi-	• Authorization rules may apply. In-Network • \$25 copay for each Medicare-covered individual therapy visit • \$10 copay for each Medicare-covered group therapy visit • \$25 copay for each Medicare-covered individual therapy visit with a psychiatrist • \$10 copay for each Medicare-covered group therapy visit with a psychiatrist • \$10 copay for each Medicare-covered group therapy visit with a psychiatrist • 20% of the cost for Medicare-covered partial hospitalization program services Out-of-Network • 25% of the cost for Medicare-covered Mental Health	therapy visit • \$10 copay for each Medicare-covered group therapy visit • \$25 copay for each Medicare-covered indi- vidual therapy visit with a psychiatrist • \$10 copay for each Medi- care-covered group therapy visit with a psychiatrist • \$25 copay for Medicare- covered partial hospitaliza- tion program services Out-of-Network • 20% of the cost for Medi- care-covered Mental Health	• Authorization rules may apply. In-Network • \$25 copay for each Medicare-covered individual therapy visit • \$10 copay for each Medicare-covered group therapy visit • \$25 copay for each Medicare-covered individual therapy visit • \$25 copay for each Medicare-covered individual therapy visit with a psychiatrist • \$10 copay for each Medicare-covered group therapy visit with a psychiatrist • \$25 copay for Medicare-covered partial hospitalization program services Out-of-Network • 20% of the cost for Medicare-covered Mental Health visits with a psychiatrist

18

visits with a psychiatrist

• 20% of the cost for

visits with a psychiatrist

• 20% of the cost for

care-covered Mental Health

visits with a psychiatrist

care-covered Mental Health visits with a psychiatrist

• 20% of the cost for

visits with a psychiatrist

visits with a psychiatrist

• 20% of the cost for

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
		Medicare-covered Mental Health visits • 20% of the cost for Medicare-covered partial hospitalization program services	Medicare-covered Mental Health visits • 20% of the cost for Medicare-covered partial hospitalization program services	 25% of the cost for Medicare-covered Mental Health visits 25% of the cost for Medicare-covered partial hospitalization program services 	 • 25% of the cost for Medicare-covered Mental Health visits • 25% of the cost for Medicare-covered partial hospitalization program services 	Medicare-covered Mental Health visits • 20% of the cost for Medicare-covered partial hospitalization program services	Medicare-covered Menta Health visits • 20% of the cost for Medicare-covered partial hospitalization program services
12 - Outpatient Substance Abuse Care	• 20% coinsurance	• Authorization rules may apply. In-Network • \$25 copay for Medicarecovered individual substance abuse outpatient treatment visits • \$10 copay for Medicarecovered group substance abuse outpatient treatment visits Out-of-Network • 20% of the cost Medicarecovered substance abuse outpatient treatment visits	 General Authorization rules may apply. In-Network \$25 copay for Medicare-covered individual substance abuse outpatient treatment visits \$10 copay for Medicare-covered group substance abuse outpatient treatment visits Out-of-Network 20% of the cost Medicare-covered substance abuse outpatient treatment visits 	• Authorization rules may apply. In-Network • \$25 copay for Medicarecovered individual substance abuse outpatient treatment visits • \$10 copay for Medicarecovered group substance abuse outpatient treatment visits Out-of-Network • 25% of the cost Medicarecovered substance abuse outpatient treatment visits	• Authorization rules may apply. In-Network • \$25 copay for Medicarecovered individual substance abuse outpatient treatment visits • \$10 copay for Medicarecovered group substance abuse outpatient treatment visits Out-of-Network • 25% of the cost Medicarecovered substance abuse outpatient treatment visits	• Authorization rules may apply. In-Network • \$25 copay for Medicare-covered individual substance abuse outpatient treatment visits • \$10 copay for Medicare-covered group substance abuse outpatient treatment visits Out-of-Network • 20% of the cost Medicare-covered substance abuse outpatient treatment visits	• Authorization rules may apply. In-Network • \$25 copay for Medicare covered individual substance abuse outpatient treatment visits • \$10 copay for Medicare covered group substance abuse outpatient treatment visits Out-of-Network • 20% of the cost Medicare-covered substance abuse outpatient treatment visits
13 - Outpatient Services	 20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services 	• Authorization rules may apply. In-Network • \$250 copay for each Medicare-covered ambulatory surgical center visit • \$250 copay for each Medicare-covered outpatient hospital facility visit Out-of-Network • 20% of the cost for Medicare-covered outpatient hospital facility visits • 20% of the cost for Medicare-covered ambula-	 General Authorization rules may apply. In-Network \$250 copay for each Medicare-covered ambulatory surgical center visit \$250 copay for each Medicare-covered outpatient hospital facility visit Out-of-Network 20% of the cost for Medicare-covered outpatient hospital facility visits 20% of the cost for Medicare-covered outpatient hospital facility visits 20% of the cost for Medicare-covered ambula- 	• Authorization rules may apply. In-Network • \$375 copay for each Medicare-covered ambulatory surgical center visit • \$375 copay for each Medicare-covered outpatient hospital facility visit Out-of-Network • 25% of the cost for Medicare-covered outpatient hospital facility visits • 25% of the cost for Medicare-covered ambula-	• Authorization rules may apply. In-Network • \$375 copay for each Medicare-covered ambulatory surgical center visit • \$375 copay for each Medicare-covered outpatient hospital facility visit Out-of-Network • 25% of the cost for Medicare-covered outpatient hospital facility visits • 25% of the cost for Medicare-covered ambula-	• Authorization rules may apply. In-Network • \$125 copay for each Medicare-covered ambulatory surgical center visit • \$125 copay for each Medicare-covered outpatient hospital facility visit Out-of-Network • 20% of the cost for Medicare-covered outpatient hospital facility visits • 20% of the cost for Medicare-covered ambulatory and control of the cost for Medicar	• Authorization rules may apply. In-Network • \$125 copay for each Medicare-covered ambutory surgical center visit • \$125 copay for each Medicare-covered outpatient hospital facility visitout-of-Network • 20% of the cost for Medicare-covered outpatient hospital facility visitout-of-Network • 20% of the cost for Medicare-covered ambutory surgical center visits

tory surgical center visits

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
14 - Ambulance Services (medically necessary am- bulance services)	• 20% coinsurance	 In-Network \$150 copay for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits. Out-of-Network 20% of the cost for Medicare-covered ambulance benefits. 	 In-Network \$150 copay for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits. Out-of-Network 20% of the cost for Medicare-covered ambulance benefits. 	 In-Network \$150 copay for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits. Out-of-Network 25% of the cost for Medicare-covered ambulance benefits. 	covered ambulance ben- efits.	In-Network • \$150 copay for Medicare-covered ambulance benefits. • If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits. Out-of-Network • 20% of the cost for Medicare-covered ambulance benefits.	In-Network • \$150 copay for Medicare-covered ambulance benefits. • If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits. Out-of-Network • 20% of the cost for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	 20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances. 	• \$65 copay for Medicare-covered emergency room visits This amount applies to-ward your <i>In-Network</i> plan deductible. This amount applies to-ward your <i>Out-of-Network</i> plan deductible. • Worldwide coverage. • If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.	• \$65 copay for Medicare- covered emergency room visits This amount applies to- ward your <i>In-Network</i> plan deductible. This amount applies to- ward your <i>Out-of-Network</i> plan deductible. • Worldwide coverage. • If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.	 General \$65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit. 	 General \$65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit. 	• \$65 copay for Medicare-covered emergency room visits This amount applies to-ward your <i>In-Network</i> plan deductible. This amount applies to-ward your <i>Out-of-Network</i> plan deductible. • Worldwide coverage. • If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.	• \$65 copay for Medicare-covered emergency room visits This amount applies toward your <i>In-Network</i> plan deductible. This amount applies toward your <i>Out-of-Network</i> plan deductible. • Worldwide coverage. • If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	 20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances. 	 General \$25 copay for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the urgently-needed-care visit. 	 General \$25 copay for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the urgently-needed-care visit. 	 General \$35 copay for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the urgently-needed-care visit. 	hospital within 3-day(s) for the same condition, you pay \$0 for the urgently-	General • \$25 copay for Medicare-covered urgently-needed-care visits • If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the urgently-needed-care visit.	General • \$25 copay for Medicare-covered urgently-needed-care visits • If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the urgently-needed-care visit.

