



| Benefit or Service   | Prior Authorization | Member Cost Share               | Additional Information   |
|--|---------------------|---------------------------------|--|
| Abdominal Aortic Aneurysm Screening  |                     | \$0 copay                       | For planned preventive services that become diagnostic during the screening, cost sharing may apply.   |
| Acupuncture - Medicare Covered for Chronic Back Pain   |                     | 20% coinsurance                 | <ul style="list-style-type: none"> <li>• Medicare criteria must be met.</li> <li>• Up to 12 visits in 90 days.</li> <li>• 8 additional sessions will be covered if improvement is demonstrated from the initial 12 visits</li> <li>• No more than 20 visits in a calendar year.</li> </ul> |
| Alternative Medicine:* 2023 name change to Health and Well Being, Acupuncture and Naturopathy, Non-Medicare Chiropractor |                     | 0% coinsurance                  | New limit: 12 visit limit which is a combination of visits from Acupuncturists, Naturopaths and Chiropractor visits not covered by Medicare. Massage therapy is not covered. X-rays performed by Chiropractor are not covered.   |
| AIR Ambulance ( <u>Non-emergency</u> )   |                     | \$300.00 copay per one-way trip | Covered, provided Medicare criteria are met.   |
| Ambulance (Emergency)  |                     | \$300.00 copay per one-way trip | Covered, including air ambulance, provided Medicare criteria are met.  |
| Ambulance (Non-Emergency)  |                     | \$300.00 copay per one-way trip | Covered, provided Medicare criteria are met.   |
| Anesthesiologist (Anesthesia)  |                     | \$0 copay                       | For professional services.   |
| Annual Wellness Visit/AWV (Also, see Welcome to Medicare Preventive Visit)   |                     | \$0 copay                       | All Medicare members who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not received a Welcome to Medicare Visit (AWV or Initial Preventive Physical Exam/IPPE) within the past 12 months                             |
| Bone mass measurement (Bone Density)   |                     | \$0 copay                       | For planned preventive services that become diagnostic during the screening, cost sharing may apply. CMS limitations apply, every 2 years; or more frequently if medically necessary.  |



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| Breast cancer screening (mammograms, mammography)               |   | \$0 copay         | "For planned preventive services that become diagnostic during the screening, cost sharing may apply.<br><ul style="list-style-type: none"> <li>• One baseline mammogram between the ages of 35 and 39</li> <li>• One screening mammogram every 12 months for age 40 and older</li> <li>• Clinical breast exams once every 24 months</li> </ul> |
| Cardiac rehabilitation services                                 | See Prior Authorization List and Procedure Code Look Up Tool. | 20% Coinsurance   | Medicare covers 2 sessions per day (1 hour each), up to 36 sessions.  |
| Cardiovascular disease risk reduction visit                     |   | \$0 copay         | For planned preventive services that become diagnostic during the screening, cost sharing may apply.  |
| Cardiovascular disease testing                                  |   | \$0 copay         | For planned preventive services that become diagnostic during the screening, cost sharing may apply.  |
| Cervical and vaginal cancer screening (Pap tests, pelvic exams) |   | \$0 copay         | For planned preventive services that become diagnostic during the screening, cost sharing may apply.<br><ul style="list-style-type: none"> <li>• All women: Every 24 months</li> <li>• High risk of cervical cancer or abnormal pap: Every 12 months</li> </ul>   |
| Chiropractic services, Medicare covered                         | See Prior Authorization List and Procedure Code Look Up Tool. | \$15.00 copay     | Only manual manipulation to correct subluxation. Massage therapy not covered. Per CMS x-rays billed by a chiropractor are not covered. X-rays are covered if performed by Radiologist. Also See supplemental benefit Health and Wellbeing.  |
| Clinical Trials   | See Prior Authorization List and Procedure Code Look Up Tool. |                   |   |



