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Medical Benefits Chart with prescription drug costs

Your medical benefits and costs as a member of the University of Vermont Medicare Advantage - Plan J Vermont Blue Advantage Group PPO

This *Medical Benefits Chart with prescription drug costs* is a part of your 2022 *Evidence of Coverage* (EOC), Chapter 4 and Chapter 6. This is an important legal document. Please keep it in a safe place.

This plan is effective January 1, 2022 - December 31, 2022.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Section 2.1 Your medical benefits and costs as a member of the plan

The *Medical Benefits Chart* on the following pages lists the services Vermont Blue Advantage Group PPO covers and what you pay out-of-pocket for each service. Refer to chapters 3 and 4 in your EOC for more information about coverage for medical services. Your out-of-pocket prescription drug costs can be found in the charts that follow your medical benefits. Refer to chapters 5 and 6 in your EOC for more information about prescription drug coverage.

Your medical benefits are listed alphabetically. Additional Benefits (if applicable) are listed alphabetically after the core medical benefits. A listing of benefits not covered by the plan immediately follows the medical benefits.

The services listed in this *Medical Benefits Chart* are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in this *Medical Benefits Chart* are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from Vermont Blue Advantage Group PPO.
    - Covered services that need approval in advance to be covered are marked in italics in the *Medical Benefits Chart*.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2022* handbook. View it online at **www.medicare.gov** or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2022, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the benefits chart.

Type of maximum	In-network and Out-of-network
Deductible for certain medical services Combined in-network and out-of-network annual deductible. Applies to services below: • Ambulance services in the U.S. and its territories • Diabetic services and supplies • Durable medical equipment (DME) and related supplies • Gradient compression stockings • Home infusion drugs and administration • Private duty nursing • Prosthetic devices and related supplies • Weight loss surgery • Wigs, wig stand, and adhesive	$100
Maximum out-of-pocket Out-of-pocket maximum for Part A and B services for both in- and out-of-network combined. Services that do not apply to this maximum are marked with an asterisk (*).	$500

All Part A and Part B deductibles and cost share amounts apply to the annual out-of-pocket maximum.

