Fallon Health

Fallon Medicare Plus Central Premier HMO
Schedule of Benefits

This *Schedule of Benefits* is part of your
2025 Fallon Medicare Plus Central Premier HMO Evidence of Coverage.
It describes your costs for health care.

You are a member of Fallon Medicare Plus through an employer group. Under this group plan, you have copayments that are different from those shown in your *2025 Fallon Medicare Plus Central Premier HMO Evidence of Coverage*. The information in this document replaces any information in your *Evidence of Coverage* that conflicts with it. If you have any questions about your benefits, please call Customer Service at 1-800-325-5669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday, (7 days a week, Oct. 1–March 31). Calls to these numbers are free.

The following changes apply to the Benefits Chart in *Chapter 4: Medical Benefits Chart (what is covered and what you pay)* of your *2025 Fallon Medicare Plus Central Premier HMO Evidence of Coverage*:

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse	You pay a $10 copayment for Medicare-covered acupuncture services to treat chronic low back pain.

Services that are covered for you	What you must pay when you get these services
specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services *For non-emergency ambulance services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	You pay a $50 copayment for Medicare-covered ambulance transport (one-way). Ambulance services covered worldwide.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	You pay a $10 copayment for each Medicare-covered office visit for chiropractic services.
Dental services *For diagnostic services, endodontics, adjunctive general services, restorative services, prosthodontic services (fixed and removable), periodontics, and oral and maxillofacial surgery (with the exception of the removal or exposure of impacted teeth) to be covered, your doctor or other plan provider must get prior authorization (approval in*	You pay a $0 copayment for each preventive dental visit. You pay copayments varying from $0 to $990 for comprehensive non-

Services that are covered for you	What you must pay when you get these services
advance) from the plan. Authorization requests must be sent directly by your treating network dental provider to the plan's dental benefit administrator, DentaQuest, for review. In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: • Preventive dental care including exam, cleaning, fluoride treatment and X-rays. Limited to twice a year. • Minor restorative (fillings); major restorative (crowns); endodontics (root canals); periodontics (gum disease procedures); oral surgery (simple extractions) and prosthodontics (dentures). There are plan exclusions, for example, full mouth debridement is limited to once every 36 months; periodontal maintenance after active therapy is limited to twice within 12 months after osseous surgery, or root planning and scaling. Reline dentures are limited to once per 36 months. Certain X-rays are allowed once per 36 months. See your "Addendum: Dental Services Copayments and Fees" for more information. • Emergency medical care, such as to relieve pain or to stop bleeding as a result of injury to the sound natural teeth or tissue, provided in the office of a physician or dentists as soon as possible after the injury. This does not include restorative or other dental care. Go to the closest provider, you do not need a referral from your PCP. • Non-routine dental care covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician. There is a provider network for non-routine dental care. • We offer additional dental service coverage as part of your Benefit Bank. For more information, see **Benefit Bank** in this chart.	orthodontic dental care. See your "Addendum: Dental Services Copayments and Fees" for more information. You pay a $15 copayment for emergency medical care of the sound natural teeth or tissue. You pay a $15 copayment for each office visit for oral surgery services. You pay a $15 copayment for Medicare-covered dental benefits. For information on additional covered dental services, see **Benefit Bank** in this chart.