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| Colorectal cancer screening (Colonoscopy, Sigmoidoscopy)            |   | \$0 copay   | For planned preventive services that become diagnostic during the screening, cost sharing may apply.<br>For age 50 and older:<br><ul style="list-style-type: none"> <li>• Sigmoidoscopy every 48 months</li> <li>• Fecal occult blood test, every 12 months</li> </ul> For at high risk of colon cancer:<br><ul style="list-style-type: none"> <li>• Screening colonoscopy every 24 months</li> </ul> Not at high risk of colon cancer:<br><ul style="list-style-type: none"> <li>• Screening colonoscopy every 10 years (120 months) but not within 48 months (2 years) of a screening</li> </ul> |
| Cosmetic surgery or procedures (Partial Exclusion)                  | See Prior Authorization List and Procedure Code Look Up Tool. |   | Only covered because of an accidental injury or to improve a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.   |
| Custodial Care (Exclusion)  | Not Covered   | Not Covered   | Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps with activities of daily living, such as bathing or dressing. Custodial care is not <i>medically necessary</i> .   |
| Dental Services (Medical Services, Not Routine Dental)              | See Prior Authorization List and Procedure Code Look Up Tool. | See specific medical services for related copays and coinsurance.   | Covered services 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. Submit claims to CHPW.   |
| Dental Services (Supplemental Routine Preventive and Comprehensive) | Referral not required for supplemental dental services.       | Cost share is anything over \$500.00 comprehensive benefit maximum. Must see Delta Dental In-Network Provider. Submit claims to Delta Dental. | Unlimited preventive (cleaning, etc.) in addition to \$500.00 comprehensive services max. Must see Delta Dental In-Network Provider. Submit claims to Delta Dental.  |



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| Depression screening   |  | \$0 copay   | For planned preventive services that become diagnostic during the screening, cost sharing may apply.   |
| Diabetes screening   |  | \$0 copay   | For planned preventive services that become diagnostic during the screening, cost sharing may apply.   |
| Diabetes self-management training, diabetic services and diabetes supplies (DME) | Prior auth required when glucose monitor, shoes or inserts (orthotics) greater than \$500.00 | \$0 cost share<br>Self management training requires a referral. | No cost share: <ul style="list-style-type: none"> <li>• Blood glucose monitor</li> <li>• Blood glucose strips</li> <li>• Lancet devices</li> <li>• Glucose-control solutions for checking accuracy of strips and monitor</li> <li>• One pair of diabetic shoes per calendar year</li> <li>• 2 sets of shoe inserts (orthotics) covered per calendar year (diabetic)</li> </ul> |
| Durable medical equipment (DME) and related supplies                             | See Prior Authorization List and Procedure Code Look Up Tool.                                | *20% Coinsurance  | Covered, provided Medicare criteria are met. DME includes, wheelchairs, hospital beds, walkers, oxygen. *When primary diagnosis is COPD the coinsurance is zero.   |
| Emergency care (Emergency Room, ER)  |  | \$100.00 (facility) copay for ER visit                          | \$100.00 copayment waived if admitted as inpatient within the same hospital within 24 hrs.   |
| Emergency care (ER Physician Service)  |  | 0% coinsurance  |  |
| Emergency care: Supplemental World Wide - Facility and Professional Services     |  | 20% Coinsurance   | \$25,000.00 Maximum - ER coinsurance is not waived if admitted to hospital. Does not count toward Medicare Out of Pocket (MOOP).   |
| Enteral Feedings, Tube Feedings (Infusion Therapy, DME)                          | See Prior Authorization List and Procedure Code Look Up Tool.                                | 20% Coinsurance   |  |
| Enteral Formula (Infusion Therapy, DME)  | See Prior Authorization List and Procedure Code Look Up Tool.                                | 20% Coinsurance   |  |