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	• 20% coinsurance	• Authorization rules may apply. In-Network • \$25 copay for Medicare-covered Occupational Therapy visits • \$25 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits Out-of-Network • 20% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • 20% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • 20% of the cost for Medicare-covered Occupational Therapy visits.	• Authorization rules may apply. In-Network • \$25 copay for Medicare-covered Occupational Therapy visits • \$25 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits Out-of-Network • 20% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • 20% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • 20% of the cost for Medicare-covered Occupational Therapy visits.	• Authorization rules may apply. In-Network • \$35 copay for Medicarecovered Occupational Therapy visits • \$35 copay for Medicarecovered Physical Therapy and/or Speech and Language Pathology visits Out-of-Network • 25% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • 25% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • 25% of the cost for Medicare-covered Occupational Therapy visits.	• Authorization rules may apply. In-Network • \$35 copay for Medicare-covered Occupational Therapy visits • \$35 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits Out-of-Network • 25% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • 25% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • 25% of the cost for Medicare-covered Occupational Therapy visits.	• Authorization rules may apply. In-Network • \$25 copay for Medicare-covered Occupational Therapy visits • \$25 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits Out-of-Network • 20% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • 20% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits • 20% of the cost for Medicare-covered Occupational Therapy visits.	 General Authorization rules may apply. In-Network \$25 copay for Medicare-covered Occupational Therapy visits \$25 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits Out-of-Network 20% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits Therapy and/or Speech and Language Pathology visits 20% of the cost for Medicare-covered Occupational Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES 18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	• 20% coinsurance	 General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered durable medical equipment Out-of-Network 20% of the cost for Medicare-covered durable medical equipment 	General • Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered durable medical equipment Out-of-Network • 20% of the cost for Medicare-covered durable medical equipment	 General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered durable medical equipment Out-of-Network 25% of the cost for Medicare-covered durable medical equipment 	• Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered durable medical equipment Out-of-Network • 25% of the cost for Medicare-covered durable medical equipment	 General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered durable medical equipment Out-of-Network 20% of the cost for Medicare-covered durable medical equipment 	General • Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered durable medical equipment Out-of-Network • 20% of the cost for Medicare-covered durable medical equipment

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	• 20% coinsurance	• Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered prosthetic devices Out-of-Network • 20% of the cost for Medicare-covered prosthetic devices	 General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered prosthetic devices Out-of-Network 20% of the cost for Medicare-covered prosthetic devices for Medicare-covered prosthetic devices. 	 General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered prosthetic devices Out-of-Network 25% of the cost for Medicare-covered prosthetic devices. 	• Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered prosthetic devices Out-of-Network • 25% of the cost for Medicare-covered prosthetic devices.	• Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered prosthetic devices Out-of-Network • 20% of the cost for Medicare-covered prosthetic devices.	• Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered prosthetic devices Out-of-Network • 20% of the cost for Medicare-covered prosthetic devices.
20 - Diabetes Programs and Supplies	• 20% coinsurance for diabetes self-management training • 20% coinsurance for diabetes supplies • 20% coinsurance for diabetic therapeutic shoes or inserts	• Authorization rules may apply. In-Network • \$0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts Out-of-Network • 20% of the cost for Medicare-covered Diabetes self-management training • 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts	• Authorization rules may apply. In-Network • \$0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts Out-of-Network • 20% of the cost for Medicare-covered Diabetes self-management training • 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts	• Authorization rules may apply. In-Network • \$0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. • 20% of the cost for Medicare-covered Therapeutic shoes or inserts Out-of-Network • 25% of the cost for Medicare-covered Diabetes self-management training • 25% of the cost for Medicare-covered Diabetes monitoring supplies • 25% of the cost for Medicare-covered Therapeutic shoes or inserts	• Authorization rules may apply. In-Network • \$0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. • 20% of the cost for Medicare-covered Therapeutic shoes or inserts Out-of-Network • 25% of the cost for Medicare-covered Diabetes self-management training • 25% of the cost for Medicare-covered Diabetes monitoring supplies • 25% of the cost for Medicare-covered Therapeutic shoes or inserts	• Authorization rules may apply. In-Network • \$0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts Out-of-Network • 20% of the cost for Medicare-covered Diabetes self-management training • 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts	• Authorization rules may apply. In-Network • \$0 copay for Medicare-covered Diabetes self-management training • 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts Out-of-Network • 20% of the cost for Medicare-covered Diabetes self-management training • 20% of the cost for Medicare-covered Diabetes monitoring supplies • 20% of the cost for Medicare-covered Therapeutic shoes or inserts

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	• 20% coinsurance for diagnostic tests and x-rays • \$0 copay for Medicare-covered lab services • Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	• Authorization rules may apply. In-Network • \$10 copay for Medicare-covered lab services • \$10 copay for Medicare-covered diagnostic procedures and tests • \$45 copay for Medicare-covered X-rays • \$45 to \$125 copay for Medicare-covered X-rays • \$45 to \$125 copay for Medicare-covered diagnostic radiology services (not including X-rays) • \$45 copay for Medicare-covered therapeutic radiology services Out-of-Network • 20% of the cost for Medicare-covered therapeutic radiology services • 20% of the cost for Medicare-covered outpatient X-rays • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic procedures, tests, and lab services	• Authorization rules may apply. In-Network • \$10 copay for Medicare-covered lab services • \$10 copay for Medicare-covered diagnostic procedures and tests • \$45 copay for Medicare-covered X-rays • \$45 to \$125 copay for Medicare-covered diagnostic radiology services (not including X-rays) • \$45 copay for Medicare-covered therapeutic radiology services Out-of-Network • 20% of the cost for Medicare-covered therapeutic radiology services • 20% of the cost for Medicare-covered outpatient X-rays • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic procedures, tests, and lab services	• Authorization rules may apply. In-Network • 0% to 20% of the cost for Medicare-covered lab services • 0% to 20% of the cost for Medicare-covered diagnostic procedures and tests • \$45 copay for Medicare-covered X-rays • 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays) • 20% of the cost for Medicare-covered therapeutic radiology services Out-of-Network • 25% of the cost for Medicare-covered therapeutic radiology services • 25% of the cost for Medicare-covered outpatient X-rays • 25% of the cost for Medicare-covered diagnostic radiology services • 25% of the cost for Medicare-covered diagnostic radiology services • 25% of the cost for Medicare-covered diagnostic radiology services	• Authorization rules may apply. In-Network • 0% to 20% of the cost for Medicare-covered lab services • 0% to 20% of the cost for Medicare-covered diagnostic procedures and tests • \$45 copay for Medicare-covered X-rays • 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays) • 20% of the cost for Medicare-covered therapeutic radiology services Out-of-Network • 25% of the cost for Medicare-covered therapeutic radiology services • 25% of the cost for Medicare-covered outpatient X-rays • 25% of the cost for Medicare-covered diagnostic radiology services • 25% of the cost for Medicare-covered diagnostic radiology services • 25% of the cost for Medicare-covered diagnostic radiology services	• Authorization rules may apply. In-Network • \$10 copay for Medicare-covered lab services • \$10 copay for Medicare-covered diagnostic procedures and tests • \$45 copay for Medicare-covered X-rays • \$45 to \$125 copay for Medicare-covered diagnostic radiology services (not including X-rays) • \$45 copay for Medicare-covered therapeutic radiology services Out-of-Network • 20% of the cost for Medicare-covered therapeutic radiology services • 20% of the cost for Medicare-covered outpatient X-rays • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic procedures, tests, and lab services	• Authorization rules may apply. In-Network • \$10 copay for Medicare-covered lab services • \$10 copay for Medicare-covered diagnostic procedures and tests • \$45 copay for Medicare-covered X-rays • \$45 to \$125 copay for Medicare-covered diagnostic radiology services (not including X-rays) • \$45 copay for Medicare-covered therapeutic radiology services Out-of-Network • 20% of the cost for Medicare-covered therapeutic radiology services • 20% of the cost for Medicare-covered outpatient X-rays • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic radiology services • 20% of the cost for Medicare-covered diagnostic procedures, tests, and lab services
22 - Cardiac and Pulmonary Rehabilitation Services	• 20% coinsurance for Cardiac Rehabilitation services • 20% coinsurance for Pulmonary Rehabilitation services • 20% coinsurance for Intensive Cardiac Rehabilitation services	 General Authorization rules may apply. In-Network \$10 copay for Medicare-covered Cardiac Rehabilitation Services \$10 copay for Medicare- 	 General Authorization rules may apply. In-Network \$10 copay for Medicarecovered Cardiac Rehabilitation Services \$10 copay for Medicare- 	 In-Network \$10 copay for Medicare-covered Cardiac Rehabilitation Services \$10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services \$10 copay for Medicare- 	 In-Network \$10 copay for Medicare-covered Cardiac Rehabilitation Services \$10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services \$10 copay for Medicare- 	 General Authorization rules may apply. In-Network \$10 copay for Medicarecovered Cardiac Rehabilitation Services \$10 copay for Medicare- 	 General Authorization rules may apply. In-Network \$10 copay for Medicare-covered Cardiac Rehabilitation Services \$10 copay for Medicare-