Exceptions: There is no limit on cost sharing for certain services. For members who have elected the hospice benefit, any Medicare cost-sharing amounts resulting from Medicare's payment of services that are not related to the terminal condition do not contribute to annual out-of-pocket maximums.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.	
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, etc. disease); • 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.	$10 copay for Medicare-covered acupuncture sessions.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Acupuncture for chronic low back pain (continued) Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse 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 • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the	20% coinsurance, after deductible, for each Medicare-covered, one-way ground or air ambulance trip. 20% coinsurance for worldwide emergency transportation, one-way ground or air ambulance trip. Urgent care, emergency care, and emergency transportation are subject to a combined $50,000 lifetime maximum benefit outside of the U.S. and its territories.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Ambulance services (continued) person's health and that transportation by ambulance is medically required You are covered for emergency transportation worldwide.*		
Annual physical exam An examination performed by a primary care provider or other provider that collects health information. Services include: • An age and gender appropriate physical exam, including vital signs and measurements. • Guidance, counseling and risk factor reduction interventions. • Administration or ordering of immunizations, lab tests or diagnostic procedures. This is an annual preventive medical exam and is more comprehensive than an annual wellness visit. This is covered once per calendar year.	There is no coinsurance, copayment, or deductible for the annual physical exam.	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months • Diagnostic mammogram when medically necessary	There is no coinsurance, copayment, or deductible for covered screening mammograms. If you have a medical condition, a follow-up (second) mammogram and/or biopsy on a separate day from the screening, the procedure is considered diagnostic and your contractual cost sharing for Medicare-covered services will apply.	
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copay for each Medicare-covered cardiac rehabilitation service. $0 copay for each Medicare-covered intensive cardiac rehabilitation service.	
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit,	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) (continued) your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.		
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation • One routine office visit per year • One (1) set of X-rays (up to 3 views)	$10 copay for each Medicare-covered visit. $10 copay for each routine care visit. $0 copay for one annual set of X-rays (up to 3 views) when performed by a chiropractor.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If you have a medical condition, such as gastrointestinal symptoms, or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and your contractual cost sharing for Medicare-covered surgical services will apply.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. We cover emergency Medicare-covered services.	$0 copay for Medicare-covered services.	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.	
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	20% coinsurance, after deductible, for Medicare-covered diabetic supplies. 20% coinsurance, after deductible, for Medicare-covered diabetic shoes and inserts. $0 copay for Medicare-covered diabetes self-management training.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 of the *Evidence of Coverage*.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **www.VermontBlueAdvantage.com/findadoctor**.	20% coinsurance, after deductible, for each Medicare-covered item and related supplies. You must have a prescription or a Certificate of Medical Necessity from your provider to obtain Durable Medical Equipment (DME) or Prosthetic and Orthotic (P&O) items and services. *Authorization rules may apply.*	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.	$0 copay in the U.S. and its territories. $10 copay worldwide. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost sharing amount for the part of your stay after you are stabilized.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Emergency care (continued) Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. You are covered for emergency medical care worldwide.*	Urgent care, emergency care, and emergency transportation are subject to a combined $50,000 lifetime maximum benefit outside of the U.S. and its territories.	
Glaucoma screening Glaucoma screening once per year for people who fall into at least one of the following high risk categories: • People with a family history of glaucoma • People with diabetes • African Americans who are age 50 and older • Hispanic Americans who are age 65 and older	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive glaucoma screening.	
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.	**Exam to diagnose and treat hearing and balance issues** $10 copay for Medicare-covered services from a primary care provider. $10 copay for Medicare-covered services from a specialist.	
Hepatitis C screening For people who are at high risk for Hepatitis C infection, including persons with a current or past history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992, we cover: • One screening exam • Additional screenings every 12 months for persons who have continued illicit	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive Hepatitis C screening.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Hepatitis C screening (continued) injection drug use since the prior negative screening test For all others born between 1945 and 1965, we cover one screening exam.		
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.	
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copay for Medicare-covered services.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Home infusion therapy **Original Medicare coverage includes:** Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Coverage for additional home infusion therapy service components are provided based on the member's condition. **Enhanced coverage includes:** In addition, Vermont Blue Advantage Group PPO home infusion therapy benefit provides coverage for the in-home administration of infusion therapy services when the Original Medicare coverage criteria are not met. Coverage is available when the infusion therapy is: • Prescribed by a physician to: ◦ Manage a chronic condition	20% coinsurance, after deductible, for Medicare-covered home infusion therapy. *Authorization rules apply.*	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Home infusion therapy (continued) ◦ Treat a condition that requires acute care if it can be managed safely at home • Certified by the physician as medically necessary for the treatment of the condition • Appropriate for use in the patient's home • Medical IV therapy, injectable therapy or total parenteral nutrition therapy Components of care available regardless of whether the patient is confined to the home: • Nursing visits • Durable medical equipment, medical supplies and solutions • Catheter care • Injectable therapy • Drugs		
Hospice care You may receive care from any Medicare-certified hospice program. 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. 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 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 Vermont Blue Advantage Group PPO.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Hospice care (continued) 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 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. 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: • If you obtain the covered services from a network provider, 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 plan cost sharing for out-of-network services For services that are covered by Vermont Blue Advantage Group PPO but are not covered by Medicare Part A or B: Vermont Blue Advantage Group PPO 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: Drugs are never covered by		

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Hospice care (continued) 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*) in the *Evidence of Coverage*. **Note**: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.		
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. $0 copay for other Part B covered vaccines.	
Inpatient hospital care 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.	$0 copay per stay. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost sharing you would pay at a network hospital. *Authorization rules may apply.*	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Inpatient hospital care (continued) Our plan provides an unlimited number of medically necessary inpatient hospital days. 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 abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/ multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. 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		

Services that are covered for you	What you must pay when you get these services	
	In-Network	Out-of-Network
Inpatient hospital care (continued) are willing to accept the Original Medicare rate. If Vermont Blue Advantage Group PPO 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 of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • 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!" This fact sheet is available on the Web at **www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.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.		

