

Summary of Benefits | 2010

- **Value Plan** (HMO)
- **Value + Rx Plan** (HMO)
- **Traditional Plan** (HMO-POS)
- **Traditional + Rx Plan** (HMO-POS)
- **Explorer + Rx Plan** (PPO)*

January 1, 2010 – December 31, 2010
Central, Eastern Oregon and Mid-Columbia Gorge
(*Deschutes & Crook Counties Only)

This Summary of Benefits is for the Value Plan (HMO), Value + Rx Plan (HMO), Traditional Plan (HMO-POS), Traditional + Rx Plan (HMO-POS), and the Explorer + Rx Plan (PPO).



(541) 385-5315, (888) 863-3637 Toll Free, (800) 735-2900 TTY
Monday – Sunday, 7 days a week, 7am – 8pm
www.ClearOneHP.com

H3864, H4754

M0039_MRK_140_CMS 09/18/2009

INTRODUCTION

Section One

Value Plan (HMO) and Value + Rx Plan (HMO)

Thank you for your interest in the Value Plan (HMO) or Value + Rx Plan (HMO). Our plans are offered by Clear One Health Plans, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plans. 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 Value Plan (HMO) or Value + Rx Plan (HMO) and ask for the "Evidence of Coverage".

Traditional Plan (HMO-POS) and Traditional + Rx Plan (HMO-POS)

Thank you for your interest in the Traditional Plan (HMO-POS) or Traditional + Rx Plan (HMO-POS). Our plans are offered by Clear One Health Plans, a Medicare Advantage Health Maintenance Organization (HMO) with a Point-of-Service option (POS). This Summary of Benefits tells you some features of our plans. 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 Traditional Plan (HMO-POS) or Traditional + Rx Plan (HMO-POS) and ask for the "Evidence of Coverage".

Explorer + Rx Plan (PPO)

Thank you for your interest in Explorer + Rx Plan (PPO). Our plan is offered by Clear One Health Plans, a Medicare Advantage Preferred Provider Organization (PPO). 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 Explorer + Rx Plan (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-for-service) Medicare Plan. Another option is a Medicare health plan, like

Value Plan (HMO), Value + Rx Plan (HMO), Traditional Plan (HMO-POS), Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (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 join or leave a plan only at certain times. Please call Value Plan (HMO), Value + Rx Plan (HMO), Traditional Plan (HMO-POS), Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (PPO) at the telephone 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 Value Plan (HMO), Value + Rx Plan (HMO), Traditional Plan (HMO-POS), Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (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 VALUE PLAN (HMO), VALUE + RX PLAN (HMO), TRADITIONAL PLAN (HMO-POS), TRADITIONAL + RX PLAN (HMO-POS), OR EXPLORER + RX PLAN (PPO) AVAILABLE?

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Member Services for more information.

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Value Plan (HMO) and Value + Rx Plan (HMO)

The service area for this plan includes: Klamath*, Lake*, Crook, Deschutes, Grant, Hood River, Jefferson, Sherman, Wasco, Wheeler Counties, OR. You must live in one of these areas to join the plan.

Traditional Plan (HMO-POS) and Traditional + Rx Plan (HMO-POS)

The service area for this plan includes: Klamath*, Lake*, Deschutes, Grant, Hood River, Jefferson, Sherman, Wasco, Wheeler Counties, OR. You must live in one of these areas to join the plan.

Explorer + Rx Plan (PPO)

The service area for this plan includes: Crook and Deschutes Counties, OR. You must live in one of these areas to join the plan.

* Indicates a partial county. Klamath County includes zip codes 97731, 97733, 97737 and 97739. Lake County includes zip codes 97735, 97638 and 97641.

WHO IS ELIGIBLE TO JOIN VALUE PLAN (HMO), VALUE + RX PLAN (HMO), TRADITIONAL PLAN (HMO-POS), TRADITIONAL + RX PLAN (HMO-POS), OR EXPLORER + RX PLAN (PPO)?

You can join Value Plan (HMO), Value + Rx Plan (HMO), Traditional Plan (HMO-POS), Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (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 Value Plan (HMO), Value + Rx Plan (HMO), Traditional Plan (HMO-POS), Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (PPO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Value Plan (HMO) and Value + Rx Plan (HMO)

Value Plan (HMO) and Value + Rx Plan (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

Traditional Plan (HMO-POS) and Traditional + Rx Plan (HMO-POS)

Traditional Plan (HMO-POS) and Traditional + Rx Plan (HMO-POS) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time.

Explorer + Rx Plan (PPO)

Explorer + Rx Plan (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; or for an up-to-date list visit us at www.clearonehp.com. Our Member Services number is listed at the end of this introduction.

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

Value Plan (HMO) and Value + Rx Plan (HMO)

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Value Plan (HMO), Value + Rx Plan (HMO), nor the Original Medicare Plan will pay for these services.

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Traditional Plan (HMO-POS) and Traditional + Rx Plan (HMO-POS)

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 Member Service number at the end of this introduction.

Explorer + Rx Plan (PPO)

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 Member Services number at the end of this introduction.

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

Value Plan (HMO) and Traditional Plan (HMO-POS)

Value Plan (HMO) and Traditional Plan (HMO-POS) do cover Medicare Part B prescription drugs. Value Plan (HMO) and Traditional Plan (HMO-POS) do NOT cover Medicare Part D prescription drugs.

Value + Rx Plan (HMO), Traditional + Rx Plan (HMO-POS), and Explorer + Rx Plan (PPO)

Value + Rx Plan (HMO), Traditional + Rx Plan (HMO-POS), and Explorer + Rx Plan (PPO) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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

Value + Rx Plan (HMO), Traditional + Rx Plan (HMO-POS), and Explorer + Rx Plan (PPO) have 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.clearonehp.com/MedicareRxList. Our Member Services number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Value + Rx Plan (HMO), Traditional + Rx Plan (HMO-POS), and Explorer + Rx Plan (PPO) use 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 enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.clearonehp.com/MedicareRxList.

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 PRESCRIPTION DRUG PLAN COSTS?

You may be able to get extra help to pay for your prescription drug premiums and 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;
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday;

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- 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 year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Value (HMO), Traditional (HMO-POS), Value + Rx Plan (HMO), Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (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, Acumentra Health, Inc. at 503-279-0100.

Value + Rx Plan (HMO), Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (PPO)

As a member of Value + Rx Plan (HMO), Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (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 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, Acumentra Health, Inc. at 503-279-0100.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may 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 Value + Rx Plan (HMO),

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Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (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 Value Plan (HMO), Value + Rx Plan (HMO), Traditional Plan (HMO-POS), Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (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 drugs for osteoporosis for certain women with Medicare.
- 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 was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

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 "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at (888) 863-3637 to obtain a copy of the plan ratings for this plan. TTY users call (800) 735-2900.