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
	• This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	covered Intensive Cardiac Rehabilitation Services • \$10 copay for Medicare- covered Pulmonary Reha- bilitation Services Out-of-Network • 20% of the cost for Medicare-covered Cardiac Rehabilitation Services • 20% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services • 20% of the cost for Medicare-covered Pulmonary Rehabilitation Services	covered Intensive Cardiac Rehabilitation Services • \$10 copay for Medicare- covered Pulmonary Reha- bilitation Services Out-of-Network • 20% of the cost for Medicare-covered Cardiac Rehabilitation Services • 20% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services • 20% of the cost for Medicare-covered Pulmonary Rehabilitation Services	covered Pulmonary Rehabilitation Services Out-of-Network • 25% of the cost for Medicare-covered Cardiac Rehabilitation Services • 25% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services • 25% of the cost for Medicare-covered Pulmonary Rehabilitation Services	covered Pulmonary Rehabilitation Services Out-of-Network • 25% of the cost for Medicare-covered Cardiac Rehabilitation Services • 25% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services • 25% of the cost for Medicare-covered Pulmonary Rehabilitation Services	covered Intensive Cardiac Rehabilitation Services • \$10 copay for Medicare- covered Pulmonary Reha- bilitation Services Out-of-Network • 25% of the cost for Medicare-covered Cardiac Rehabilitation Services • 25% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services • 25% of the cost for Medicare-covered Pulmonary Rehabilitation Services	covered Intensive Cardiac Rehabilitation Services • \$10 copay for Medicare- covered Pulmonary Reha- bilitation Services Out-of-Network • 25% of the cost for Medicare-covered Cardiac Rehabilitation Services • 25% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services • 25% of the cost for Medicare-covered Pulmonary Rehabilitation Services
PREVENTIVE SERVICES, WELLNESS/ EDUCATION AND OTHER SUPPLEMENTAL BEN- EFIT PROGRAMS							
23 -Preventive Services, Wellness/Education and other Supplemental Ben- efit Programs	 No coinsurance, copayment or deductible for the following: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered 	l e	 General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. In-Network \$10 copay for an annual physical exam The plan covers the following supplemental education/wellness programs: 	 General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. In-Network \$20 copay for an annual physical exam The plan covers the following supplemental education/wellness programs: 	 General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. In-Network \$20 copay for an annual physical exam The plan covers the following supplemental education/wellness programs: 	 General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. In-Network \$10 copay for an annual physical exam The plan covers the following supplemental education/wellness programs: 	• \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. • Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. In-Network • \$10 copay for an annual physical exam • The plan covers the following supplemental education/wellness programs:

Benefit Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
once a year for women with Medicare at high risk. Colorectal Cancer Screening Diabetes Screening Influenza Vaccine Hepatitis B Vaccine for people with Medicare who are at risk HIV Screening, \$0 copay for the HIV screening, but you Generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services	• Health Club Membership/Fitness Classes • Nursing Hotline • \$0 copay for Enhanced Preventive Health Services. • Contact plan for details. Out-of-Network • \$20 copay for an annual physical exam • \$35 copay for Medicare-covered preventive services • \$35 copay for Enhanced Preventive Health Services • 20% of the cost for supplemental education/wellness programs • 20% of the cost for Enhanced Preventive Health Services	• Health Club Membership/Fitness Classes • Nursing Hotline • \$0 copay for Enhanced Preventive Health Services. • Contact plan for details. Out-of-Network • \$20 copay for an annual physical exam • \$35 copay for Medicarecovered preventive services • \$35 copay for Enhanced Preventive Health Services • 20% of the cost for supplemental education/wellness programs • 20% of the cost for Enhanced Preventive Health Services Services	• Health Education • Health Club Membership/Fitness Classes • Nursing Hotline • \$0 copay for Enhanced Preventive Health Services. • Contact plan for details. Out-of-Network • \$30 copay for an annual physical exam • \$45 copay for Medicare-covered preventive services • \$45 copay for Enhanced Preventive Health Services • 25% of the cost for supplemental education/wellness programs	• Health Education • Health Club Membership/Fitness Classes • Nursing Hotline • \$0 copay for Enhanced Preventive Health Services. • Contact plan for details. Out-of-Network • \$30 copay for an annual physical exam • \$45 copay for Medicare-covered preventive services • \$45 copay for Enhanced Preventive Health Services • 25% of the cost for supplemental education/wellness programs	• Health Club Membership/Fitness Classes • Nursing Hotline • \$0 copay for Enhanced Preventive Health Services. • Contact plan for details. Out-of-Network • \$20 copay for an annual physical exam • \$35 copay for Medicare-covered preventive services • \$35 copay for Enhanced Preventive Health Services • 20% of the cost for supplemental education/wellness programs • 20% of the cost for Enhanced Preventive Health Services	• Health Club Membership/Fitness Classes • Nursing Hotline • \$0 copay for Enhanced Preventive Health Services. • Contact plan for details. Out-of-Network • \$20 copay for an annual physical exam • \$35 copay for Medicare-covered preventive services • \$35 copay for Enhanced Preventive Health Services • 20% of the cost for supplemental education/wellness programs • 20% of the cost for Enhanced Preventive Health Services

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible R (PPO)
	can be given by a registered				1		1
	dietitian and may include						
	a nutritional assessment						
	and counseling to help you						
	manage your diabetes or						
	kidney disease						
	Personalized Prevention						
	Plan						
	• Services (Annual Wellness						
	Visits)						
	Pneumococcal Vaccine.						
	You may only need the						
	Pneumonia vaccine once						
	in your lifetime. Call your						
	doctor for more informa-						
	tion.						
	Prostate Cancer Screening						
	Prostate Specific Antigen (DSA)						
	(PSA) test only. Covered						
	once a year for all men						
	with Medicare over age 50.						
	• Smoking and Tobacco						
	Use Cessation (counsel-						
	ing to stop smoking and tobacco use). Covered if						
	ordered by your doctor.						
	Includes two counseling at-						
	tempts within a 12-month						
	period. Each counseling						
	attempt includes up to four						
	face-to-face visits.						
	• Screening and behavioral						
	counseling interventions						
	in primary care to reduce						
	alcohol misuse						
	Screening for depression						
	in adults						
	• Screening for sexu-						
	ally transmitted infections						
	(STI) and high-intensity						
	behavioral counseling to						
	prevent STIs						

