

## SCHEDULE OF COPAYMENTS AND LIMITATIONS PERSONAL CHOICE 65

GENERAL INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Annual Out-of-Network Deductible	N/A	\$250
Maximum Annual Out-of-Network Coinsurance	N/A	\$2,000
Overall Out-of-Network Lifetime Maximum	N/A	\$1,000,000
INPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Care <sup>2</sup> (includes Substance Abuse and Rehabilitation Services) <sup>4</sup>	Covered in full – You are covered for unlimited days each benefit period.	Covered 80% after deductible is met, 70 day limit
Inpatient Mental Health Care <sup>2</sup> (Includes mental health care services that require a hospital stay.) 1190 day Lifetime Benefit Maximum in a Medicare approved Mental Health Facility	Covered in full – <sup>+</sup> You are covered for unlimited days each benefit period.	Covered 80% after deductible is met, 70 day limit  20 day limit per calendar year in an inpatient psychiatric facility <sup>3</sup>
Skilled Nursing Facility Care <sup>2</sup> (No prior hospital stay is required)	Covered in full – You are covered for 100 days each benefit period.	Covered 80% after deductible is met.
Inpatient Services (when the hospital or SNF days are not covered or are no longer covered) <sup>2</sup>	You pay 100%.	You pay 100%.
OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
Home Health Care <sup>2</sup>	There is no copayment for Medicare covered home health visits.	Covered 80% after deductible is met.
Hospice Care	You must receive care from a Medicare certified Hospice	You must receive care from a Medicare certified Hospice
Physician Services, including Doctor's Office Visits	You pay \$15 for each primary care doctor office visit for Medicare-covered services. You pay \$25 for each specialist visit for Medicare-covered services.	Covered 80% after deductible is met.
Chiropractic Office Visit	You pay \$25 for each Medicare-covered visit. (manual manipulation of the spine to correct subluxation)	Covered 80% after deductible is met.
Podiatry Services	You pay \$25 for each Medicare covered visit (medically necessary foot care)	Covered 80% after deductible is met.
Outpatient Mental Health Care <sup>2</sup> (includes partial hospitalization services)	For Medicare-covered Mental Health services, you pay \$25 for each individual/group therapy visit.	Covered 50% after deductible is met, 20 visits per calendar year

OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
Outpatient Substance Abuse Services <sup>2</sup>	For Medicare-covered services, you pay \$25 for each individual/group therapy visit.	Covered 80% after deductible is met. 30 visits per calendar year and a Lifetime maximum of 120 out-of-network visits
Outpatient Surgery <sup>2</sup>	You pay \$0 for each Medicare covered visit to an ambulatory surgical center. You pay \$0 for each Medicare covered visit to an outpatient hospital facility.	Covered 80% after deductible is met.
Ambulance Services	You pay \$0 for Medicare covered ambulance services	Covered 80% after deductible is met.
*Emergency Care	You pay \$40 for each Medicare covered emergency room visit.	Services performed within the United States will be covered at the Plan (in-network) benefit level.
*Urgently Needed Care	You pay \$15-\$40 for each Medicare covered urgently needed care visit.	Services performed within the United States will be covered at the Plan (in-network) benefit level.
Outpatient Rehabilitation Services <sup>2</sup> (Physical Therapy, Occupational Therapy, Cardiac Rehabilitation, and Speech and Language Therapy)	You pay \$25 for each Medicare covered Occupational Therapy visit. You pay \$25 for each Medicare-covered Physical Therapy and/or Speech and Language Therapy visit.	Covered 80% after deductible is met.  Cardiac Rehabilitation is limited to 18 visits per calendar year.
Durable Medical Equipment and Related Supplies <sup>2</sup>	Covered in full	Covered 80% after deductible is met.
Prosthetic Devices and Related Supplies <sup>2</sup>	Covered in full	Covered 80% after deductible is met.
Diabetes Self-Monitoring Training and Supplies	There is no copayment for Diabetes Self-Monitoring Training. There is no copayment for Diabetes Supplies.	Covered 80% after deductible is met.
Medical Nutrition Therapy (For people with diabetes or renal (kidney) disease (but not on dialysis), and after a transplant when referred by a doctor.	There is no copayment for Medical Nutrition Therapy.	Covered 80% after deductible is met.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	There is no copayment for the following Medicare covered services: clinical/diagnostic lab services or radiation therapy. You pay \$0 for each Medicare covered X-ray visit.	Covered 80% after deductible is met.
Certain Covered Injectables	Covered in full	Covered 80% after deductible is met.
Chemotherapy	You are covered in full for chemotherapy.	Covered 80% after deductible is met.
Allergy Testing and Immunology	You are covered in full for allergy testing. You pay \$25 for each allergy immunotherapy treatment.	Covered 80% after deductible is met.

# Medical



PREVENTIVE CARE AND SCREENING TESTS	IN-NETWORK	OUT-OF-NETWORK
Bone Mass Measurements	There is no copayment for each Medicare covered Bone Mass Measurement.	Covered 80% after deductible is met.
Colorectal Screening (Office Visit copay may apply)	There is no copayment for each Medicare covered Colorectal Screening Exams.	Covered 80% after deductible is met.
Immunizations (Pneumonia vaccine, Flu shots, Hepatitis B vaccine)	There is no copayment for the Pneumonia and Flu vaccines. There is no copayment for the Hepatitis B vaccine.	Covered 80% after deductible is met.  (The out-of-network deductible does not apply to pneumococcal and influenza immunizations.)
Mammography Screening	There is no copayment for Medicare covered Screening Mammograms.	Covered 80% after deductible is met.
Pap Smears, Pelvic Exams, and Clinical Breast Exam	You pay \$0 for each Medicare covered Pap Smear. You pay \$0 for each additional Pap Smear up to 1 Pap Smear(s) every calendar year. You pay \$25 for each Medicare covered Pelvic Exam. You pay \$25 for each additional Pelvic Exam up to 1 Pelvic Exam(s) every calendar year.	Covered 80% after deductible is met.
Prostate Cancer Screening Exams (Office Visit copay may apply)	There is no copayment for Medicare covered Prostate Cancer Screening exams.	Covered 80% after deductible is met.
Cardiovascular Disease Testing	There is no copayment for Medicare covered Cardiovascular screening blood tests.	Covered 80% after deductible is met.
Physical Exams (Office Visit copay may apply)	There is no copayment for routine physical exams. You are covered up to 1 exam every calendar year.	Covered 80% after deductible is met.

OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Renal Dialysis (kidney)	There is no copayment for renal dialysis.	Covered 80% after deductible is met.
Hearing Services	You pay \$25 for each Medicare covered hearing exam (diagnostic hearing exams.)	Covered 80% after deductible is met.
Vision Care	You pay \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye.)	Covered 80% after deductible is met.

\*This Copayment will be waived if the Member is admitted to the Hospital. Urgent and Emergency care are covered Worldwide.

<sup>1</sup>190-day Lifetime Maximum includes Mental Health and Substance Abuse Treatment received in a Medicare Approved Mental Health Facility.

<sup>2</sup>Prior Authorization (approval in advance) required.

<sup>3</sup>The Maximum of 20 Out-of-Network inpatient days in a psychiatric facility per calendar year is part of, not separate from the 70-day maximum for out-of-network inpatient hospital days.

<sup>4</sup>A 90-day lifetime maximum applies to inpatient substance abuse treatment received in a Substance Abuse Treatment Facility. This benefit is separate from any inpatient substance abuse hospital care.

+For a Medicare-covered stay in a network hospital