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| Eye exam - Medicare Covered (medical vision disease)       |                     | *\$40.00 copay       | Exams to diagnose diseases and conditions of the eye covered by Medicare. *When the primary diagnosis is diabetes for a retinal exam and the exam is performed by an endocrinologist or ophthalmologist, the copay is zero. If provider is not participating then plan approved referral is required. Submit claims to CHPW |
| Eye exam - Routine Vision (VSP Advantage)                  |                     | In network \$0 copay | Through VSP - One WellVision exam every year. Members must use the VSP Advantage Network for in-network benefits. Submit claims to VSP. Out of network - \$45.00 is allowed toward the cost of the exam.  |
| Eye Wear - Medicare covered (Post Cataract Vision Surgery) |                     | 20% Coinsurance      | Covered, provided Medicare criteria are met. One pair of eyeglasses or contact lenses includes insertion of an intraocular lens after each surgery. Submit claims to CHPW.  |



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| <p>Eye Wear - Prescription Contacts, frames, vision lenses, upgrades (VSP Choice)</p>          |  | <ul style="list-style-type: none"> <li>• Available every 2 years.</li> <li>• In VSP Choice network</li> <li>• Frame or contact lenses instead of glasses - \$150.00 every year allowed toward cost.</li> <li>• In VSP Choice network - Lenses (for glasses) - \$0 copay for the following lenses:                             <ul style="list-style-type: none"> <li>o Single Vision</li> <li>o Lined bifocal</li> <li>o Lined trifocal</li> <li>o Lenticular</li> </ul> </li> <li>• Lens enhancements not included in the \$0 copay. Lens enhancements are member's responsibility. Average 30% savings on lens and enhancements.</li> </ul> | <p>Members must use the VSP Choice Network for in-network benefits. Submit claims to VSP. Out of network - Any amount over the out of network annual allowance is patient responsibility.</p> <ul style="list-style-type: none"> <li>• Frame, \$70 allowed toward costs.</li> <li>• Contact lenses (in lieu of lenses and frame) \$105.</li> <li>• Single vision Lenses - up to \$30</li> <li>• Lined bifocal - up to \$50</li> <li>• Lined trifocal - up to \$65</li> <li>• Lenticular - up to \$100</li> <li>• Progressive - up to \$50</li> </ul> |
| <p>Eye and Vision Services Not Covered by Medicare (Exclusions)</p>                            |  | <p>Not Covered. See Additional Information</p>  | <ul style="list-style-type: none"> <li>• Radial keratotomy not covered</li> <li>• LASIK surgery not covered</li> <li>• Vision Therapy not covered</li> <li>• Low Vision Aids not covered</li> </ul>  |
| <p>Genetic Testing Not Related to Pregnancy</p>  | <p>See Prior Authorization List and Procedure Code Look Up Tool.</p> | <p>20% Coinsurance</p>  |  |
| <p>Hearing exam (Medicare covered to diagnose and treat specific diseases and conditions:)</p> |  | <p>\$20.00 copay</p>  | <p>Covered, provided Medicare criteria are met. Routine hearing exams, hearing aids, and hearing aid fittings are not covered by Medicare.</p>   |
| <p>Hearing exam (Routine not covered by Medicare) Exclusion</p>                                | <p>Not Covered</p>   | <p>Not Covered</p>  | <p>Not Covered</p>   |



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| Hearing services (hearing aid fittings, hearing aids) Exclusion | Not Covered   | Not Covered       | Not Covered  |
| HIV screening   |   | \$0 copay         | For planned preventive services that become diagnostic during the screening, cost sharing may apply.   |
| Home health agency care   | See Prior Authorization List and Procedure Code Look Up Tool.   | \$0 coinsurance   | 20% coinsurance for durable medical equipment (DME) still applies when related to Home Health services.  |
| Homemaker Services (Exclusion)                                  | Not Covered   | Not Covered       | Services include basic household assistance, light housekeeping or light meal preparation.   |
| Hospice care (inpatient and home)                               | No.   |                   | You pay nothing for hospice care from a Medicare certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan.   |
| Hyperbaric oxygen treatment                                     | See Prior Authorization List and Procedure Code Look Up Tool.   | 20% Coinsurance   |  |
| Immunizations   |   | \$0 Coinsurance   | Covered:<br>- pneumonia<br>- influenza (flu shot)<br>- Hepatitis B<br>- COVID-19<br>- Other vaccines if at risk and meet Original Medicare Part B coverage rules<br>*Shingles vaccine (Zostavax) is covered under pharmacy - Part D Benefit* |
| Infusion Therapy, Home Infusion Therapy                         | Not Required for Infusion Therapy Services. Services related to the Infusion Therapy care may require prior authorization, for example medication, enteral nutrition. Review Prior Authorization list for related services. | 20% coinsurance   | Not Required for Infusion Therapy Services. Services related to the Infusion Therapy care may require prior authorization, for example medication, enteral nutrition. Review Prior Authorization list for related services.                  |