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
	• Intensive behavioral counseling for Cardiovascular Disease (bi-annual) • Intensive behavioral therapy for obesity • Welcome to Medicare Preventive Visits (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visits or an Annual Wellness Visit. After your first 12 months, you can get one • Annual Wellness Visit every 12 months.						
24 - Kidney Disease and Conditions	• 20% coinsurance for renal dialysis • 20% coinsurance for kidney disease education services	• Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered renal dialysis • \$0 copay for Medicare-covered kidney disease education services Out-of-Network • 20% of the cost for Medicare-covered kidney disease education services • 20% of the cost for Medicare-covered renal dialysis	• Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered renal dialysis • \$0 copay for Medicare-covered kidney disease education services Out-of-Network • 20% of the cost for Medicare-covered kidney disease education services • 20% of the cost for Medicare-covered kidney disease education services • 20% of the cost for Medicare-covered renal dialysis	In-Network • 20% of the cost for Medicare-covered renal dialysis • \$0 copay for Medicare-covered kidney disease education services Out-of-Network • 25% of the cost for Medicare-covered kidney disease education services • 25% of the cost for Medicare-covered renal dialysis	In-Network • 20% of the cost for Medicare-covered renal dialysis • \$0 copay for Medicare-covered kidney disease education services Out-of-Network • 25% of the cost for Medicare-covered kidney disease education services • 25% of the cost for Medicare-covered renal dialysis	• Authorization rules may apply. • In-Network • 20% of the cost for Medicare-covered renal dialysis • \$0 copay for Medicare-covered kidney disease education services • Out-of-Network • 20% of the cost for Medicare-covered kidney disease education services • 20% of the cost for Medicare-covered renal dialysis	General • Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered renal dialysis • \$0 copay for Medicare-covered kidney disease education services Out-of-Network • 20% of the cost for Medicare-covered kidney disease education services • 20% of the cost for Medicare-covered kidney disease education services • 20% of the cost for Medicare-covered renal dialysis

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
PRESCRIPTION DRUG BENEFITS							
25 - Outpatient Prescription Drugs	• Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	Drugs covered under Medicare Part B General • Most drugs not covered. • 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. • 20% of the cost for Medicare Part B drugs Out-of-Network. Drugs covered under Medicare Part D General • This plan does not offer prescription drug coverage.	Drugs covered under Medicare Part B General • 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. • 20% of the cost for Medicare Part B drugs out-of-network. Drugs covered under Medicare Part D General • This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.thehealthplan.com/Gold/Landing_Pages/Formulary/ on the web. • Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers. • The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them	Drugs covered under Medicare Part B General • Most drugs not covered. • 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. • 25% of the cost for Medicare Part B drugs Out-of-Network. Drugs covered under Medicare Part D General • This plan does not offer prescription drug coverage.	Drugs covered under Medicare Part B General • 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. • 25% of the cost for Medicare Part B drugs out-of-network. Drugs covered under Medicare Part D General • This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.thehealthplan.com/Gold/Landing_Pages/Formulary/ on the web. • Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers. • The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them	Drugs covered under Medicare Part B General • Most drugs not covered. • 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. • 20% of the cost for Medicare Part B drugs Out-of-Network. Drugs covered under Medicare Part D General • This plan does not offer prescription drug coverage.	Drugs covered under Medicare Part B General 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. 20% of the cost for Medicare Part B drugs Out-of-Network. Drugs covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.thehealthplan.com/Gold/Landing_Pages/Formulary/ on the web. Different out-of-pocket costs may apply for people who have limited incomes, live in long term care facilities, or have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
		1	at an in-network pharmacy		at an in-network pharmacy		at an in-network pharma
			outside of the plan's service		outside of the plan's service		outside of the plan's servi
			area (for instance when you		area (for instance when you		area (for instance when y
			travel).		travel).		travel).
			• Total yearly drug costs are		Total yearly drug costs are		• Total yearly drug costs
			the total drug costs paid		the total drug costs paid		the total drug costs paid
			by both you and a Part D		by both you and a Part D		by both you and a Part I
			plan.		plan.		plan.
			• The plan may require you		• The plan may require you		• The plan may require y
			to first try one drug to treat		to first try one drug to treat		to first try one drug to tr
			your condition before it		your condition before it		your condition before it
			will cover another drug for		will cover another drug for		will cover another drug f
			that condition.		that condition.		that condition.
			 Some drugs have quantity 		Some drugs have quantity		• Some drugs have quant
			limits.		limits.		limits.
			Your provider must get		Your provider must get		Your provider must get
			prior authorization from		prior authorization from		prior authorization from
			Geisinger Gold Preferred 1		Geisinger Gold Preferred 2		Geisinger Gold Preferred
			\$0 Deductible Rx (PPO)		\$0 Deductible Rx (PPO)		\$0 Deductible Rx (PPO)
			for certain drugs.		for certain drugs.		for certain drugs.
			You must go to certain		• You must go to certain		• You must go to certain
			pharmacies for a very		pharmacies for a very		pharmacies for a very
			limited number of drugs,		limited number of drugs,		limited number of drugs
			due to special handling,		due to special handling,		due to special handling,
			provider coordination, or		provider coordination, or		provider coordination, o
			patient education require-		patient education require-		patient education require
			ments that cannot be met		ments that cannot be met		ments that cannot be me
			by most pharmacies in your		by most pharmacies in your		by most pharmacies in yo
			network. These drugs are		network. These drugs are		network. These drugs are
			listed on the plan's website,		listed on the plan's website,		listed on the plan's websi
			formulary, printed materi-		formulary, printed materi-		formulary, printed mater
			als, as well as on the Medi-		als, as well as on the Medi-		als, as well as on the Me
			care Prescription Drug Plan		care Prescription Drug Plan		care Prescription Drug P
			Finder on Medicare.gov.		Finder on Medicare.gov.		Finder on Medicare.gov.
			If the actual cost of a drug		If the actual cost of a drug		If the actual cost of a dru
			is less than the normal		is less than the normal		is less than the normal
			cost-sharing amount for		cost-sharing amount for		cost-sharing amount for
			that drug, you will pay the		that drug, you will pay the		that drug, you will pay the
			actual cost, not the higher		actual cost, not the higher		actual cost, not the high
			cost-sharing amount.		cost-sharing amount.		cost-sharing amount.
			• If you request a formulary		• If you request a formulary		• If you request a formul
			exception for a drug and		exception for a drug and		exception for a drug and

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
			Geisinger Gold Preferred 1		Geisinger Gold Preferred 2		Geisinger Gold Preferred 3
			\$0 Deductible Rx (PPO)		\$0 Deductible Rx (PPO)		\$0 Deductible Rx (PPO)
			approves the exception, you		approves the exception, you		approves the exception, you
			will pay Tier 4: Non-Pre-		will pay Tier 4: Non-Pre-		will pay Tier 4: Non-Pre-
			ferred Brand cost sharing		ferred Brand cost sharing		ferred Brand cost sharing
			for that drug.		for that drug.		for that drug.
			In-Network S		In-Network		In-Network
			• \$0 deductible.		• \$0 deductible.		• \$0 deductible.
			Initial Coverage		Initial Coverage		Initial Coverage
			You pay the following		You pay the following		You pay the following
			until total yearly drug costs		until total yearly drug costs		until total yearly drug costs
			reach \$2,970:		reach \$2,970:		reach \$2,970:
			Retail Pharmacy		Retail Pharmacy		Retail Pharmacy
			• Tier 1: Preferred Generic		• Tier 1: Preferred Generic		• Tier 1: Preferred Generic
			• - \$3 copay for a one-		• - \$3 copay for a one-		• - \$3 copay for a one-
			month (34-day) supply		month (34-day) supply		month (34-day) supply
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			• \$9 copay for a three-		• \$9 copay for a three-		• \$9 copay for a three-
			month (90-day) supply		month (90-day) supply		month (90-day) supply
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			• Not all drugs on this tier		Not all drugs on this tier		• Not all drugs on this tier
			are available at this ex-		are available at this ex-		are available at this ex-
			tended day supply. Please		tended day supply. Please		tended day supply. Please
			contact the plan for more		contact the plan for more		contact the plan for more
			information.		information.		information.
			• Tier 2: Non-Preferred		• Tier 2: Non-Preferred		• Tier 2: Non-Preferred
			Generic		Generic General Genera		Generic
			• \$7 copay for a one-		• \$7 copay for a one-		• \$7 copay for a one-
			month (34-day) supply		month (34-day) supply		month (34-day) supply
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			• \$21 copay for a three-		• \$21 copay for a three-		• \$21 copay for a three-
			month (90-day) supply		month (90-day) supply		month (90-day) supply
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			• Not all drugs on this tier		Not all drugs on this tier		• Not all drugs on this tier
			are available at this ex-		are available at this ex-		are available at this ex-
			tended day supply. Please		tended day supply. Please		tended day supply. Please
			contact the plan for more		contact the plan for more		contact the plan for more
			information.		information.		information.
			• Tier 3: Preferred Brand		• Tier 3: Preferred Brand		• Tier 3: Preferred Brand
			• \$39 copay for a one-		• \$39 copay for a one-		• \$39 copay for a one-
					1 * '		month (34-day) supply
			month (34-day) supply		month (34-day) supply		of drugs in this tier
			of drugs in this tier		of drugs in this tier		or drugs in this tier