Please call Clear One Health Plans for more information about Value Plan (HMO), Value + Rx Plan (HMO), Traditional Plan (HMO-POS), Traditional + Rx Plan (HMO-POS), or Explorer + Rx Plan (PPO).

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

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 7:00 a.m. - 8:00 p.m. Pacific

Current and Prospective members should call toll-free (888) 863-3637 for questions related to the Medicare Advantage Program. (TTY/TDD (800) 735-2900).

Current and Prospective members should call locally (541) 385-5315 for questions related to the Medicare Advantage Program. (TTY/TDD (800) 735-2900).

Current members should call toll-free (800) 570-1673 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800) 735-2900).

Prospective members should call toll-free (888) 863-3637 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800) 735-2900).

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Current members should call locally (800) 570-1673 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800) 735-2900).

Prospective members should call locally (541) 385-5315 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800) 735-2900).

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.

If you have special needs, this document may be available in other formats.

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Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
<p>IMPORTANT INFORMATION</p> <p>1-Premium and Other Important Information</p>	<p>In 2009 the monthly Part B Premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because</p>	<p>General \$124 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$3,400 out-of-pocket limit.</p> <p>This limit includes only Medicare-covered services.</p> <p>(See page 50 for additional information about Premium and Other Important Information)</p>	<p>General \$140 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$3,400 out-of-pocket limit.</p> <p>This limit includes only Medicare-covered services.</p> <p>(See page 50 for additional information about Premium and Other Important Information)</p>	<p>General \$153 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$3,400 out-of-pocket limit.</p> <p>This limit includes only Medicare-covered services.</p> <p>(See page 50 for additional information about Premium and Other Important Information)</p>	<p>General \$186 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$3,400 out-of-pocket limit.</p> <p>This limit includes only Medicare-covered services.</p> <p>(See page 50 for additional information about Premium and Other Important Information)</p>	<p>General \$147 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$3,400 out-of-pocket limit.</p> <p>This limit includes only Medicare-covered services.</p> <p>Out-of-Network \$10,000 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services: Supplemental Services: - Dental Services</p> <p>(See page 50 for</p>

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Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
	<p>of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>					<p>additional information about Premium and Other Important Information)</p>
<p>2-Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).</p>	<p>In-Network Referral required for network specialists (for certain benefits).</p>	<p>In-Network You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).</p>	<p>In-Network Referral required for network specialists (for certain benefits).</p>	<p>In-Network Referral required for network specialists (for certain benefits).</p>

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Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
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INPATIENT CARE						
3-Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2009 the amounts for each benefit period were: <u>Days 1-60:</u> \$1,068 deductible <u>Days 61-90:</u> \$267 per day <u>Days 91-150:</u> \$534 per lifetime reserve day These amounts will change for 2010. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.	In-Network For Medicare-covered hospital stays: <u>Days 1-4:</u> \$200 copay per day <u>Days 5-90:</u> \$0 copay per day \$0 copay for each additional hospital day. \$800 out of pocket limit every stay. No limit to the number of days covered by the plan each benefit period ³ .	In-Network For Medicare-covered hospital stays: <u>Days 1-4:</u> \$125 copay per day <u>Days 5-90:</u> \$0 copay per day \$0 copay for each additional hospital day. \$500 out of pocket limit every stay. No limit to the number of days covered by the plan each benefit period ³ .	In-Network For Medicare-covered hospital stays: <u>Days 1-4:</u> \$200 copay per day <u>Days 5-90:</u> \$0 copay per day \$0 copay for each additional hospital day. \$800 out of pocket limit every stay. No limit to the number of days covered by the plan each benefit period ³ .	In-Network For Medicare-covered hospital stays: <u>Days 1-4:</u> \$125 copay per day <u>Days 5-90:</u> \$0 copay per day \$0 copay for each additional hospital day. \$500 out of pocket limit every stay. No limit to the number of days covered by the plan each benefit period ³ .	In-Network \$500 copay for each Medicare-covered hospital stay. \$0 copay for additional hospital days. \$500 out of pocket limit every stay. No limit to the number of days covered by the plan benefit period ³ .

³ A benefit period begins the day you go to the hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a

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Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
	<p>Lifetime reserve days can only be used once.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 15% of the cost for each hospital stay.</p>

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.

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Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
4-Inpatient Mental Health Care	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p>In-Network For Medicare-covered hospital stays: <u>Days 1-4:</u> \$200 copay per day <u>Days 5 - 90:</u> \$0 copay per day</p> <p>\$800 out of pocket limit every stay.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network For Medicare-covered hospital stays: <u>Days 1-4:</u> \$125 copay per day <u>Days 5 - 90:</u> \$0 copay per day</p> <p>\$500 out of pocket limit every stay.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network For Medicare-covered hospital stays: <u>Days 1-4:</u> \$200 copay per day <u>Days 5 - 90:</u> \$0 copay per day</p> <p>\$800 out of pocket limit every stay.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network For Medicare-covered hospital stays: <u>Days 1-4:</u> \$125 copay per day <u>Days 5 - 90:</u> \$0 copay per day</p> <p>\$500 out of pocket limit every stay.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network \$500 copay for each Medicare-covered hospital stay.</p> <p>\$500 out of pocket limit every stay.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 15% of the cost for each hospital stay.</p>

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Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
<p>5-Skilled Nursing Facility (SNF)</p> <p>(in a Medicare-certified skilled nursing facility)</p>	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p><u>Days 1-20:</u> \$0 per day</p> <p><u>Days 21-100:</u> \$133.50 per day</p> <p>These amounts will change for 2010.</p> <p>100 days for each benefit period.</p> <p>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</p>	<p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: <u>Days 1-20:</u> \$0 copay per day</p> <p><u>Days 21-100:</u> \$50 copay per day</p> <p>Plan covers up to 100 days each benefit period³.</p> <p>No prior hospital stay is required.</p>	<p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: <u>Days 1-20:</u> \$0 copay per day</p> <p><u>Days 21-100:</u> \$25 copay per day</p> <p>Plan covers up to 100 days each benefit period³.</p> <p>No prior hospital stay is required.</p>	<p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: <u>Days 1-20:</u> \$0 copay per day</p> <p><u>Days 21-100:</u> \$50 copay per day</p> <p>Plan covers up to 100 days each benefit period³.</p> <p>No prior hospital stay is required.</p>	<p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: <u>Days 1-20:</u> \$0 copay per day</p> <p><u>Days 21-100:</u> \$25 copay per day</p> <p>Plan covers up to 100 days each benefit period³.</p> <p>No prior hospital stay is required.</p>	<p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: <u>Days 1-20:</u> \$0 copay per day</p> <p><u>Days 21-100:</u> \$50 copay per day</p> <p>Plan covers up to 100 days each benefit period³.</p> <p>No prior hospital stay is required.</p> <p>Out-of-Network 15% of the cost for each SNF stay.</p>

³ A benefit period begins the day you go to the hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

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Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
	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.					
6-Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits. Out-of-Network 15% for 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.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
OUTPATIENT CARE						
8-Doctor Office Visits	20% coinsurance ^{1,2}	<p>General See "Physical Exams," for more information.</p> <p>In-Network \$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare covered visit.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p>	<p>General See "Physical Exams," for more information.</p> <p>n-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare covered visit.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p>	<p>General See "Physical Exams," for more information.</p> <p>In-Network \$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare covered visit.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p>	<p>General See "Physical Exams," for more information.</p> <p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare covered visit.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p>	<p>General See "Physical Exams," for more information.</p> <p>In-Network \$20 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$30 copay for each in-area, network urgent care Medicare covered visit.</p> <p>\$30 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$30 copay for each primary care doctor visit.</p>

¹ 2009, you pay a total of \$135. NOTE: The Medicare Part B deductible may change each year.