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Inpatient mental health care • Covered services include mental health care services that require a hospital stay Plan covers 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a psychiatric unit of a general hospital. If your hospital stay is longer than 90 days, our plan provides for up to 100 additional days of coverage, subject to the Medicare lifetime limit of 190 days.	$0 copay per stay.	
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations	The cost sharing amounts for these services are the same as those listed within the appropriate service category in this chart. *Authorization rules may apply.*	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued) • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy		
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	
Medicare Part B prescription drugs 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 • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens	\$0 copay for each Medicare-covered Part B drug. \$0 copay for each Medicare-covered Part B chemotherapy drug and the administration. *Authorization rules may apply.*	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Medicare Part B prescription drugs (continued) • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: **www.VermontBlueAdvantage.com/member-resources** We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 of your *Evidence of Coverage* 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 of your *Evidence of Coverage* below.		
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Obesity screening and therapy to promote sustained weight loss (continued) comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.		
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$0 copay for each covered opioid treatment service.	
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests	$0 for Medicare-covered X-rays and diagnostic radiological services. $0 copay for Medicare-covered therapeutic radiological services. $0 copay for blood. $0 copay for outpatient diagnostic procedures and tests. $0 copay for Medicare-covered lab services in a non-hospital lab.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Outpatient diagnostic tests and therapeutic services and supplies (continued) • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests	$0 copay for Medicare-covered lab services in a hospital setting.	
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is	$0 copay Medicare-covered observation services.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Outpatient hospital observation (continued) available on the Web at **www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.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.		
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital	\$0 copay for Medicare-covered outpatient hospital surgical services. \$0 copay for all other Medicare-covered outpatient hospital services. \$0 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA and PET. \$0 copay for Medicare-covered lab services. \$0 copay for Medicare-covered surgery in an ambulatory surgical center. \$0 copay for Medicare-covered arthroplasty hip and knee surgical services in an ambulatory surgical center. *Authorization rules may apply.*	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Outpatient hospital services (continued) overnight, you might still be considered an "outpatient." If you are not sure if you are 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!" This fact sheet is available on the Web at **www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.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.		
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$0 copay for each Medicare-covered outpatient individual or group therapy visit. $0 copay for Medicare-covered mental health care individual or group therapy visit provided **via telehealth**.	
Outpatient rehabilitation services 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).	$0 copay for each Medicare-covered physical therapy visit up to 30 visits, including evaluations. $0 copay for each Medicare-covered occupational therapy visit up to 30 visits, including evaluations. $0 copay for each Medicare-covered speech therapy visit up to 30 visits, including evaluations.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Outpatient substance abuse services Coverage is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.	$0 copay for each Medicare-covered outpatient individual or group therapy visit. $0 copay for Medicare-covered outpatient substance abuse individual or group therapy visit provided **via telehealth**.	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **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."	$0 copay for Medicare-covered outpatient hospital surgical services. $0 copay for each Medicare-covered ambulatory surgical center visit. $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center. *Authorization rules may apply.*	
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$0 copay.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Physician/Practitioner services, including doctor's office visits Covered services include: • 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: urgently needed services, primary care, physician specialist services, individual sessions for mental health specialty services. ◦ 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. ◦ You can also use Vermont Blue Advantage Online Visits to access telehealth services provided by Amwell for urgent care, mental health, and psychiatric services by visiting **www.VermontBlueAdvantage.com/telehealth** or calling **1-855-635-1393**. TTY users call **711**. • Some telehealth services including consultation, diagnosis, and treatment	\$10 copay for each Medicare-covered primary care provider visit. \$10 copay for each Medicare-covered specialist visit. Unless listed below, your cost share for a **telehealth visit** is the same as an in office visit of the same type. \$0 copay for primary care physician and mental health visits **via telehealth**. \$0 copay for Vermont Blue Advantage Online Visits provided by Amwell, including urgent care, mental health, and psychiatric services. *Authorization rules may apply to surgical services furnished in a physician's office.*	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Physician/Practitioner services, including doctor's office visits (continued) by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare. • 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 • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ 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**		