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
			• \$117 copay for a three-		• \$117 copay for a three-		• \$117 copay for a thre
			month (90-day) supply		month (90-day) supply		month (90-day) supply
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			Not all drugs on this tier		• Not all drugs on this tier		• Not all drugs on this tie
			are available at this ex-		are available at this ex-		are available at this ex-
			tended day supply. Please		tended day supply. Please		tended day supply. Please
			contact the plan for more		contact the plan for more		contact the plan for more
			information.		information.		information.
			• Tier 4: Non-Preferred		• Tier 4: Non-Preferred		• Tier 4: Non-Preferred
			Brand		Brand		Brand
			• \$69 copay for a one- month (34-day) supply		• \$69 copay for a one-		• \$69 copay for a one-
			of drugs in this tier		month (34-day) supply of drugs in this tier		month (34-day) supply
			• \$207 copay for a three-		• \$207 copay for a three-		of drugs in this tier
			month (90-day) supply		month (90-day) supply		• \$207 copay for a three manth (00 day) suppl
			of drugs in this tier		of drugs in this tier		month (90-day) suppl of drugs in this tier
			• Not all drugs on this tier		Not all drugs on this tier		• Not all drugs on this tie
			are available at this ex-		are available at this ex-		are available at this ex-
			tended day supply. Please		tended day supply. Please		tended day supply. Please
			contact the plan for more		contact the plan for more		contact the plan for more
			information.		information.		information.
			• Tier 5: Specialty Tier		• Tier 5: Specialty Tier		• Tier 5: Specialty Tier
			• 33% coinsurance for		• 33% coinsurance for		• 33% coinsurance for
			a one-month (34-day)		a one-month (34-day)		a one-month (34-day)
			supply of drugs in this		supply of drugs in this		supply of drugs in this
			tier		tier		tier
			Long Term Care Pharmacy		Long Term Care Pharmacy		Long Term Care Pharmae
			• Tier 1: Preferred Generic		• Tier 1: Preferred Generic		• Tier 1: Preferred General
			•\$3 copay for a one-		• \$3 copay for a one-		• \$3 copay for a one-
			month (34-day) supply		month (34-day) supply		month (34-day) suppl
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			• Tier 2: Non-Preferred		• Tier 2: Non-Preferred		• Tier 2: Non-Preferred
			Generic		Generic		Generic
			• \$7 copay for a one-		• \$7 copay for a one-		• \$7 copay for a one-
			month (34-day) supply		month (34-day) supply		month (34-day) suppl
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			• Tier 3: Preferred Brand		• Tier 3: Preferred Brand		• Tier 3: Preferred Brand
			• \$39 copay for a one-		• \$39 copay for a one-		• \$39 copay for a one-
			month (34-day) supply		month (34-day) supply		month (34-day) suppl
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			• Tier 4: Non-Preferred		• Tier 4: Non-Preferred		• Tier 4: Non-Preferred
		1	Brand		Brand		Brand

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
			• \$69 copay for a one-		• \$69 copay for a one-		• \$69 copay for a one-
			month (34-day) supply		month (34-day) supply		month (34-day) supply
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			Tier 5: Specialty Tier33% coinsurance for		• Tier 5: Specialty Tier		• Tier 5: Specialty Tier
			a one-month (34-day)		• 33% coinsurance for		• 33% coinsurance for
			supply of drugs in this		a one-month (34-day)		a one-month (34-day) supply of drugs in this
			tier		supply of drugs in this		tier
			• Please note that brand		• Please note that brand		• Please note that brand
			drugs must be dispensed		drugs must be dispensed		drugs must be dispensed
			incrementally in long-term		incrementally in long-term		incrementally in long-tern
			care facilities. Generic		care facilities. Generic		care facilities. Generic
			drugs may be dispensed in-		drugs may be dispensed in-		drugs may be dispensed in
			crementally. Contact your		crementally. Contact your		crementally. Contact your
			plan about cost-sharing		plan about cost-sharing		plan about cost-sharing
			billing/collection when less		billing/collection when less		billing/collection when les
			than a one-month supply is		than a one-month supply is		than a one-month supply
			dispensed.		dispensed.		dispensed.
			Mail Order		Mail Order		Mail Order
			• Tier 1: Preferred Generic		• Tier 1: Preferred Generic		• Tier 1: Preferred Generic
			• \$9 copay for a three-		• \$9 copay for a three-		• \$9 copay for a three-
			month (90-day) supply		month (90-day) supply		month (90-day) supply
			of drugs in this tier • Not all drugs on this tier		of drugs in this tier		of drugs in this tier
			are available at this ex-		• Not all drugs on this tier are available at this ex-		• Not all drugs on this tier are available at this ex-
			tended day supply. Please		tended day supply. Please		tended day supply. Please
			contact the plan for more		contact the plan for more		contact the plan for more
			information.		information.		information.
			Tier 2: Non-Preferred		Tier 2: Non-Preferred		Tier 2: Non-Preferred
			Generic		Generic		Generic
			• \$21 copay for a three-		• \$21 copay for a three-		• \$21 copay for a three-
			month (90-day) supply		month (90-day) supply		month (90-day) supply
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			Not all drugs on this tier		Not all drugs on this tier		Not all drugs on this tier
			are available at this ex-		are available at this ex-		are available at this ex-
			tended day supply. Please		tended day supply. Please		tended day supply. Please
			contact the plan for more		contact the plan for more		contact the plan for more
			information.		information.		information.
			Tier 3: Preferred Brand		Tier 3: Preferred Brand		Tier 3: Preferred Brand
			• \$117 copay for a three-		• \$117 copay for a three-		• \$117 copay for a three
J.			month (90-day) supply		month (90-day) supply		month (90-day) supply

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
			• Not all drugs on this tier		• Not all drugs on this tier		• Not all drugs on this
			are available at this ex-		are available at this ex-		are available at this ex-
			tended day supply. Please		tended day supply. Please		tended day supply. Ple
			contact the plan for more		contact the plan for more		contact the plan for m
			information.		information.		information.
			• Tier 4: Non-Preferred		• Tier 4: Non-Preferred		• Tier 4: Non-Preferred
			Brand		Brand		Brand
			• \$207 copay for a three-		• \$207 copay for a three-		• \$207 copay for a t
			month (90-day) supply		month (90-day) supply		month (90-day) sup
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			 Not all drugs on this tier 		Not all drugs on this tier		• Not all drugs on this
			are available at this ex-		are available at this ex-		are available at this ex-
			tended day supply. Please		tended day supply. Please		tended day supply. Ple
			contact the plan for more		contact the plan for more		contact the plan for n
			information.		information.		information.
			Coverage Gap		Coverage Gap		Coverage Gap
			• After your total yearly		After your total yearly		• After your total year
			drug costs reach \$2,970,		drug costs reach \$2,970,		drug costs reach \$2,97
			you receive limited cover-		you receive limited cover-		you receive limited co
			age by the plan on certain		age by the plan on certain		age by the plan on cer
			drugs. You will also receive		drugs. You will also receive		drugs. You will also re
			a discount on brand name		a discount on brand name		a discount on brand 1
			drugs and generally pay no		drugs and generally pay no		drugs and generally p
			more than 47.5% for the		more than 47.5% for the		more than 47.5% for
			plan's costs for brand drugs		plan's costs for brand drugs		plan's costs for brand
			and 79% of the plan's costs		and 79% of the plan's costs		and 79% of the plan's
			for generic drugs until your		for generic drugs until your		for generic drugs unti
			yearly out-of-pocket drug		yearly out-of-pocket drug		yearly out-of-pocket
			costs reach \$4,750.		costs reach \$4,750.		costs reach \$4,750.
			Additional Coverage Gap		Additional Coverage Gap		Additional Coverage
			• The plan covers few for-		• The plan covers few for-		• The plan covers few
			mulary generics (less than		mulary generics (less than		mulary generics (less
			10% of formulary generic		10% of formulary generic		10% of formulary gen
			drugs) through the cover-		drugs) through the cover-		drugs) through the co
			age gap.		age gap.		age gap.
			• The plan offers additional		• The plan offers additional		• The plan offers addi
			coverage in the gap for the		coverage in the gap for the		coverage in the gap fo
			following tiers.		following tiers.		following tiers.
			• You pay the following:		You pay the following:		You pay the following
			Retail Pharmacy		Retail Pharmacy		Retail Pharmacy
			• Tier 1: Preferred Generic		• Tier 1: Preferred Generic		• Tier 1: Preferred Ge
			• \$3 copay for a one-		• \$3 copay for a one-		• \$3 copay for a on