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
						\$40 copay for each specialist visit.
9-Chiropractic Services	<p>Routine care not covered.</p> <p>20% coinsurance^{1,2} 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.</p>	<p>In-Network \$25 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic 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 or other qualified providers.</p>	<p>In-Network \$25 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic 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 or other qualified providers.</p>	<p>In-Network \$25 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic 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 or other qualified providers.</p>	<p>In-Network \$25 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic 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 or other qualified providers.</p>	<p>In-Network \$30 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic 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 or other qualified providers.</p> <p>Out-of-Network \$30 copay for chiropractic benefits.</p>

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
10-Podiatry Services	Routine care not covered. 20% coinsurance ^{1,2} for medically necessary foot care, including care for medical conditions affecting the lower limbs.	General Authorization rules may apply. In-Network \$25 copay for each Medicare covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.	General Authorization rules may apply. In-Network \$25 copay for each Medicare covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.	General Authorization rules may apply. In-Network \$25 copay for each Medicare covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.	General Authorization rules may apply. In-Network \$25 copay for each Medicare covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.	General Authorization rules may apply. In-Network \$30 copay for each Medicare covered visit. Medicare-covered podiatry benefits are for medically necessary foot care. Out-of-Network 15% of the cost for podiatry benefits.
11-Outpatient Mental Health Care	45% coinsurance ^{1,2} for most outpatient mental health services.	General Authorization rules may apply. In-Network \$25 copay for each Medicare-covered individual or group therapy visit.	General Authorization rules may apply. In-Network \$25 copay for each Medicare-covered individual or group therapy visit.	General Authorization rules may apply. In-Network \$25 copay for each Medicare-covered individual or group therapy visit.	General Authorization rules may apply. In-Network \$25 copay for each Medicare-covered individual or group therapy visit.	General Authorization rules may apply. In-Network \$30 copay for each Medicare-covered individual therapy visit. \$20 copay for each Medicare-

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
						covered group therapy visit. Out-of-Network 15% of the cost for Mental Health benefits. 15% of the cost for Mental Health benefits with a psychiatrist.
12-Outpatient Substance Abuse Care	20% coinsurance ^{1,2} .	General Authorization rules may apply. In-Network \$25 copay for Medicare-covered individual or group visits.	General Authorization rules may apply. In-Network \$25 copay for Medicare-covered individual or group visits.	General Authorization rules may apply. In-Network \$25 copay for Medicare-covered individual or group visits.	General Authorization rules may apply. In-Network \$25 copay for Medicare-covered individual or group visits.	General Authorization rules may apply. In-Network \$30 copay for Medicare-covered individual visits. \$20 copay for Medicare-covered group visits. Out-of-Network 15% of the cost for outpatient substance abuse benefits.

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
13-Outpatient Services/Surgery	<p>20% coinsurance^{1,2} for the doctor.</p> <p>20%^{1,2} of outpatient facility charges.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$200 copay for each Medicare covered ambulatory surgical center visit.</p> <p>\$200 copay for each Medicare covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$125 copay for each Medicare covered ambulatory surgical center visit.</p> <p>\$125 copay for each Medicare covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$200 copay for each Medicare covered ambulatory surgical center visit.</p> <p>\$200 copay for each Medicare covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$125 copay for each Medicare covered ambulatory surgical center visit.</p> <p>\$125 copay for each Medicare covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 10% of the cost for each Medicare covered ambulatory surgical center visit.</p> <p>10% of the cost for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network 15% of the cost for ambulatory surgical center benefits.</p> <p>15% of the cost for outpatient hospital facility benefits.</p> <p>(See page 49 for additional</p>

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
						information about Outpatient Services/Surgery)
14-Ambulance Services (medically necessary ambulance services)	20% coinsurance. ^{1,2}	General Authorization rules may apply. In-Network \$50 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network \$50 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network \$50 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network \$50 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network \$50 copay for Medicare-covered ambulance benefits. Out-of-Network \$50 copay for ambulance benefits.
15-Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance ^{1,2} for the doctor. 20% ^{1,2} of facility charge, or a set copay per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition	General 50% of the cost (up to \$50) for Medicare-covered emergency room visits. <u>Worldwide coverage.</u> If you are immediately admitted to the hospital, you pay \$0 for the	General 50% of the cost (up to \$50) for Medicare-covered emergency room visits. <u>Worldwide coverage.</u> If you are immediately admitted to the hospital, you pay \$0 for the	General 50% of the cost (up to \$50) for Medicare-covered emergency room visits. <u>Worldwide coverage.</u> If you are immediately admitted to the hospital, you pay \$0 for the	General 50% of the cost (up to \$50) for Medicare-covered emergency room visits. <u>Worldwide coverage.</u> If you are immediately admitted to the hospital, you pay \$0 for the	General 50% of the cost (up to \$50) for Medicare-covered emergency room visits. <u>Worldwide coverage.</u> If you are immediately admitted to the hospital, you pay \$0 for the

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
	<p>within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>emergency room visit.</p> <p>If you are admitted to the hospital within 72 hours for the same condition, you pay \$0 for the emergency room visit.</p>	<p>emergency room visit.</p> <p>If you are admitted to the hospital within 72 hours for the same condition, you pay \$0 for the emergency room visit.</p>	<p>emergency room visit.</p> <p>If you are admitted to the hospital within 72 hours for the same condition, you pay \$0 for the emergency room visit.</p>	<p>emergency room visit.</p> <p>If you are admitted to the hospital within 72 hours for the same condition, you pay \$0 for the emergency room visit.</p>	<p>emergency room visit.</p> <p>If you are admitted to the hospital within 72 hours for the same condition, you pay \$0 for the emergency room visit.</p>
<p>16-Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area).</p>	<p>20% coinsurance^{1,2} or a set copay.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>\$25 copay for Medicare-covered urgently needed care visits.</p>	<p>General</p> <p>\$25 copay for Medicare-covered urgently needed care visits.</p>	<p>General</p> <p>\$25 copay for Medicare-covered urgently needed care visits.</p>	<p>General</p> <p>\$25 copay for Medicare-covered urgently needed care visits.</p>	<p>General</p> <p>\$30 copay for Medicare-covered urgently needed care visits.</p>
<p>17-Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance.^{1,2}</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$25 copay for Medicare-covered Occupational Therapy visits.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$25 copay for Medicare-covered Occupational Therapy visits.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$25 copay for Medicare-covered Occupational Therapy visits.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$25 copay for Medicare-covered Occupational Therapy visits.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$30 copay for Medicare-covered Occupational Therapy visits.</p>