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Physician/Practitioner services, including doctor's office visits (continued) ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment. • Consultation your doctor has with other physicians via telephone, 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)		
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs **Note:** For services other than office visits, refer to the following sections of this benefit chart for member cost-sharing: • Physician/Practitioner services, including doctor's office visits • Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	$10 copay for each Medicare-covered service.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test or digital rectal exam. If you have a medical condition, or a follow-up test/exam, the procedure is considered diagnostic and your contractual cost sharing for Medicare-covered services will apply.	
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	20% coinsurance of the approved amount, after deductible, for Medicare-covered devices and supplies. **Note:** You must have a prescription or a Certificate of Medical Necessity from your provider to obtain Durable Medical Equipment (DME) or Prosthetic and Orthotic (P&O) items and services. *Authorization rules may apply.*	
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$0 copay for each Medicare-covered service.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Screening for lung cancer with low dose computed tomography (LDCT) (continued) *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.		
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the *Evidence of Coverage*) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	$0 copay for Medicare-covered renal dialysis services, home health care visits, equipment and supplies. $0 copay for kidney disease education services.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called "SNFs.") Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to	\$0 copay per day for days 1-99. \$0 copay per day beyond 100 days. *Authorization rules may apply.*	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Skilled nursing facility (SNF) care (continued) pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital		
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD).	$0 copay for each Medicare-covered service.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Supervised Exercise Therapy (SET) (continued) Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.		
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the	$10 copay in the U.S. and its territories. $0 copay for Vermont Blue Advantage Online Visits provided by Amwell. $0 copay worldwide. Urgent care, emergency care, and emergency transportation are subject to a combined $50,000 lifetime maximum benefit outside of the U.S. and its territories.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Urgently needed services (continued) same as for such services furnished in-network. You can use Amwell Online Visits to access telehealth services by visiting **www.VermontBlueAdvantage.com/telehealth** or by calling **1-855-635-1393**. TTY users call **711**. You are covered for urgently needed services worldwide.*		
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 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.)	**Exam to diagnose and treat diseases and conditions of the eye.** $10 copay for primary care physician eye exam. $0 copay for glaucoma screening. $0 copay for diabetic retinopathy exam. **Eyeglasses or contacts after cataract surgery** $10 copay for Medicare-covered services. **Enhanced Vision Benefits*** $10 copay for up to 1 supplemental routine eye exam every 12 months.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Vision care (continued) **Enhanced vision benefits* above Original Medicare:** You are also eligible for 1 routine eye exam per year.		
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.	
Additional Benefits		
Contraceptives We cover: • Oral contraceptives • Spermicidal jellies or foams • Diaphragms • Intrauterine devices • Progesterone-containing subcutaneous implants (Norplant®) • Cervical caps	$0 copay for contraceptive devices.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Gradient compression stockings We cover gradient compression stockings that squeeze the leg to reduce and prevent swelling as well as improve blood flow.	$10 copay, after deductible, for gradient compression stockings.	
Private duty nursing We provide nursing to individuals who need skilled care and require individualized care that's more intense than what is available under other benefits when ordered by a physician who is involved with your ongoing care. Private duty nursing does **not** cover services provided by, or within the scope of practice of, medical assistants, nurse's aides, home health aides, or other non-nurse level caregivers.	$10 copay, after deductible, for private duty nursing with an annual coverage limit of 14 hours.	
Weight loss surgery Original Medicare covers weight loss surgery under strict criteria. Our requirements are less strict. We cover it when the following criteria are met: • BMI (body mass index) of: ◦ 40 or greater ◦ 35 with at least one co-morbidity directly related to your obesity, i.e., sleep apnea, high blood pressure, diabetes, etc. ◦ 30 to 34.9 if you are of Asian origin with co-morbidity of diabetes or metabolic syndrome • Participation in a medically supervised weight loss program within 12 months preceding surgery	$10 copay, after deductible, for weight loss surgery. *Authorization rules may apply*.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
Weight loss surgery (continued) • Physician evaluation to assess other obesity causes and candidacy for surgery • Preoperative evaluation by licensed mental health provider to assess ability to understand, tolerate, and comply with all phases of care while adhering to long-term commitment to follow-up requirements Types of medically necessary surgery considered are: • Open and laparoscopic gastric bypass using a Roux-en-Y anastomosis • Open or laparoscopic biliopancreatic bypass with duodenal switch • Laparoscopic adjustable gastric banding • Sleeve gastrectomy		
Wigs, wig stand, adhesive Wigs must be prescribed by a physician and medically necessary. A wig (cranial/scalp prosthesis) is considered medically necessary, when generalized hair loss is present due to one or more of the following conditions: • Chemotherapy for the treatment of cancer • Radiation therapy for the treatment of cancer • Scalp injury • Third degree burn • Alopecia totalis • Alopecia areata • Congenital baldness present since birth	\$10 copay, after deductible, for wigs, wig stands, and adhesive. *Authorization rules may apply.*	

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and, therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in the *Evidence of Coverage*.)