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs **Membership in Health Club/Fitness Classes** • We cover fitness/gym memberships and approved online fitness program services as part of your Benefit Bank. For more information, see **Benefit Bank** in this chart. **Nutritional Benefit** • Unlimited group or individual nutritional therapy counseling is available to all members when provided by a registered dietician or other nutrition professional in the network. Members must receive services from network providers. **Health Education** • A communication that is filled with information to help keep you well. • WW® – We cover WW online memberships through the Benefit Bank. For more information, see **Benefit Bank** in this chart. • Health/wellness education classes – Members must receive services from network providers and may pay a copayment depending on the type of class and its location. • Case Management and Disease Case Management programs are available for members with chronic conditions such as diabetes, coronary artery disease and asthma. • An Infusion Drug program is available for members with infusion drug therapies to help ensure that infusion drugs are administered in the most appropriate and convenient setting for the member. For more information on any of these health and wellness education programs, call Customer Service at the number on the back cover of this document.	You pay $0 for: – Nutritional Benefit – Newsletter – Case Management and Disease Case Management programs – Infusion Drug program You may pay a $10 copayment for each health/wellness education class. For information on covered fitness memberships, approved online fitness program services and WW online memberships, see **Benefit Bank** in this chart.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. We cover: • 1 supplemental routine hearing exam every year. • Hearing aids covered for certain manufacturers through Amplifon only. Limit of two hearing aids per member per year. We offer additional hearing aid coverage as part of your Benefit Bank. For more information, see **Benefit Bank** in this chart.	You pay a $15 specialist office visit copayment for each Medicare-covered diagnostic hearing exam. There is no copayment for 1 supplemental routine hearing exam every year. You pay copayments varying from $695 to $2,645 for covered hearing aids from Amplifon. See the "List of Covered Hearing

Services that are covered for you	What you must pay when you get these services
	Aids and Copayments" for details on the specific hearing aid coverage through Amplifon on fallonhealth.org/medicare or call Customer Service. For information on additional prescription hearing aid coverage, see **Benefit Bank** in this chart.
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Fallon Medicare Plus Central Premier HMO. You pay a $10 primary care doctor or a $15 specialist office visit copayment for hospice consultation services.

Services that are covered for you	What you must pay when you get these services
follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by Fallon Medicare Plus Central Premier HMO but are not covered by Medicare Part A or B: Fallon Medicare Plus Central Premier HMO will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Inpatient hospital care *For inpatient hospital care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. You are covered for an unlimited number of days in an acute care hospital. This includes substance use disorder services, but it does not include rehabilitation services. You are covered for up to 90 days of care in each benefit period in an inpatient rehabilitation facility or rehabilitation unit of an acute care hospital. If you exceed the 90-day limit in a benefit period, you may use your lifetime reserve days for additional coverage. See Chapter 12 for an explanation of "benefit period."	You pay a $300 annual deductible for inpatient admissions; this includes medical, surgical and rehabilitation services. There is no copayment or deductible for substance use disorder inpatient admissions when the primary reason is substance detoxification and/or rehabilitation. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Fallon Medicare Plus Central Premier HMO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an *outpatient*. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!*	

Services that are covered for you	What you must pay when you get these services
This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital *For inpatient services in a psychiatric hospital to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include mental health care services that require a hospital stay. • There is a 190-day lifetime limit on mental health care in a psychiatric hospital. You may use your lifetime reserve days for additional coverage once you have used the initial 90 days, if you have not reached your 190-day limit. See Chapter 12 for an explanation of "benefit period." • You are covered for an unlimited number of days of inpatient mental health care in an acute care hospital.	You pay a $300 annual deductible for inpatient psychiatric admissions.
Medicare Part B prescription drugs *For certain Medicare Part B prescription drugs to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* *Certain Part B drugs, including some anti-emetics, anti-inflammatories and chemotherapy may be subject to Part B step therapy. You can find a list of those drugs at the link below.* Part B drugs can be filled for up to a 90-day supply. These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication	There is no coinsurance, copayment, or deductible for drugs that are administered by a health care professional. You pay a $10 primary care doctor or $15 specialist office visit copayment. There are no service category or plan level deductibles for Part B covered prescription drugs or insulin. You pay up to a $35 copay for one-month's supply of Part B insulin when used with an item of durable medical equipment.

Services that are covered for you	What you must pay when you get these services
costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive Drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin	**For prescription drugs that are covered under Original Medicare you pay:** *Retail Cost-Sharing* Generic drugs: $10 copay for up to a 30-day supply $20 copay for up to a 60-day supply $30 copay for up to a 90-day supply Brand-name drugs: $50 copay for up to a 30-day supply $100 copay for up to a 60-day supply $150 copay for up to a 90-day supply *Mail-Order Cost-Sharing* Generic drugs: $10 copay for up to a 30-day supply $20 copay for up to a 60-day supply $20 copay for up to a 90-day supply Brand-name drugs: $50 copay for up to a 30-day supply $100 copay for up to a 60-day supply $100 copay for up to a 90-day supply Additionally, you may pay less for certain Part B rebatable drugs due to the Inflation Reduction Act (IRA) of 2022. The IRA requires drug companies that raise their drug prices faster than the rate of inflation to pay Medicare a rebate, which may lower your