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
		\$25 copay for Medicare-covered Physical and/or Speech/ Language Therapy visits.	\$25 copay for Medicare-covered Physical and/or Speech/ Language Therapy visits.	\$25 copay for Medicare-covered Physical and/or Speech/ Language Therapy visits.	\$25 copay for Medicare-covered Physical and/or Speech/ Language Therapy visits.	<p>\$30 copay for Medicare-covered Physical and/or Speech/ Language Therapy visits.</p> <p>Out-of-Network 15% of the cost for Occupational Therapy benefits.</p> <p>15% of the cost for Physical and/or Speech/Language Therapy visits.</p>
<p>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</p> <p>18-Durable Medical Equipment</p> <p>(includes wheelchairs, oxygen, etc.)</p>	20% coinsurance. ^{1,2}	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
		(See page 50 for additional information about Durable Medical Equipment)	(See page 50 for additional information about Durable Medical Equipment)	(See page 50 for additional information about Durable Medical Equipment)	(See page 50 for additional information about Durable Medical Equipment)	<p>Out-of-Network 20% of the cost for durable medical equipment.</p> <p>(See page 50 for additional information about Durable Medical Equipment)</p>
<p>19-Prosthetic Devices</p> <p>(includes braces, artificial limbs and eyes, etc.)</p>	20% coinsurance. ^{1,2}	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items.</p> <p>(See page 50 for additional information about Prosthetic Devices)</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items.</p> <p>(See page 50 for additional information about Prosthetic Devices)</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items.</p> <p>(See page 50 for additional information about Prosthetic Devices)</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items.</p> <p>(See page 50 for additional information about Prosthetic Devices)</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p> <p>Out-of-Network 20% of the cost for prosthetic devices.</p> <p>(See page 50 for additional information about Prosthetic Devices)</p>

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
<p>20-Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies</p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, & self-management training)</p>	<p>20% coinsurance.^{1,2}</p> <p>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 can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$10 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Out-of-Network 15% of the cost for Diabetes self-monitoring training.</p> <p>15% of the cost for Nutrition Therapy for Diabetes.</p> <p>15% of the cost for Diabetes supplies.</p>

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
21-Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	<p>20% coinsurance^{1,2} for diagnostic tests and x-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>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</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: - X-rays - diagnostic radiology services (not including X-rays) - therapeutic radiology services</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>\$0 to \$300 copay for Medicare-covered diagnostic procedures and tests.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: - X-rays - diagnostic radiology services (not including X-rays) - therapeutic radiology services</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>\$0 to \$200 copay for Medicare-covered diagnostic procedures and tests.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: - X-rays - diagnostic radiology services (not including X-rays) - therapeutic radiology services</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>\$0 to \$300 copay for Medicare-covered diagnostic procedures and tests.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: - X-rays - diagnostic radiology services (not including X-rays) - therapeutic radiology services</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>\$0 to \$200 copay for Medicare-covered diagnostic procedures and tests.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 10% of the cost for Medicare-covered lab services.</p> <p>\$0 to \$300 copay [or 10% of the cost] for Medicare-covered diagnostic procedures and tests.</p> <p>10% of the cost for Medicare-covered X-rays.</p> <p>\$100 to \$300 copay [or 10% of the cost] for Medicare-covered diagnostic radiology services.</p> <p>10% of the cost for Medicare-</p>

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
	<p>or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>					<p>covered therapeutic radiology services.</p> <p>Out-of-Network 15% of the cost for diagnostic procedures, tests, and lab services.</p> <p>15% of the cost for therapeutic radiology services.</p> <p>15% of the cost for outpatient x-rays.</p> <p>15% of the cost for diagnostic radiology services.</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
<p>PREVENTIVE SERVICES</p> <p>22-Bone Mass Measurement</p> <p>(for people with Medicare who are at risk)</p>	<p>20% coinsurance.^{1,2}</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement.</p> <p>Out-of-Network</p> <p>15% of the cost for Medicare-covered bone mass measurement.</p>
<p>23-Colorectal Screening Exams</p> <p>(for people with Medicare age 50 and older)</p>	<p>20% coinsurance.^{1,2}</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings.</p> <p>Out-of-Network</p> <p>15% of the cost for colorectal screenings.</p>

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
24-Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines. 20% coinsurance ^{1,2} for Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines. Out-of-Network 15% of the cost for immunizations.
25-Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance ² . No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammo-gram covered for	In-Network \$0 copay for Medicare-covered screening mammograms.	In-Network \$0 copay for Medicare-covered screening mammograms.	In-Network \$0 copay for Medicare-covered screening mammograms.	In-Network \$0 copay for Medicare-covered screening mammograms.	In-Network \$0 copay for Medicare-covered screening mammograms. Out-of-Network 15% of the cost for screening mammograms.

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SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
	women with Medicare between age 35 and 39.					
26-Pap Smears and Pelvic Exams (for women with Medicare)	\$0 copay for Pap smears. Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance ² for Pelvic Exams.	In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.	In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.	In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.	In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.	In-Network \$0 copay for Medicare-covered pap smears and pelvic exams. Out-of-Network 15% of the cost for pap smears and pelvic exams.
27-Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance ² for the digital rectal exam. \$0 for the PSA test; 20% coinsurance ² for other related services. Covered once a year for all men with Medicare over age 50.	In-Network \$0 copay for Medicare-covered prostate cancer screening.	In-Network \$0 copay for Medicare-covered prostate cancer screening.	In-Network \$0 copay for Medicare-covered prostate cancer screening.	In-Network \$0 copay for Medicare-covered prostate cancer screening.	In-Network \$0 copay for Medicare-covered prostate cancer screening. Out-of-Network 15% of the cost for prostate cancer screening.

² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you pay more.

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
28-End-Stage Renal Disease	<p>20% coinsurance^{1,2} for renal dialysis.</p> <p>20% coinsurance^{1,2} for Nutrition Therapy for End-Stage Renal Disease. 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 can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>In-Network \$0 copay for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>In-Network \$0 copay for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>In-Network \$0 copay for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>In-Network \$0 copay for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>In-Network \$20 copay for renal dialysis.</p> <p>\$10 copay for Nutrition Therapy for End-Stage Renal Disease.</p> <p>Out-of-Network 15% of the cost for Nutrition Therapy for End-Stage Renal Disease.</p> <p>\$30 copay for renal dialysis.</p>

¹ 2009, you pay a total of \$135. NOTE: The Medicare Part B deductible may change each year.

² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you pay more.

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
29-Prescription Drugs	<p>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.</p>	<p>Drugs covered under Medicare Part B.</p> <p>Most drugs not covered.</p> <p><u>General</u> 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p><u>General</u> This plan does not offer prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B.</p> <p>Most drugs not covered.</p> <p><u>General</u> 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p><u>General</u> This plan does not offer prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B.</p> <p><u>General</u> 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p><u>General</u> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.clearchoiceh.com/MedicareRx List on the web.</p> <p>Different out-of-pocket costs may apply for people who have limited</p>	<p>Drugs covered under Medicare Part B.</p> <p><u>General</u> 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p><u>General</u> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.clearchoiceh.com/MedicareRx List on the web.</p> <p>Different out-of-pocket costs may apply for people who have limited</p>	<p>Drugs covered under Medicare Part B.</p> <p><u>General</u> 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>15% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p><u>General</u> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.clearchoiceh.com/MedicareRx List on the web.</p> <p>Different out-of-pocket costs may apply for people who have limited</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				<p>incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service).</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p>	<p>incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service).</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p>	<p>incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service).</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits. Your provider must get prior authorization from Value + Rx Plan (HMO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website,</p>	<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits. Your provider must get prior authorization from Traditional + Rx Plan (HMO-POS) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website,</p>	<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits. Your provider must get prior authorization from Explorer +Rx Plan (PPO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website,</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				<p>formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Value + Rx (HMO) approves the exception, you will pay Preferred Brand cost sharing for that drug.</p> <p>In-Network \$125 yearly deductible.</p>	<p>formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Traditional + Rx (HMO-POS) approves the exception, you will pay Preferred Brand cost sharing for that drug.</p> <p>In-Network \$0 yearly deductible.</p>	<p>formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Explorer + Rx (PPO) approves the exception, you will pay Preferred Brand cost sharing for that drug.</p> <p>In-Network \$0 yearly deductible.</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				<p>Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,830:</p> <p>Retail Pharmacy Preferred Generic - \$10 copay for a one-month (31-day) supply of drugs in this tier - \$20 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Preferred Brand - \$31 copay for a one-month (31-day) supply of drugs in this tier - \$62 copay for a three-month (90-day) supply of drugs in this tier</p>	<p>Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,830:</p> <p>Retail Pharmacy Generic - \$5 copay for a one-month (31-day) supply of drugs in this tier - \$10 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Preferred Brand - \$25 copay for a one-month (31-day) supply of drugs in this tier - \$50 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Non-Preferred Brand - \$55 copay for a one-month (31-</p>	<p>Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,830:</p> <p>Retail Pharmacy Generic - \$5 copay for a one-month (31-day) supply of drugs in this tier - \$10 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Preferred Brand - \$25 copay for a one-month (31-day) supply of drugs in this tier - \$50 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Non-Preferred Brand - \$55 copay for a one-month (31-</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				<p><u>Specialty</u> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Long Term Care Pharmacy <u>Preferred Generic</u> - \$10 copay for a one-month (31-day) supply of drugs in this tier</p> <p><u>Preferred Brand</u> - \$31 copay for a one-month (31-day) supply of drugs in this tier</p>	<p>day) supply of drugs in this tier - \$110 copay for a three-month (90-day) supply of drugs in this tier</p> <p><u>Specialty</u> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Long Term Care Pharmacy <u>Generic</u> - \$5 copay for a one-month (31-day) supply of drugs in this tier</p> <p><u>Preferred Brand</u> - \$25 copay for a one-month (31-day) supply of drugs in this tier</p> <p><u>Non-Preferred Brand</u> - \$55 copay for a one-month (31-</p>	<p>day) supply of drugs in this tier - \$110 copay for a three-month (90-day) supply of drugs in this tier</p> <p><u>Specialty</u> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Long Term Care Pharmacy <u>Generic</u> - \$5 copay for a one-month (31-day) supply of drugs in this tier</p> <p><u>Preferred Brand</u> - \$25 copay for a one-month (31-day) supply of drugs in this tier</p> <p><u>Non-Preferred Brand</u> - \$55 copay for a one-month (31-</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				<p><u>Specialty</u> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Mail Order Preferred Generic - \$20 copay for a three-month (90-day) supply of drugs in this tier</p> <p><u>Preferred Brand</u> - \$62 copay for a three-month 90-day supply of drugs in this tier</p>	<p>day) supply of drugs in this tier</p> <p><u>Specialty</u> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Mail Order Generic - \$10 copay for a three-month (90-day) supply of drugs in this tier</p> <p><u>Preferred Brand</u> - \$50 copay for a three-month (90-day) supply of drugs in this tier</p> <p><u>Non-Preferred Brand</u> - \$110 copay for a three-month (90-day) supply of drugs in this tier</p>	<p>day) supply of drugs in this tier</p> <p><u>Specialty</u> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Mail Order Generic - \$10 copay for a three-month (90-day) supply of drugs in this tier</p> <p><u>Preferred Brand</u> - \$50 copay for a three-month (90-day) supply of drugs in this tier</p> <p><u>Non-Preferred Brand</u> - \$110 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Coverage Gap</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				<p>Coverage Gap After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of: - A \$ 2.50 copay for generic including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or - 5% coinsurance.</p> <p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the</p>	<p>Coverage Gap After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of: - A \$2.50 copay for generic including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or - 5% coinsurance.</p> <p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the</p>	<p>After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of: - A \$2.50 copay for generic including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or - 5% coinsurance.</p> <p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				<p>plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Value + Rx Plan (HMO).</p> <p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network</p>	<p>plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Traditional + Rx Plan (HMO-POS).</p> <p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network</p>	<p>area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Explorer + Rx Plan (PPO).</p> <p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				until total yearly drug costs reach \$2,830: <u>Preferred Generic</u> - \$10 copay for a one-month (31-day) supply of drugs in this tier <u>Preferred Brand</u> - \$31 copay for a one-month (31-day) supply of drugs in this tier <u>Specialty</u> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier Out-of-Network Coverage Gap After your total	until total yearly drug costs reach \$2,830: <u>Generic</u> - \$5 copay for a one-month (31-day) supply of drugs in this tier <u>Preferred Brand</u> - \$25 copay for a one-month (31-day) supply of drugs in this tier <u>Non-Preferred Brand</u> - \$55 copay for a one-month (31-day) supply of drugs in this tier <u>Specialty</u> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier Out-of-Network Coverage Gap After your total	until total yearly drug costs reach \$2,830: <u>Generic</u> - \$5 copay for a one-month (31-day) supply of drugs in this tier <u>Preferred Brand</u> - \$25 copay for a one-month (31-day) supply of drugs in this tier <u>Non-Preferred Brand</u> - \$55 copay for a one-month (31-day) supply of drugs in this tier <u>Specialty</u> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier Out-of-Network Coverage Gap After your total