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| Injections, Injectable drugs (Prescription drugs Medicare Part B medical benefits) | See Prior Authorization List and Procedure Code Look Up Tool. | 20% Coinsurance  | Covered, provided Medicare criteria are met. Includes chemotherapy related drugs, drugs related to home dialysis, B12, etc.  |
| Inpatient hospital Blood (including inpatient skilled nursing facility/SNF)        |   | No Blood Deductible<br>0% coinsurance  | Coverage begins with the first pint of blood needed. Includes storage and administration. The patient is responsible for any other applicable coinsurance amounts.   |
| Outpatient Blood   |   | No Blood Deductible<br>0% coinsurance  | Coverage begins with the fourth pint of blood needed. Coverage of storage and administration begins with the first pint of blood needed. The patient is responsible for any other applicable coinsurance amounts.  |
| Inpatient hospital (acute) care  | See Prior Authorization List and Procedure Code Look Up Tool. | Days:<br>1-4 - \$500.00 per day<br>5-90 - \$0 per day<br>Over 90 Days \$0                | All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.  |
| Inpatient Professional Services  |   | 20% Coinsurance  |  |
| Inpatient Hospital (facility) mental health, psychiatric, psychiatrist)-care       | See Prior Authorization List and Procedure Code Look Up Tool. | Days:<br>1-10 - \$175.00 per day<br>11-90 - \$0 per day<br>Lifetime reserve days= 60-\$0 | All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply. Not psychiatric hospital, same cost shares as acute care. Plan covers 90 days for an inpatient stay. 190-day lifetime limitation in a psychiatric facility. <u>This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</u> |
| Inpatient rehabilitation services (physical, speech, occupational therapies)       | See Prior Authorization List and Procedure Code Look Up Tool. | Days:<br>1-4 - \$500.00 per day<br>5-90 - \$0 per day<br>Over 90 Days \$0                | All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply. Same cost shares as acute care.  |
| Inpatient services covered during a non-covered inpatient stay                     |   | 20% coinsurance  | Covered, provided Medicare criteria are met.   |





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| Inpatient substance abuse (SUD)  | See Prior Authorization List and Procedure Code Look Up Tool.  | Days:<br>1-4 - \$450.00 per day<br>5-90 - \$0 per day<br>Over 90 - \$0 per day | All admissions, planned and urgent, require notification within 24 hrs. or next business day. Same cost shares as acute care.  |
| Kidney disease and conditions (Hemodialysis, Dialysis, End Stage Renal Disease/ESRD) | NO. Effective 01/01/2016 Notification is required.   | 20% coinsurance  |  |
| Kidney disease education (on dialysis)   | No.  | 0% cost share  | Medicare covers 6 sessions of kidney disease education per lifetime per Medicare.  |
| Mastectomy related bras and supplies (DME)   | If over \$500.00   | 20% cost share   |  |
| Meal, Meals Benefit (Supplemental)   |  | 0% cost share  | Meals can be delivered to the home upon discharge from a hospital or skilled nursing facility. 2 meals per day up to 14 days after discharge, up to 6 occurrences per year. Meals to dine with members that are inpatient are not covered. |
| Medical nutrition therapy education  | No   | 0% cost share  | Education for people with diabetes, kidney disease (patient not on dialysis) post kidney transplant. 3 hrs. for first year. 2 hrs. each year after the first year.   |
| Nurse Advice Line  |  | 0% cost share  | 24 hour nurse hotline available: 1-866-418-1002 or TTY 1-866-418-1006  |
| Obesity screening and obesity (counseling) therapy                                   |  | 0% cost share  | Covered, provided Medicare criteria are met, e.g., body mass index (BMI) of 30 or more, etc.   |
| Organ (Living) Donation (Transplant)   | See Prior Authorization List and Procedure Code Look Up Tool.  | 20% coinsurance  | All admissions, planned and urgent, require notification within 24 hrs. or next business day.  |
| Orthotics (Supportive Devices for feet)  | Only covered for diabetic foot disease.<br><br>Prior auth required for orthotics (shoe inserts) greater than \$500.00. | \$0 cost share   | • 2 sets of shoe inserts (orthotics) covered per calendar year only for diabetic foot disease.   |