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
			month (34-day) supply of all drugs covered in this tier • \$9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy • Tier 1: Preferred Generic • \$3 copay for a one-month (34-day) supply of all drugs covered in this tier • Mail Order • Tier 1: Preferred Generic • \$9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Catastrophic Coverage • After your yearly out-of-pocket drug costs reach \$4,750, you pay the greater of: • -5% coinsurance, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs. Out-of-Network • Plan drugs may be		month (34-day) supply of all drugs covered in this tier • \$9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy • Tier 1: Preferred Generic • \$3 copay for a one-month (34-day) supply of all drugs covered in this tier • Mail Order • Tier 1: Preferred Generic • \$9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Catastrophic Coverage • After your yearly out-of-pocket drug costs reach \$4,750, you pay the greater of: • -5% coinsurance, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs. Out-of-Network • Plan drugs may be		month (34-day) supply of all drugs covered in this tier • \$9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy • Tier 1: Preferred Generic • \$3 copay for a one-month (34-day) supply of all drugs covered in this tier • Mail Order • Tier 1: Preferred Generic • \$9 copay for a three-month (90-day) supply of all drugs covered in this tier • Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Catastrophic Coverage • After your yearly out-of-pocket drug costs reach \$4,750, you pay the greater of: • -5% coinsurance, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs. Out-of-Network • Plan drugs may be

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	(PPO) \$0 De	referred 2 eductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
		1	covered in special circum-		special circum-		covered in special circum-
			stances, for instance, illness		r instance, illness		stances, for instance, illnes
			while traveling outside		eling outside		while traveling outside
			of the plan's service area	· · · · · · · · · · · · · · · · · · ·	i's service area		of the plan's service area
			where there is no network		re is no network		where there is no network
			pharmacy. You may have to		You may have to		pharmacy. You may have
			pay more than your nor-		than your nor-		pay more than your nor-
			mal cost-sharing amount		haring amount		mal cost-sharing amount
			if you get your drugs at an	' " '	your drugs at an		if you get your drugs at ar
			out-of-network pharmacy.		work pharmacy.		out-of-network pharmacy.
			In addition, you will likely		n, you will likely		In addition, you will likely
			have to pay the pharmacy's	·	y the pharmacy's		have to pay the pharmacy'
			full charge for the drug		for the drug		full charge for the drug
			and submit documenta-		it documenta-		and submit documenta-
			tion to receive reimburse-		eive reimburse-		tion to receive reimburse-
			ment from Geisinger Gold		Geisinger Gold		ment from Geisinger Gold
			Preferred 1 \$0 Deductible		2 \$0 Deductible		Preferred 3 \$0 Deductible
			Rx (PPO).	Rx (PPO).			Rx (PPO).
			Out-of-Network Initial	l "	twork Initial		Out-of-Network Initial
			Coverage	Coverage			Coverage
			 You will be reimbursed 		be reimbursed		You will be reimbursed
			up to the plan's cost of the	= = =	plan's cost of the		up to the plan's cost of the
			drug minus the following		is the following		drug minus the following
			for drugs purchased out-of-		ourchased out-of-		for drugs purchased out-o
			network until total yearly		ntil total yearly		network until total yearly
			drug costs reach \$2,970:	"	reach \$2,970:		drug costs reach \$2,970:
			• Tier 1: Preferred Generic		referred Generic		• Tier 1: Preferred Generic
			• \$3 copay for a one-	*	pay for a one-		• \$3 copay for a one-
			month (34-day) supply		(34-day) supply		month (34-day) supply
			of drugs in this tier		s in this tier		of drugs in this tier
			• Tier 2: Non-Preferred		Ion-Preferred		• Tier 2: Non-Preferred
			Generic	Generic			Generic
			• \$7 copay for a one-	1	pay for a one-		• \$7 copay for a one-
			month (34-day) supply		(34-day) supply		month (34-day) supply
			of drugs in this tier		s in this tier		of drugs in this tier
			• Tier 3: Preferred Brand		referred Brand		• Tier 3: Preferred Brand
			• \$39 copay for a one-		opay for a one-		• \$39 copay for a one-
			month (34-day) supply		(34-day) supply		month (34-day) supply
			of drugs in this tier	I &	s in this tier		of drugs in this tier
			• Tier 4: Non-Preferred		Ion-Preferred		• Tier 4: Non-Preferred
			Brand	Brand			Brand
			• \$69 copay for a one-	• \$69 cc	opay for a one-		• \$69 copay for a one-

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
	1		month (34-day) supply		month (34-day) supply		month (34-day) supply
			of drugs in this tier		of drugs in this tier		of drugs in this tier
			• Tier 5: Specialty Tier		• Tier 5: Specialty Tier		• Tier 5: Specialty Tier
			• 33% coinsurance for		• 33% coinsurance for		• 33% coinsurance for
			a one-month (34-day)		a one-month (34-day)		a one-month (34-day)
			supply of drugs in this		supply of drugs in this		supply of drugs in this
			tier		tier		tier
			Out-of-Network Coverage		Out-of-Network Coverage		Out-of-Network Coverage
			Gap		Gap		Gap
			• You will be reimbursed		• You will be reimbursed		• You will be reimbursed
			up to 21% of the plan		up to 21% of the plan		up to 21% of the plan
			allowable cost for generic		allowable cost for generic		allowable cost for generic
			drugs purchased out-of-		drugs purchased out-of-		drugs purchased out-of-
			network until total yearly		network until total yearly		network until total yearly
			out-of-pocket drug costs		out-of-pocket drug costs		out-of-pocket drug costs
			reach \$4,750. Please note		reach \$4,750. Please note		reach \$4,750. Please note
			that the plan allowable cost		that the plan allowable cost		that the plan allowable cos
			may be less than the out-		may be less than the out-		may be less than the out-
			of-network pharmacy price		of-network pharmacy price		of-network pharmacy price
			paid for your drug(s).		paid for your drug(s).		paid for your drug(s).
			• You will be reimbursed		• You will be reimbursed		• You will be reimbursed
			up to 52.5% of the plan		up to 52.5% of the plan		up to 52.5% of the plan
			allowable cost for brand		allowable cost for brand		allowable cost for brand
			name drugs purchased out-		name drugs purchased out-		name drugs purchased out
			of-network until your total		of-network until your total		of-network until your total
			yearly out-of-pocket drug		yearly out-of-pocket drug		yearly out-of-pocket drug
			costs reach \$4,750. Please		costs reach \$4,750. Please		costs reach \$4,750. Please
			note that the plan allow-		note that the plan allow-		note that the plan allow-
			able cost may be less than		able cost may be less than		able cost may be less than
			the out-of-network phar-		the out-of-network phar-		the out-of-network phar-
			macy price paid for your		macy price paid for your		macy price paid for your
			drug(s).		drug(s).		drug(s).
			Additional Out-of-Network		Additional Out-of-Network		Additional Out-of-Networ
			Coverage Gap		Coverage Gap		Coverage Gap
			• The plan covers few for-		• The plan covers few for-		• The plan covers few for-
			mulary generics (less than		mulary generics (less than		mulary generics (less than
			10% of formulary generic		10% of formulary generic		10% of formulary generic
			drugs) through the cover-		drugs) through the cover-		drugs) through the cover-
			age gap.				age gap.
			• You will be reimbursed		age gap. • You will be reimbursed		• You will be reimbursed
			for these drugs purchased		for these drugs purchased		for these drugs purchased
			out-of-network up to the				out-of-network up to the
			out of network up to the		out-of-network up to the		out of fictions up to the