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				<p>yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Value + Rx Plan (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Value + Rx Plan (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage After your yearly</p>	<p>yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Traditional + Rx Plan (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Traditional + Rx Plan (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage After your yearly</p>	<p>yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Explorer + Rx Plan (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Explorer + Rx Plan (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage After your yearly</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
				<p>out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> - 5% coinsurance. 	<p>out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> - 5% coinsurance. 	<p>out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> - 5% coinsurance.
30-Dental Services	Preventive dental services (such as cleaning) not covered.	<p>General Authorization rules may apply.</p> <p>In-Network In general, preventive dental benefits (such as cleaning) not covered. \$25 copay for Medicare covered dental benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network In general, preventive dental benefits (such as cleaning) not covered. \$25 copay for Medicare covered dental benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network In general, preventive dental benefits (such as cleaning) not covered. \$25 copay for Medicare covered dental benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network In general, preventive dental benefits (such as cleaning) not covered. \$25 copay for Medicare covered dental benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network In general, preventive dental benefits (such as cleaning) not covered. \$30 copay for Medicare covered dental benefits.</p> <p>Out-of-Network 15% of the cost for comprehensive dental benefits.</p>

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Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
31-Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance ^{1,2} for diagnostic hearing exams.	In-Network \$0 copay for hearing aids. \$25 copay for Medicare-covered diagnostic hearing exams. \$25 copay for up to 1 routine hearing test every year. \$250 limit for hearing aids every two years.	In-Network \$0 copay for hearing aids. \$25 copay for Medicare-covered diagnostic hearing exams. \$25 copay for up to 1 routine hearing test every year. \$250 limit for hearing aids every two years.	In-Network \$0 copay for hearing aids. \$25 copay for Medicare-covered diagnostic hearing exams. \$25 copay for up to 1 routine hearing test every year. \$250 limit for hearing aids every two years.	In-Network \$0 copay for hearing aids. \$25 copay for Medicare-covered diagnostic hearing exams. \$25 copay for up to 1 routine hearing test every year. \$250 limit for hearing aids every two years.	In-Network \$0 copay for hearing aids. \$30 copay for Medicare-covered diagnostic hearing exams. \$30 copay for up to 1 routine hearing test every year. \$250 limit for hearing aids every two years. Out-of-Network 15% of the cost for hearing exams. \$0 copay for hearing aids.
32-Vision Services	20% coinsurance ^{1,2} for diagnosis and treatment of diseases and	In-Network \$0 copay for: - one pair of eyeglasses or contact lenses	In-Network \$0 copay for: - one pair of eyeglasses or contact lenses	In-Network \$0 copay for: - one pair of eyeglasses or contact lenses	In-Network \$0 copay for: - one pair of eyeglasses or contact lenses	In-Network \$0 copay for: - one pair of eyeglasses or contact lenses

¹ 2009, you pay a total of \$135. NOTE: The Medicare Part B deductible may change each year.

² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you pay more.

¹ 2009, you pay a total of \$135. NOTE: The Medicare Part B deductible may change each year.

² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you pay more.

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
	<p>conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>after cataract surgery</p> <ul style="list-style-type: none"> - glasses - contacts - lenses - frames <p>\$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$25 copay for up to 1 routine eye exam(s) every two years.</p> <p>\$100 limit for eye wear every two years.</p> <p>(See page 49 for additional information about Vision Services)</p>	<p>after cataract surgery</p> <ul style="list-style-type: none"> - glasses - contacts - lenses - frames <p>\$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$25 copay for up to 1 routine eye exam(s) every two years.</p> <p>\$100 limit for eye wear every two years.</p> <p>(See page 49 for additional information about Vision Services)</p>	<p>after cataract surgery</p> <ul style="list-style-type: none"> - glasses - contacts - lenses - frames <p>\$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$25 copay for up to 1 routine eye exam(s) every two years.</p> <p>\$100 limit for eye wear every two years.</p> <p>(See page 49 for additional information about Vision Services)</p>	<p>after cataract surgery</p> <ul style="list-style-type: none"> - glasses - contacts - lenses - frames <p>\$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$25 copay for up to 1 routine eye exam(s) every two years.</p> <p>\$100 limit for eye wear every two years.</p> <p>(See page 49 for additional information about Vision Services)</p>	<p>after cataract surgery</p> <ul style="list-style-type: none"> - glasses - contacts - lenses - frames <p>\$30 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$30 copay for up to 1 routine eye exam(s) every two years.</p> <p>\$100 limit for eye wear every two years.</p> <p>(See page 49 for additional information about Vision Services)</p> <p>Out-of-Network 15% of the cost for eye exams.</p> <p>\$0 copay for eye wear.</p>

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
33-Physical Exams	<p>20% coinsurance^{1,2} for one exam within the first 12 months of your new Medicare Part B coverage.</p> <p>When you get Medicare Part B, you can get a one-time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>In-Network \$0 copay for routine exams. Limited to 1 exam every year.</p>	<p>In-Network \$0 copay for routine exams. Limited to 1 exam every year.</p>	<p>In-Network \$0 copay for routine exams. Limited to 1 exam every year.</p>	<p>In-Network \$0 copay for routine exams. Limited to 1 exam every year.</p>	<p>In-Network \$0 copay for routine exams. Limited to 1 exam every year.</p> <p>Out-of-Network 15% of the cost for routine exams.</p>
34-Health/Wellness Education	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related</p>	<p>In-Network This plan covers the following health/wellness education benefits: - Nutritional Training - Other Wellness Benefits</p>	<p>In-Network This plan covers the following health/wellness education benefits: - Nutritional Training - Other Wellness Benefits</p>	<p>In-Network This plan covers the following health/wellness education benefits: - Nutritional Training - Other Wellness Benefits</p>	<p>In-Network This plan covers the following health/wellness education benefits: - Nutritional Training - Other Wellness Benefits</p>	<p>In-Network This plan covers the following health/wellness education benefits: - Nutritional Training - Other Wellness Benefits</p>

¹ 2009, you pay a total of \$135. NOTE: The Medicare Part B deductible may change each year.

² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you pay more.