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| Outpatient diagnostic tests and therapeutic services (lab, radiology, x-ray)               | See Prior Authorization List and Procedure Code Look Up Tool. | 0% Medicare covered lab<br>\$15 copay x-ray outpatient facility fee does not include scans (CT, MRI, PET, etc.) Does not include professional fees.<br>20% Other diagnostic procedures (includes scans and professional fees) |  |
| Outpatient hospital services, includes observation   | See Prior Authorization List and Procedure Code Look Up Tool. | \$250.00 copay outpatient facility fee maximum. Does not include professional services.   |  |
| Outpatient mental health (not psychiatrist)  |   | \$30.00 copay   | Copay the same for group therapy. Must be Medicare eligible provider. Per CMS, some 'counselors' are not eligible to perform services for Medicare and Medicare Advantage members.                                 |
| Outpatient psychiatrist care   |   | \$30.00 copay   | Copay the same for group therapy.  |
| Outpatient rehabilitation services (physical (PT), speech (ST), occupational therapy (OT)) | See Prior Authorization List and Procedure Code Look Up Tool. | \$30.00 copay for therapy services<br><br>\$30.00 copay and or 20% facility fees for other additional services when performed in a facility.  | 12 visits allowed for each type of therapy. 12 PT, 12 OT and 12 ST. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 12 visits. |
| Outpatient substance abuse services  | See Prior Authorization List and Procedure Code Look Up Tool. | 20% coinsurance   | Opioid Treatment Services, to allow codes G2067 through G2080, the provider must be certified with SAMSAH and enrolled with Medicare.  |
| Outpatient surgery, ambulatory surgical centers (ASC)                                      | See Prior Authorization List and Procedure Code Look Up Tool. | \$250.00 copay for ASC Facility Services  |  |
| Over the Counter (OTC) medication/pharmacy   | Not Covered   | Not Covered   |  |



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| Partial hospitalization service (intensive outpatient mental health services)      |   | 20% coinsurance   | Must be Medicare eligible provider. Per CMS, some 'counselors' are not eligible to perform services for Medicare and Medicare Advantage members.  |
| Physician/Practitioner/PCP services, including doctor's office visits              |   | \$0 copay for PCP E & M service<br>20% coinsurance for all other services                         |   |
| Physical Exam, See Welcome to Medicare Preventive Visit and Annual Wellness Visit  |   | See Welcome to Medicare Preventive Visit and Annual Wellness Visit                                | See Welcome to Medicare Preventive Visit and Annual Wellness Visit  |
| Podiatry Services (Foot Care) When Not Covered by Medicare (Supplemental Benefit)  |   | No copay \$0.00<br>0% Coinsurance   | 4 visits each year - Not limited to Medicare covered diagnosis codes. NEW, when the primary care is Diabetes an additional 4 visits each year for a total of 8 Non-Medicare covered visits.<br>The specialist copay does not apply to podiatrists for these services. |
| Podiatry Services (Foot Care) Medical Medicare Covered                             |   | No copay \$0.00<br>0% Coinsurance   | Limited to Medicare covered diagnosis codes.<br>The specialist copay does not apply to podiatrists for these services.  |
| Prescription drugs Medicare Part B medical benefits (injectable drugs, injections) | See Prior Authorization List and Procedure Code Look Up Tool. | 20% coinsurance   | Includes chemotherapy related drugs, drugs related to home dialysis, etc.   |
| Prescription drugs Medicare Part D pharmacy benefit (drug list, formulary)         |   | Pharmacy, Part D is not covered   | Over the counter (OTC) not covered  |
| Primary Care Physician (PCP)   |   | \$0 copay for evaluation and management (E & M) service<br>20% coinsurance for all other services |   |