Original Preferred 1 Medicare (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
	plan's cost of the drug minus the following: Tier 1: Preferred Generic • \$3 copay for a onemonth (34-day) supply of all drugs covered in this tier Out-of-Network Catastrophic Coverage • After your yearly out-of-pocket drug costs reach \$4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs.		plan's cost of the drug minus the following: Tier 1: Preferred Generic • \$3 copay for a one- month (34-day) supply of all drugs covered in this tier Out-of-Network Cata- strophic Coverage • After your yearly out-of- pocket drug costs reach \$4,750, you will be reim- bursed for drugs purchased out-of-network up to the plan's cost of the drug mi- nus your cost share, which is the greater of: • 5% coinsurance, or • \$2.65 copay for ge- neric (including brand drugs treated as generic) and a \$6.60 copay for all other drugs.		plan's cost of the drug menus the following: Tier 1: Preferred Generical *\$3 copay for a one-month (34-day) supported all drugs covered in this tier **Out-of-Network Catastrophic Coverage** After your yearly out-opocket drug costs reach \$4,750, you will be reimbursed for drugs purchastout-of-network up to the plan's cost of the drug menus your cost share, which is the greater of: **5% coinsurance, or **2.65 copay for generic (including brand drugs treated as generand a \$6.60 copay for all other drugs.

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES							
26 - Dental Services	Preventive dental services (such as cleaning) not covered.	• Authorization rules may apply. In-Network • \$0 copay for Medicare-covered dental benefits • \$20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • \$20 to \$30 copay for up to 1 dental x-ray(s) every year Out-of-Network • \$35 copay for Medicare-covered comprehensive dental benefits • 20% of the cost for supplemental preventive dental benefits	• Authorization rules may apply. In-Network • \$0 copay for Medicare-covered dental benefits • \$20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • \$20 to \$30 copay for up to 1 dental x-ray(s) every year Out-of-Network • \$35 copay for Medicare-covered comprehensive dental benefits • 20% of the cost for supplemental preventive dental benefits	• Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered dental benefits • \$20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • \$20 to \$30 copay for up to 1 dental x-ray(s) every year Out-of-Network • \$45 copay for Medicare-covered comprehensive dental benefits • 25% of the cost for supplemental preventive dental benefits	• Authorization rules may apply. In-Network • 20% of the cost for Medicare-covered dental benefits • \$20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • up to 30 copay for up to 1 dental x-ray(s) every year Out-of-Network • \$45 copay for Medicare-covered comprehensive dental benefits • 25% of the cost for supplemental preventive dental benefits	• Authorization rules may apply. In-Network • \$0 copay for Medicare-covered dental benefits • \$20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • \$20 to \$30 copay for up to 1 dental x-ray(s) every year Out-of-Network • \$35 copay for Medicare-covered comprehensive dental benefits • 20% of the cost for supplemental preventive dental benefits	• Authorization rules may apply. In-Network • \$0 copay for Medicare-covered dental benefits • \$20 copay for a visit that includes: • up to 1 oral exam(s) every six months • up to 1 cleaning(s) every six months • \$20 to \$30 copay for up to 1 dental x-ray(s) every year Out-of-Network • \$35 copay for Medicare-covered comprehensive dental benefits • 20% of the cost for supplemental preventive dental benefits
27 - Hearing Services	 Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams. 	In-Network • \$25 copay for Medicare- covered diagnostic hearing exams • \$25 copay for up to 1 supplemental routine hear- ing exam(s) every year • \$0 copay for up to 1 hear- ing aid fitting-evaluation(s) every three years • \$0 copay for up to 1 hear- ing aid(s) every three years Out-of-Network	In-Network • \$25 copay for Medicare- covered diagnostic hearing exams • \$25 copay for up to 1 supplemental routine hear- ing exam(s) every year • \$0 copay for up to 1 hear- ing aid fitting-evaluation(s) every three years • \$0 copay for up to 1 hear- ing aid(s) every three years Out-of-Network	 In-Network \$35 copay for Medicare-covered diagnostic hearing exams \$35 copay for up to 1 supplemental routine hearing exam(s) every year \$0 copay for up to 1 hearing aid fitting-evaluation(s) every three years \$0 copay for up to 1 hearing aid(s) every three years \$0 copay for up to 1 hearing aid(s) every three years 	In-Network • \$35 copay for Medicare- covered diagnostic hearing exams • \$35 copay for up to 1 supplemental routine hear- ing exam(s) every year • \$0 copay for up to 1 hear- ing aid fitting-evaluation(s) every three years • \$0 copay for up to 1 hear- ing aid(s) every three years Out-of-Network	In-Network • \$25 copay for Medicare- covered diagnostic hearing exams • \$25 copay for up to 1 supplemental routine hear- ing exam(s) every year • \$0 copay for up to 1 hear- ing aid fitting-evaluation(s) every three years • \$0 copay for up to 1 hear- ing aid(s) every three years Out-of-Network	In-Network • \$25 copay for Medicare-covered diagnostic hearing exams • \$25 copay for up to 1 supplemental routine hearing exam(s) every year • \$0 copay for up to 1 hearing aid fitting-evaluation(s) every three years • \$0 copay for up to 1 hearing aid(s) every three years Out-of-Network

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
		 \$35 copay for Medicare-covered diagnostic hearing exams. \$35 copay for supplemental hearing exams. \$0 copay for supplemental hearing aids. The plan will pay up to \$800 for all of the following services combined: Supplemental Hearing Aids In and <i>Out-of-Network</i> \$800 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both <i>In-Network</i> and out-of-network benefits. 	 \$35 copay for Medicare-covered diagnostic hearing exams. \$35 copay for supplemental hearing exams. \$0 copay for supplemental hearing aids. The plan will pay up to \$800 for all of the following services combined: Supplemental Hearing Aids In and <i>Out-of-Network</i> \$800 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both <i>In-Network</i> and out-of-network benefits. 	 \$45 copay for Medicare-covered diagnostic hearing exams. \$45 copay for supplemental hearing exams. \$0 copay for supplemental hearing aids. The plan will pay up to \$800 for all of the following services combined: Supplemental Hearing Aids In and <i>Out-of-Network</i> \$800 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both <i>In-Network</i> and out-of-network benefits. 	 \$45 copay for Medicare-covered diagnostic hearing exams. \$45 copay for supplemental hearing exams. \$0 copay for supplemental hearing aids. The plan will pay up to \$800 for all of the following services combined: Supplemental Hearing Aids In and <i>Out-of-Network</i> \$800 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both <i>In-Network</i> and out-of-network benefits. 	 \$35 copay for Medicare-covered diagnostic hearing exams. \$35 copay for supplemental hearing exams. \$0 copay for supplemental hearing aids. The plan will pay up to \$800 for all of the following services combined: Supplemental Hearing Aids In and <i>Out-of-Network</i> \$800 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both <i>In-Network</i> and out-of-network benefits. 	 \$35 copay for Medicare-covered diagnostic hearing exams. \$35 copay for supplemental hearing exams. \$0 copay for supplemental hearing aids. The plan will pay up to \$800 for all of the following services combined: Supplemental Hearing Aids In and <i>Out-of-Network</i> \$800 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both <i>In-Network</i> and out-of-network benefits.
28 - Vision Services	 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk. 	In-Network • \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. • \$0 to \$25 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • \$25 copay for up to 1 supplemental routine eye exam(s) every year • \$0 copay for glasses • \$0 copay for contacts • \$0 copay for lenses • \$0 copay for frames Out-of-Network • \$35 copay for Medicare-covered eye exams • \$35 copay for supplemental eye exams • \$0 copay for Medicare-	In-Network • \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. • \$0 to \$25 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • \$25 copay for up to 1 supplemental routine eye exam(s) every year • \$0 copay for glasses • \$0 copay for contacts • \$0 copay for lenses • \$0 copay for frames Out-of-Network • \$35 copay for Medicare-covered eye exams • \$35 copay for supplemental eye exams • \$30 copay for Medicare-	In-Network • \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • \$0 to \$35 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • \$35 copay for up to 1 supplemental routine eye exam(s) every year • \$0 copay for glasses • \$0 copay for contacts • \$0 copay for lenses • \$0 copay for frames Out-of-Network • \$45 copay for Medicare-covered eye exams • \$45 copay for supplemental eye exams • \$0 copay for Medicare-	In-Network • \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • \$0 to \$35 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • \$35 copay for up to 1 supplemental routine eye exam(s) every year • \$0 copay for glasses • \$0 copay for contacts • \$0 copay for lenses • \$0 copay for frames Out-of-Network • \$45 copay for Medicare-covered eye exams • \$45 copay for supplemental eye exams • \$0 copay for Medicare-	In-Network • \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. • \$0 to \$25 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • \$25 copay for up to 1 supplemental routine eye exam(s) every year • \$0 copay for glasses • \$0 copay for contacts • \$0 copay for lenses • \$0 copay for frames Out-of-Network • \$35 copay for Medicare-covered eye exams • \$35 copay for supplemental eye exams • \$35 copay for Medicare-	In-Network • \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. • \$0 to \$25 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • \$25 copay for up to 1 supplemental routine eye exam(s) every year • \$0 copay for glasses • \$0 copay for contacts • \$0 copay for lenses • \$0 copay for frames Out-of-Network • \$35 copay for Medicare-covered eye exams • \$35 copay for supplemental eye exams • \$0 copay for Medicare-