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
	illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	\$0 copay for each Medicare-covered smoking cessation counseling session.	\$0 copay for each Medicare-covered smoking cessation counseling session.	\$0 copay for each Medicare-covered smoking cessation counseling session.	\$0 copay for each Medicare-covered smoking cessation counseling session.	\$0 copay for each Medicare-covered smoking cessation counseling session. Out-of-Network 15% of the cost for Health and Wellness services.
35-Transportation (Routine)	Not covered.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.
36-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.
37-Point-of-Service	You may go to any doctor, specialist or hospital that accepts Medicare.		General Authorization rules may apply. Out-of-Network Point of Services coverage is available for the following benefits: - Doctor office visits - Outpatient mental health care		General Authorization rules may apply. Out-of-Network Point of Services coverage is available for the following benefits: - Doctor office visits - Outpatient mental health care	

SUMMARY OF BENEFITS

Section Two

Benefit	Original Medicare	Value (HMO)	Traditional (HMO-POS)	Value + Rx (HMO)	Traditional + Rx (HMO-POS)	Explorer + Rx (PPO)
			<ul style="list-style-type: none"> - Diagnostic tests, x-rays, lab services, and radiology services <p>10% of the cost for</p> <ul style="list-style-type: none"> - Doctor office visits - Outpatient mental health care - Diagnostic tests, x-rays, lab services, and radiology services <p>(See page 49 for additional information about Point-of-Service)</p>		<ul style="list-style-type: none"> - Diagnostic tests, x-rays, lab services, and radiology services <p>10% of the cost for</p> <ul style="list-style-type: none"> - Doctor office visits - Outpatient mental health care - Diagnostic tests, x-rays, lab services, and radiology services <p>(See page 49 for additional information about Point-of-Service)</p>	

Additional Information

Section Three

DO I NEED A REFERRAL TO SEE A SPECIALIST?

Clear One Health Plans does not require a referral from your Primary Care Provider (PCP) to schedule a doctor office visit with most contracted specialists. Referrals are required for an initial visit to in-network Physical Therapists, Occupational Therapists, and Speech Therapists.

While a referral from your PCP is not required before you see most specialists, many procedures performed by in-network specialists do require prior authorization (approval in advance) from Clear One Health Plans in order to be covered.

Explorer + Rx (PPO) Plan:

Referrals are not required for out-of-network Medicare-covered services. For out-of-network covered services see Section Two.

Out-of-network Medicare-covered services do not require prior authorization from Clear One Health Plans. Generally, services provided by in-network providers will cost less than services provided by out-of-network providers. Clear One Health Plans will provide services for all covered benefits regardless of whether they are received in-network, as long as they are medically necessary.

AM I COVERED WHEN I TRAVEL?

Yes! Clear One Plans give you the protection of **worldwide coverage** for the following medically necessary services:

- Ambulance (ground or air),
- Emergency care,
- Urgent care, and
- Out-of-area Dialysis services.

Other coverage with out-of-network providers varies by plan. Please see below.

Value (HMO) and Value + Rx (HMO) Plan:

In addition to the **worldwide coverage** benefits listed above, all other Medicare-covered services (such as elective

procedures), provided by out-of-network providers, require prior authorization (approval in advance) from Clear One Health Plans to be covered.

Traditional (HMO-POS) and Traditional + Rx (HMO-POS) Plan:

In addition to the **worldwide coverage** benefits listed above, you can see out-of-network providers for some services. Please see "Point of Service" heading in Section Two.

Explorer + Rx (PPO) Plan:

In addition to the **worldwide coverage** benefits listed above, you have the freedom to see either in-network or out-of-network providers for any of the covered services listed in Section Two. Generally, services provided by in-network providers will cost less than services provided by out-of-network providers.

WHAT IF I DON'T NEED PART D PRESCRIPTION DRUG COVERAGE NOW? CAN I SIGN UP FOR IT LATER?

Generally, if you don't sign up for a Medicare Prescription Drug Plan (PDP) when you are first eligible, you can sign up between November 15 and December 31 each year, for coverage to begin January 1 of the following year. There may be other opportunities; such as if you move or lose other coverage that is at least as good as the Medicare Prescription Drug Plan.

Please Note: Medicare will not allow you to add a stand-alone Medicare Prescription Drug Plan (PDP) from another company to the Clear One Value Plan (HMO) or the Clear One Traditional Plan (HMO).

If you do not enroll in a Medicare Prescription Drug Plan when you are first eligible, you may have to pay a Medicare late-enrollment penalty (higher premium) if you sign up for a Medicare Prescription Drug Plan at a later date. The longer you wait to enroll in a Medicare Prescription Drug Plan, the higher the penalty may be.

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WHAT EXTRA HELP IS AVAILABLE FOR PEOPLE WITH LOW INCOME?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, the Medicaid office, or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

HOW DO YOU COVER OUTPATIENT SERVICES/SURGERY ON THE EXPLORER + RX (PPO) PLAN?

For Outpatient Services/Surgeries provided by in-network providers, Explorer + Rx (PPO) plan members will pay 10% of allowed charges up to a maximum of \$400 per outpatient surgery. For services provided by out-of-network providers, Explorer + Rx (PPO) plan members pay 15% of Medicare allowed charges.

WHAT ARE MEDICARE PART B COVERED DRUGS?

Medicare Part B drugs are medications that are covered for everyone on Medicare. These include, but are not limited to: injectable/IV drugs administered by a doctor and are not usually self-administered (such as infusion drugs for cancer chemotherapy and the treatment of Rheumatoid Arthritis). Please contact Clear One Health Plans for help in determining if your medications are considered Part B drugs.

WHAT IS THE "POINT OF SERVICE" BENEFIT ON THE TRADITIONAL (HMO-POS) AND TRADITIONAL + RX (HMO-POS) PLANS?

For Medicare-covered benefits listed under "Point of Service" in Section Two, Traditional Plan (HMO-POS) and Traditional + Rx Plan (HMO-POS) members have the freedom to see either in-network or out-of-network providers for selected services. This benefit is limited to doctor office visits for an evaluation. Please note that if an out-of-network provider recommends a surgery or procedure, you will generally use an in-network provider for that surgery or procedure unless it is approved in advance by Clear One Health Plans.

For doctor office visits, lab and X-ray services, and outpatient mental health care with out-of-network providers, Clear One Health Plans will pay 90% of what Original Medicare would pay for the services. Traditional Plan (HMO-POS) and Traditional + Rx Plan (HMO-POS) members pay the remaining 10%.

HOW MUCH IS COVERED FOR EYEGASSES AND CONTACT LENSES?

Clear One Health Plans will reimburse you up to \$100 every 2 calendar years for eye glasses or contact lenses. You may purchase eye hardware from any licensed, qualified provider. For a routine eye exam, a copay or coinsurance will apply.

If you have had a recent cataract surgery that implants an intraocular lens, Clear One Health Plans will cover one pair of basic eyeglasses with standard frames (or one set of contact lenses) at no cost.

HOW DO YOU COVER DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC DEVICES?

For covered DME and prosthetic devices purchased from an in-network provider, you pay 20% of the cost. The Value (HMO), Value + Rx (HMO), Traditional (HMO-POS), and Traditional + Rx (HMO-POS) plans have an out-of-pocket maximum of \$500 per

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calendar year for DME and/or Prosthetics combined. After that, Clear One Health Plans will pay 100% of the cost for the remainder of the calendar year.

The Explorer + Rx (PPO) plan does not have an out-of-pocket maximum for DME and/or Prosthetics. Coinsurance for this benefit would apply to your plan out-of-pocket maximum.