Services that are covered for you	What you must pay when you get these services
Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://fallonhealth.org/find-insurance/medicare/covered-meds.aspx We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	cost. CMS will post an updated list of rebatable drugs and corresponding adjustments each quarter as part of the Medicare Part B Quarterly Sales Pricing (ASP) file. Therefore, it is possible that any adjustment could vary from quarter to quarter. Visit https://www.cms.gov/inflation-reduction-act-and-medicare/inflation-rebates-medicare to view the most recent list.
Outpatient mental health care *For Transcranial Magnetic Stimulation Therapy (TMS), Electro-Convulsive Therapy (ECT), and Intensive Outpatient Therapy (IOP) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	You pay a $10 copayment for each Medicare-covered individual or group therapy in-office visit without a psychiatrist. You pay a $15 copayment for each Medicare-covered individual or group therapy in-office visit with a psychiatrist. You pay a $0 copayment for each Medicare-covered individual or group therapy telehealth visit with or without a psychiatrist.
Outpatient rehabilitation services *For physical therapy visits beyond the 60th visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* *For occupational therapy visits beyond the 60th visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* *For speech language therapy visits beyond the 35th visit to be covered,*	You pay a $10 copayment for each Medicare-covered physical, occupational or speech language therapy visit.

Services that are covered for you	What you must pay when you get these services
your doctor or other plan provider must get prior authorization (approval in advance) from the plan. Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	
Outpatient substance use disorder services Medicare-covered outpatient substance use disorder treatment services are covered when provided in a clinic or hospital outpatient by a psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, and physician assistant department. Covered services include, but are not limited to: • Psychotherapy • Member education regarding diagnosis and treatment	You pay a $10 copayment for each Medicare-covered individual or group therapy in-office visit. You pay a $0 copayment for each Medicare-covered individual or group therapy telehealth visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers *For outpatient surgery to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	You pay a $50 copayment for each Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility. You do not pay the outpatient surgery copayment in a hospital outpatient facility if you are admitted to the hospital on the same day of the surgery.
Physician/Practitioner services, including doctor's office visits *For some outpatient services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. For more information, see Chapter 3.* *For reconstructive surgery to be covered, your PCP or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include:	You pay a $10 copayment for each primary care doctor visit for Medicare-covered benefits. You pay a $15 copayment for each specialist visit for Medicare-covered benefits. You pay a $15 copayment for

Services that are covered for you	What you must pay when you get these services

• Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location
• Consultation, diagnosis, and treatment by a specialist
• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment
• Certain telehealth services, including: primary care; specialist care; outpatient mental health services; opioid treatment and outpatient substance use disorder services.
  o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.
  o Covered telehealth services are limited to those that involve both an audio and video component and must be done in real-time over a secure communication method administered by your provider. These services can replace some in-person visits to your provider.
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  o You have an in-person visit within 6 months prior to your first telehealth visit
  o You have an in-person visit every 12 months while receiving these telehealth services
  o Exceptions can be made to the above for certain circumstances
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  o You're not a new patient **and**
	each Medicare-covered diagnostic hearing exam.
	
	You pay a $0 copayment for telehealth services from the following:
	• Primary care provider
	• Approved telehealth vendor
	• Outpatient mental health providers
	• Outpatient substance use disorder providers
	
	You pay a $15 copayment for telehealth services from a specialist, except as noted above for outpatient mental health or outpatient substance abuse provider telehealth services.
	
	You pay a $15 copayment for Medicare-covered dental benefits.
	
	You pay $50 copayment for each Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility.
	
	You do not pay the outpatient surgery copayment in a hospital outpatient facility if you are admitted to the hospital on the same day of surgery.