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| Prostate cancer screening exams (PSA)   |   | \$0 copay         | For planned preventive services that become diagnostic during the screening, cost sharing may apply.<br>For men over age 50:<br><ul style="list-style-type: none"> <li>• Every 12 months: Digital rectal exam</li> <li>• Every 12 months PSA test</li> </ul>   |
| Prosthetic devices and related supplies (DME)   | See Prior Authorization List and Procedure Code Look Up Tool. | 20% coinsurance   |  |
| Pulmonary rehabilitation services   | See Prior Authorization List and Procedure Code Look Up Tool. | 20% coinsurance   | Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. |
| Screening and counseling to reduce alcohol misuse   |   | \$0 copay         | For planned preventive services that become diagnostic during the screening, cost sharing may apply.   |
| Screening for sexually transmitted infections (STIs) and counseling to prevent STIs                   |   | \$0 copay         | For planned preventive services that become diagnostic during the screening, cost sharing may apply.   |
| Shoes, Diabetic- SEE Diabetes self-management training, diabetic services and diabetes supplies (DME) |   |                   |  |
| Shoes, Orthopedic/Prosthetic with Braces (DME)  | See Prior Authorization List and Procedure Code Look Up Tool. | 20% coinsurance   | Limited coverage. Prosthetic/Orthopedic Shoes that are part of a leg brace are covered and included in the cost of the leg brace.  |



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| Skilled nursing inpatient facility (SNF) care (Part A)  | See Prior Authorization List and Procedure Code Look Up Tool. | Days:<br>1-20 - \$ 00.00 per day<br>21-100 - \$200.00 per day | No (zero) acute inpatient hospital days required prior to SNF admission. Custodial (not medically necessary) care is not covered. All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time member is admitted to a new SNF stay the copay will apply.         |
| Skilled nursing facility (SNF) inpatient care (Part B)  |   | 20% coinsurance   | Part B (outpatient) coinsurance and benefit limits apply.  |
| Skilled nursing facility (SNF) Blood  |   | No blood deductible<br>0% coinsurance                         |  |
| Sleep Studies   | No.   | 20% coinsurance   |  |
| Smoking and tobacco use cessation   |   | 0% Coinsurance  | <ul style="list-style-type: none"> <li>• Contact Optum at 1-866-784-8454 (1-866-QUIT-4-LIFE).</li> <li>• No disease - 8 sessions per calendar year</li> <li>• Disease related - 8 sessions per calendar year</li> </ul>  |
| Sterilization Reversal (Exclusion)  | Not Covered   | Not Covered   | Reversal of sterilization procedures and non-prescription contraceptive supplies.  |
| Specialist Physician Care/Services (does not apply to psychiatrists, mental health, lab or radiology) |   | *\$40.00 copay for E & M service.                             | 20% coinsurance for all other services.<br>*Zero copay when primary diagnosis is diabetes for endocrinologist<br>*Zero copay when primary diagnosis is COPD for pulmonologist.<br>*Zero copay when primary diagnosis is CHF for cardiologist.<br>*See Eye Exam – Medicare Covered - for Retinal Exam benefit |
| Telemedicine, Telehealth (Virtual care)   |   | Must meet Original Medicare criteria.                         | Covered. Must meet Original Medicare criteria.   |