All exclusions or limitations on services are described in the *Medical Benefits Chart* or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		✓ Covered for chronic low back pain
Cosmetic surgery or procedures		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.		
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 in the *Evidence of Coverage* for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		✓ Covered only when medically necessary.
Radial keratotomy, LASIK surgery, and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		✓ Covered only as described in the benefit chart. Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.	✓	
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.

Chapter 6. What you pay for your Part D prescription drugs

Note: Please read Chapter 6 *What you pay for your Part D prescription drugs* in its entirety in the *Evidence of Coverage* booklet. The contents below are only selected sections from that chapter.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for Vermont Blue Advantage Group PPO members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under Vermont Blue Advantage Group PPO. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
You begin in this payment stage when you fill your first prescription of the year. During this stage, **you pay the full cost** of your drugs. You stay in this stage until you have paid $100 for your retail drugs ($100 is the amount of your retail pharmacy deductible). The deductible does not apply to prescriptions filled via mail order. (Details are in Section 4 below.)	During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**, until you reach the plan's prescription drug out-of-pocket maximum of $750. Once you have paid $750 out-of-pocket for covered prescription drugs, the plan will cover prescription drugs at no cost to you for the rest of the calendar year (through December 31, 2022). You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $7,050. (Details are in Chapter 6, Section 5 below and in your *Evidence of Coverage*.)	Because there is no coverage gap for the plan, this payment stage does not apply to you.	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2022). You have a prescription drug out-of-pocket maximum of $750, so the Catastrophic Coverage Stage copays described in Section 7 may not apply. (Details are in Section 7 below.)

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs

Section 4.1 You stay in the Deductible Stage until you have paid your deductible amount

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is $100 for 2022. Part D deductible does not apply to mail order medications.

- Your "**full cost**" is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The "**deductible**" (if applicable) is the amount you must pay for your Part D retail prescription drugs before the plan begins to pay its share. Deductible does not apply to mail-order Part D prescription drugs.

Once you have paid $100 for your retail drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has three cost sharing tiers

Every drug on the plan's Drug List is in one of three cost sharing tiers. In general, the higher the cost sharing tier number, the higher your cost for the drug:

- **Tier 1** – **Generic:** These are generic drugs in the lowest cost-sharing tier.
- **Tier 2** – **Preferred Brand:** This tier contains brand-name drugs.
- **Tier 3** – **Non-Preferred Brand:** These are brand-name drugs not in a preferred tier. This is the highest cost-sharing tier.

To find out which cost sharing tier your drug is in, look it up in the plan's Drug List. Your group covers additional drugs not on the Drug List. For more information, call Customer Service.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in the *Evidence of Coverage* and the plan's *Provider/Pharmacy Directory*.

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.

- "**Copayment**" means that you pay a fixed amount each time you fill a prescription.
- "**Coinsurance**" means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower.*
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5, in the *Evidence of Coverage* for information about when we will cover a prescription filled at an out-of-network pharmacy.

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

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)
Cost Sharing Tier 1 (Generic)	$5	$5
Cost Sharing Tier 2 (Preferred Brand)	$20	$20
Cost Sharing Tier 3 (Non-Preferred Brand)	$40	$40

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some non-specialty drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a non-specialty drug, see Chapter 5, Section 2.4 in the *Evidence of Coverage*.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a non-specialty drug.

Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower.*

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

Tier	Standard retail cost sharing (90-day supply)	Mail-order cost sharing (90-day supply)
Cost Sharing Tier 1 (Generic)	$15	$10
Cost Sharing Tier 2 (Preferred Brand)	$60	$40
Cost Sharing Tier 3 (Non-Preferred Brand)	$120	$80

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $7,050

You stay in the Initial Coverage Stage until your out-of-pocket costs reach $7,050. Medicare has rules about what counts and what does not count as your out-of-pocket costs. (See Section 5.6 of the *Evidence of Coverage* for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $7,050, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

The *Part D Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $7,050 limit in a year.

We will let you know if you reach this $7,050 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

SECTION 6 There is no Coverage Gap for Vermont Blue Advantage Group PPO

Section 6.1 You do not have a Coverage Gap for your Part D drugs

There is no coverage gap for Vermont Blue Advantage Group PPO. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,050 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be a copayment of $3.95 for a generic drug or a drug that is treated like a generic, and $9.85 for all other drugs.
- **Our plan pays the rest** of the cost.