Services that are covered for you	What you must pay when you get these services
○ The check-in isn't related to an office visit in the past 7 days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Reconstructive surgery ○ Surgery for post-mastectomy patients for reconstruction of the breast on which the mastectomy was performed. ○ Surgery and reconstruction of the other breast to produce a symmetrical appearance. ○ Treatment of any physical complications resulting from the mastectomy including lymphedema.	
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: emergency	You pay a $10 copayment for each Medicare-covered urgently needed care visit in the United States and its territories. You pay a $75 copayment for each urgently needed care visit outside of the United States and its territories.

Services that are covered for you	What you must pay when you get these services
services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered. Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition), routine care/visits, and/or elective procedures are not covered.	
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Tints, antireflective coating, UV lenses or oversized lenses are covered only when deemed medically necessary by the treating physician. • One supplemental routine eye exam every year. • One pair of routine eyeglasses (prescription lenses and frames) or contact lenses every calendar year. • The plan coverage limit includes new eyeglasses, contact lenses, lens replacement, frame replacement, upgrades, fitting, adjustment or repair. Must be purchased from an EyeMed network provider. Members pay all charges over the plan coverage limit per calendar year. The following exclusions apply: o Store promotions or coupons o The one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery o Two pairs of glasses in lieu of bifocals	There is no copayment for Medicare-covered glaucoma tests. You pay a $15 copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. You pay a $15 copayment for 1 supplemental routine eye exam every year. You pay $0 for one pair of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery when obtained from an EyeMed provider. Coverage is limited to the specific eyeglasses and contacts covered by Medicare. You will pay any cost over the Medicare-allowed charge if you purchase upgrades. There is a $150 plan coverage limit for one pair of routine eyeglasses or contacts every year; excludes the one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. For information on additional prescription eyewear coverage, see **Benefit Bank** in this chart.

Services that are covered for you	What you must pay when you get these services
o Non-prescription lenses and/or contact lenses o Non-prescription sunglasses We also cover eyewear as part of your Benefit Bank. For more information, see **Benefit Bank** in this chart.	

Chapter 6: What you pay for your Part D prescription drugs explains the six cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier.

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Retail cost-sharing (in-network) (up to a 30-day supply)	Mail-order cost-sharing (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred generic drugs)	$0 copay	$0 copay	$0 copay	$0 copay
Cost-Sharing Tier 2 (Generic drugs)	$10 copay	$10 copay	$10 copay	$10 copay
Cost-Sharing Tier 3 (Preferred brand drugs)	$25 copay	$25 copay	$25 copay	$25 copay
Cost-Sharing Tier 4 (Non-preferred drugs)	$50 copay	$50 copay	$50 copay	$50 copay
Cost-Sharing Tier 5 (Specialty drugs)	$50 copay	$50 copay	$50 copay	$50 copay
Cost-Sharing Tier 6 (Select care drugs (certain vaccines and anti-opioid drugs))	$0 copay	$0 copay	$0 copay	$0 copay

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 9 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

Section 5.4 A table that shows your costs for a *long-term* (up to a 100-day) supply of a drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 100-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a long-term supply of a covered Part D prescription drug:

Tier	Retail cost-sharing (in-network) (up to a 100-day supply)	Mail-order cost-sharing (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred generic drugs)	$0 copay for up to a 100-day supply	$0 copay for up to a 100-day supply
Cost-Sharing Tier 2 (Generic drugs)	$30 copay for up to a 90-day supply	$20 copay for up to a 90-day supply
Cost-Sharing Tier 3 (Preferred brand drugs)	$75 copay for up to a 90-day supply	$50 copay for up to a 90-day supply
Cost-Sharing Tier 4 (Non-preferred drugs)	$150 copay for up to a 90-day supply	$100 copay for up to a 90-day supply
Cost-Sharing Tier 5 (Specialty drugs)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Cost-Sharing Tier 6 (Select care drugs (certain vaccines and anti-opioid drugs))	A long-term supply is not available for drugs in Tier 6.	A long-term supply is not available for drugs in Tier 6.

At a retail pharmacy, you won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier. When obtained through mail-order, your cost-sharing for up to a three-month supply of covered insulin will be no more than $70 regardless of the cost-sharing tier.