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| Telemedicine, Telehealth (Virtual care) - Supplemental |   | Member cost share same as in-person cost shares for: Urgently Needed Services; Primary Care Physician Services; Physician Specialist Services; Individual and Group Sessions for Mental Health Specialty Services; Individual and Group Sessions for Psychiatric Services; Individual and Group Sessions for Outpatient Substance Abuse. |  |
| Transplant Evaluation/Work-Up                          | See Prior Authorization List and Procedure Code Look Up Tool. | 0% coinsurance (lab)   |  |
| Transplant   | See Prior Authorization List and Procedure Code Look Up Tool. | 20% coinsurance  | Corneal transplant does not require prior authorization (PA), other transplants do require PA. All admissions, planned and urgent, require notification within 24 hrs. or next business day.           |
| Transportation SEE AMBULANCE                           | See Ambulance   | See Ambulance  | See Ambulance  |
| Unlisted Codes with Charge Greater Than \$250.00       | See Prior Authorization List and Procedure Code Look Up Tool. |  | Unlisted codes is the actual, AMA description of the service. Medical necessity documentation and pricing must be submitted with the request.<br><b>Example: 43499, Unlisted procedure, esophagus.</b> |
| Urgently needed care                                   |   | \$0 copay for evaluation and management (E & M) service<br>20% coinsurance for all other services  |  |
| Vision Care SEE EYE EXAM AND EYE WEAR                  | See Eye Exam and Eye Wear                                     | See Eye Exam and Eye Wear  | See Eye Exam and Eye Wear  |



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| Welcome to Medicare Preventive Visit (Initial Preventive Physical Exam/IPPE or Annual Wellness Visit/AWV) |                     | \$0 copay         | 1 visit lifetime max within 12 months of Part B effective date. For planned preventive services that become diagnostic during the screening, cost sharing may apply. If greater than 12 months from the effective date and did not receive a Welcome Exam see Annual Physical Exam  |
| Wig (DME)   | Yes if +\$500.00    | 20% coinsurance   | Must be medically necessary and meet criteria to covered by Medicare.   |
| Lung Cancer Screening   |                     | \$0 copay         | Limited to ages 55 through 77, once per year.   |
| Fitness Benefit   |                     | \$0 copay         | Membership at participating fitness centers or 2 Home Fitness Kits per year:<br>Includes:<br><ul style="list-style-type: none"> <li>• Access to Silver&amp; Fit website including The Silver Slate newsletter, healthy aging education program, motivational tips and rewards.</li> <li>• 34 Home Fitness Kits to choose from</li> <li>• Single fitness center access; can be changed once per month.</li> <li>• Customer Service, open Monday through Friday, 5 AM through 6 PM PST</li> <li>• Tele <a href="tel:1-877-427-4788">1-877-427-4788</a></li> </ul> |
| Supervised Exercise Therapy (SET)   |                     | 20% coinsurance   | Only for members who have symptomatic peripheral artery disease (PAD). No referral is required. The SET provider must meet Medicare requirements.<br>Covered up to 36 sessions over a 12-week period if all of the components of a SET program are met.   |



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| Medicare Diabetes Prevention Program (MDPP) |                     | No Cost Shares   | <p>Provider must be enrolled in Medicare as an MDPP supplier to bill for MDPP services.</p> <ul style="list-style-type: none"> <li>• Therapeutic exercise-training program for PAD.</li> <li>• Conducted in a hospital outpatient setting, or a physician’s office</li> <li>• Delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in <b>exercise therapy for PAD</b></li> </ul> |
| Pulmonary rehabilitation services           |                     | 20% Coinsurance  | Medicare covers 2 sessions per day (1 hour each), up to 36 sessions. Prior Authorization required after 36 sessions.  |
| Transgender Services                        |                     | Cost share determined by service, e.g. outpatient hospital copay, specialist visit, etc. | The procedure code must be covered by Original Medicare with an allowed amount on the Medicare fee schedule. The PCLT can be referenced for covered codes and prior authorization requirements: <a href="https://forms.chpw.org/pclt">https://forms.chpw.org/pclt</a> .   |
| Health and Wellbeing                        |                     | 0% coinsurance   | 12 visit limit which is a combination of visits from Acupuncturists, Naturopaths and Chiropractor visits not covered by Medicare. Massage therapy is not covered. X-rays performed by Chiropractor are not covered.   |
| Member Total Out-of-Pocket (MOOP)           |                     | \$8,850.00   |   |