Benefit	Original Medicare	Preferred 1 (PPO)	Preferred 1 \$0 Deductible Rx (PPO)	Preferred 2 (PPO)	Preferred 2 \$0 Deductible Rx (PPO)	Preferred 3 (PPO)	Preferred 3 \$0 Deductible Rx (PPO)
		covered eye wear • \$0 copay for supplemental eye wear • The plan will pay up to \$200 for all of the following services combined: • Medicare-covered • Eye Wear • Supplemental • Eye Wear In and <i>Out-of-Network</i> \$200 plan coverage limit for eye wear every two years. This limit applies to both <i>In-Network</i> and out-of-network benefits.	covered eye wear • \$0 copay for supplemental eye wear • The plan will pay up to \$200 for all of the following services combined: • Medicare-covered • Eye Wear • Supplemental • Eye Wear In and <i>Out-of-Network</i> \$200 plan coverage limit for eye wear every two years. This limit applies to both <i>In-Network</i> and out-of-network benefits.	covered eye wear • \$0 copay for supplemental eye wear • The plan will pay up to \$200 for all of the following services combined: • Medicare-covered • Eye Wear • Supplemental • Eye Wear In and <i>Out-of-Network</i> \$200 plan coverage limit for eye wear every two years. This limit applies to both <i>In-Network</i> and out-of-network benefits.	covered eye wear • \$0 copay for supplemental eye wear • The plan will pay up to \$200 for all of the following services combined: • Medicare-covered • Eye Wear • Supplemental • Eye Wear In and <i>Out-of-Network</i> \$200 plan coverage limit for eye wear every two years. This limit applies to both <i>In-Network</i> and out-of-network benefits.	covered eye wear • \$0 copay for supplemental eye wear • The plan will pay up to \$200 for all of the following services combined: • Medicare-covered • Eye Wear • Supplemental • Eye Wear In and <i>Out-of-Network</i> \$200 plan coverage limit for eye wear every two years. This limit applies to both <i>In-Network</i> and out-of-network benefits.	covered eye wear • \$0 copay for supplemental eye wear • The plan will pay up to \$200 for all of the following services combined: • Medicare-covered • Eye Wear • Supplemental • Eye Wear In and <i>Out-of-Network</i> \$200 plan coverage limit for eye wear every two years. This limit applies to both <i>In-Network</i> and out-of-network benefits.
Over-the-Counter Items	• Not covered.	General • The plan does not cover Over-the-Counter items.	General • The plan does not cover Over-the-Counter items.	General • The plan does not cover Over-the-Counter items.	General • The plan does not cover Over-the-Counter items.	General • The plan does not cover Over-the-Counter items.	General • The plan does not cover Over-the-Counter items.
Transportation (Routine)	• Not covered.	In-NetworkThis plan does not cover supplemental routine transportation.	In-NetworkThis plan does not cover supplemental routine transportation.	In-NetworkThis plan does not cover supplemental routine transportation.	In-NetworkThis plan does not cover supplemental routine transportation.	 In-Network This plan does not cover supplemental routine transportation. 	 In-Network This plan does not cover supplemental routine transportation.
Acupuncture	• Not covered.	In-Network • This plan does not cover Acupuncture.	In-Network • This plan does not cover Acupuncture.	In-Network • This plan does not cover Acupuncture.	In-Network • This plan does not cover Acupuncture.	In-Network • This plan does not cover Acupuncture.	In-Network • This plan does not cover Acupuncture.

2013 Monthly Premiums by County of Residence

Please locate your county in the list below for plan availability and monthly premium.

	Preferred 1 (PPO)	Preferred 1	Preferred 2 (PPO)	Preferred 2	Preferred 3 (PPO)	Preferred 3
		\$0 Deductible Rx (PPO)		\$0 Deductible Rx (PPO)		\$0 Deductible Rx (PPO)
Adams	\$33	\$74	\$25	\$60	NA	NA
Berks	\$33	\$74	\$25	\$60	NA	NA
Blair	\$98	\$150	\$25	\$60	NA	NA
Cambria	\$98	\$150	\$25	\$60	NA	NA
Cameron	\$98	\$150	\$25	\$60	NA	NA
Carbon	NA	NA	\$26	\$61	\$96	\$148
Centre	\$98	\$150	\$20	\$55	NA	NA
Clearfield	\$98	\$150	\$20	\$55	NA	NA
Clinton	\$98	\$150	\$20	\$55	NA	NA
Columbia	\$98	\$150	\$20	\$55	NA	NA
Cumberland	\$98	\$150	\$20	\$55	NA	NA
Dauphin	\$33	\$74	\$20	\$55	NA	NA
Fulton	\$98	\$150	\$20	\$55	NA	NA
Huntingdon	\$98	\$150	\$20	\$55	NA	NA
Jefferson	\$98	\$150	\$25	\$60	NA	NA
Juniata	\$98	\$150	\$25	\$60	NA	NA
Lackawanna	\$98	\$150	\$20	\$55	NA	NA
Lancaster	\$33	\$74	\$20	\$55	NA	NA
Lebanon	\$33	\$74	\$20	\$55	NA	NA
Lehigh	NA NA	NA	\$26	\$61	\$96	\$148
Luzerne	\$98	\$150	\$20	\$55	NA	NA
Lycoming	\$98	\$150	\$20	\$55	NA	NA
Mifflin	\$98	\$150	\$25	\$60	NA	NA
Monroe	\$98	\$150	\$25	\$60	NA	NA
Montour	\$98	\$150	\$20	\$55	NA	NA
Northampton	NA	NA	\$26	\$61	\$96	\$148
Northumberland	\$98	\$150	\$20	\$55	NA	NA
	\$98	\$150	\$25	\$60	NA	NA
Perry Pike	\$98	\$150	\$25	\$60	NA	NA
Potter	\$98	\$150	\$25	\$60	NA NA	NA NA
Schuylkill	\$98	\$150	\$25	\$60	NA NA	NA NA
					NA NA	NA NA
Snyder	\$98	\$150	\$20	\$55		
Somerset	\$98	\$150	\$25	\$60	NA	NA NA
Sullivan	\$98	\$150	\$20	\$55	NA	NA
Susquehanna	\$98	\$150	\$25	\$60	NA	NA
Tioga	\$98	\$150	\$20	\$55	NA	NA
Union	\$98	\$150	\$20	\$55	NA	NA
Wayne	\$98	\$150	\$25	\$60	NA	NA
Wyoming	\$98	\$150	\$20	\$55	NA	NA
York	\$33	\$74	\$20	\$55	NA	NA