WHAT IS THE OUT-OF-POCKET LIMIT?

This is NOT a deductible. This is the most you will pay for any and all copayments and coinsurance for covered Medical services in a calendar year.

Please note: Deductibles, copayments, and coinsurance for Part D prescription drugs do not count towards the out-of-pocket maximum.

If your expenditures for copays and coinsurance reach the out-of-pocket limit listed in Section Two for your plan, you will not pay any more copays or coinsurance for covered medical services for the remainder of the calendar year.

Please note that on the Explorer + Rx (PPO) plan there is an out-of-pocket limit for in-network providers (\$3,400) and a separate out-of-pocket maximum (\$10,000) for out of network providers.

The \$500 maximum out-of-pocket limit for Durable Medical Equipment and Prosthetics is applied toward in-network benefits. The out-of-pocket limit is listed in Section Two. This does not apply to the Explorer + Rx (PPO) plan.

MEMBER GRIEVANCE & APPEAL RIGHTS

Clear One Health Plans offers grievance, coverage determinations (including exceptions) and appeals processes. Generally, grievances are complaints regarding the quality of care you receive, or the quality of service we provide, including

problems obtaining appointments and disrespectful or rude behavior of staff.

You have the right to appeal any coverage denial. The type of appeal and timeframe for resolution depends on what is being denied. We will tell you how to appeal in the letter we send you explaining our denial decision. We quickly review appeals involving urgently needed care and act as fast as necessary, given the clinical urgency of the condition. Reviews that are clinically urgent will take no longer than 72 hours.

Organization determinations are coverage decisions and include exception requests for a prescription drug. An exception request 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 drug at a lower out-of-pocket cost.

More detailed information is contained in your Evidence of Coverage that you will receive within ten days after your effective date of enrollment.

You can ask our Member Services Department how to request a coverage determination or how to file a grievance or an appeal at 541-385-5315, 888-863-3637 toll-free, or 800-735-2900 TTY, 7 days a week, 7am-8pm PST.

THE CONTRACT WITH MEDICARE

Clear One Health Plans is a health plan with a Medicare contract for 2010. The Medicare program pays us to manage health services for people with Medicare who are members of our Medicare Advantage plans.

Medicare contracts with Medicare Advantage Organizations like Clear One Health Plans, on an annual basis, from January 1 through December 31. Medicare Advantage Organizations or Medicare may choose not to renew the contract for the following

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year. Non-renewal of the contract may result in termination of the beneficiary's enrollment in the plan. In addition, the plan may reduce its service area and no longer offer services in the area where the beneficiary resides.

If either Medicare or the Medicare Advantage Organization chooses not to renew the contract for the following year, affected plan members will have Medicare "guaranteed issue" rights to enroll in another plan available in their area without penalty due to pre-existing medical conditions.

For more information, contact Medicare at 800-Medicare (800-633-4227) toll-free, or 877-486-2048 TTY, 24 hours a day, 7 days a week. If you have special needs, this document may be available in other formats.

PHARMACY ACCESS

In most cases, if you are enrolled in a Clear One plan with Part D prescription drug coverage (Value + Rx (HMO), Traditional + Rx (HMO-POS), or the Explorer + Rx (PPO)) your prescriptions are covered only if they are filled at a network pharmacy. Clear One Health Plans' network pharmacies include retail, mail order, long term care, Indian/Tribal/Urban (Indian Health Service). For a list of contracted pharmacies or covered drugs, visit www.clearonehp.com, call us at 888-863-3637 toll free, or 800-735-2900 TTY, 7 days a week, 7am – 8pm.

CHANGING PREFERENCES FOR PREMIUM WITHHOLD AND DIRECT BILLING

If you decide to switch to premium withhold or move from premium withhold to direct bill, it could take up to three months for it to take effect and ultimately you will remain held responsible for those premiums.

HOW DO I FILL A PRESCRIPTION THROUGH MAIL-ORDER PHARMACY SERVICES?

You can use our mail-order service to obtain a three-month (90-day) supply of prescriptions for some drugs. These drugs are either "generic", "brand", "preferred brand" or "non-preferred brand" drugs. These are drugs that you take on a regular basis, for chronic or long-term medical conditions.

You also have the option of using a preferred retail pharmacy in our network to obtain a supply of maintenance medications. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for an extended supply of maintenance medications, which may result in no out-of-pocket payment difference to you.

WHAT SERVICES ARE NOT COVERED OR ARE LIMITED?

The following are some of the items and services that aren't covered under the Original Medicare Plan or by our plan. This is a partial list and does not include all limitations and exclusions.

- Acupuncture.
- Care received in any non-Medicare approved hospital or skilled nursing facility.
- Cosmetic surgery or procedures.
- Custodial care.
- EBT (Electronic Beam Tomography) Scans.
- Elective or voluntary enhancement procedures, services, supplies and medications.
- Experimental or investigational medical and surgical procedures, equipment and medications.
- Immunizations for the sole purpose of travel.
- Incontinence supplies.
- Long term services.
- Naturopath services.
- Orthognathic Surgery for TMJ.
- Orthopedic shoes (some exceptions apply).
- Private room in a hospital, unless medically necessary

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- Radial keratotomy, LASIK surgery, vision therapy, and other low vision aids and services.
- Routine dental care such as cleanings, fillings, or dentures.
- Routine lab work, X-rays, or EKG's (testing done without medical indication) except as outlined in the Preventive Services section of this Summary of Benefits.

DEFINITIONS

Authorization - approval in advance that an **in-network** health care provider must obtain from Clear One before providing certain services (like hospitalization and elective surgeries). If an authorization is required, it's the in-network provider's responsibility to obtain authorization from Clear One before providing the service. (Services requiring authorizations are indicated in Section Two).

Coinsurance – a percentage of the cost of the service or medication paid by the member to the provider.

Copay (copayment) – a fixed dollar amount paid by the member to a provider for a covered service or medication.

Coverage Gap – also called the “donut hole.” In a Medicare Prescription Drug Plan (Part D), after the initial coverage limit has been reached (\$2,830 in 2010) and until your out-of-pocket expenses for covered medications reaches a certain amount (\$4,550 in 2010), you will generally be responsible for 100% of the cost of your medications.

Deductible – the amount you pay for covered services before the plan coverage begins (applies to the Value + Rx (HMO) plan drug coverage only).

Donut Hole – see Coverage Gap.

Formulary – a list of prescription medications covered by your plan.

In-Network Providers - doctors and other health care professionals that contract with Clear One Health Plans to provide covered services to our plan members.

Out-of-Network Providers - any Medicare provider not in the Clear One provider network.

Primary Care Provider (PCP) – a Medicare provider that is licensed to provide basic medical care. They help coordinate your care with other providers. PCPs can include Family Practice, General Practice, and Internal Medicine providers

Referral – when one provider (usually a Primary Care Provider) directs a patient to another provider (usually a specialist) for a doctor office visit.