

Summary of Benefits



PUGET SOUND
HEALTH PARTNERS

Sound+Rx (HMO)
Charter+Rx (HMO)
Apex+Rx (HMO)
Apex+Rx King County (HMO)
Summit+Rx (HMO-POS)



Section I - Introduction 2011 Summary of Benefits

Sound+Rx (HMO), Charter+Rx (HMO), Apex+Rx (HMO) & Summit+Rx (HMO-POS)
January 1, 2011 - December 31, 2011
Counties: King, Lewis, Pierce, Snohomish, Thurston

Thank you for your interest in Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS). Our plans are offered by Puget Sound Health Partners INC., a Medicare Advantage Health Maintenance Organization (HMO), with a Point-of-Service (POS) for our Summit Plus Rx Plan. This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) and ask for the "Evidence of Coverage".

You have choice in your health care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) at the telephone number listed at the end of this introduction or **1-800-MEDICARE** (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How can I compare my options?

You can compare Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where is Sound+Rx (HMO), Charter+Rx (HMO), Apex+Rx (HMO) and Summit+Rx (HMO-POS) available?

The service area for these plans include: King, Lewis, Pierce, Snohomish, and Thurston Counties, WA. You must live in one of these areas to join one of our plans.

Who is eligible to join Sound+Rx (HMO), Charter+Rx (HMO), Apex+Rx (HMO) and Summit+Rx (HMO-POS)?

You can join Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Sound Plus Rx (HMO),

Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) unless they are members of our organization and have been since their dialysis began.

Can I choose my Doctors?

Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) have formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at www.OurPSHP.com. Our customer service number is listed at the end of this introduction.

What happens if I go to a Doctor who's not in your network?

If you choose to go to a doctor outside of our network, you must pay for these services yourself except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

Where can I get my prescriptions if I join this plan?

Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.OurPSHP.com. Our customer service number is listed at the end of this introduction.

Does my plan cover Medicare Part B or Part D Drugs?

Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) covers both Medicare Part B prescription

drugs and Medicare Part D prescription drugs.

What is a Prescription Drug Formulary?

Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.OurPSHP.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How can I get extra help with my prescription drug plan cost or get extra help with other Medicare costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs.

To see if you qualify for getting extra help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY/ TDD users should call 1-877-486-2048, 24 hours a day 7 days a week; and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.

- The Social Security Administration at **1-800-772-1213** between 7 am and 7 pm, Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

What are my protections in this plan?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plan decides whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What is a Medication Therapy Management (MTM) program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) for more details.

What types of drugs may be covered under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Sound Plus Rx (HMO), Charter Plus Rx (HMO), Apex Plus Rx (HMO) and Summit Plus Rx (HMO-POS) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

Where can I find information on plan ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools

on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for these plans. Our customer service number is listed below.

This document may be available in a different format or language. For additional information, call customer service at the phone number listed below.

Please call Puget Sound Health Partners for more information about: Sound+Rx (HMO), Charter+Rx (HMO), Apex+Rx (HMO) & Summit+Rx (HMO-POS).

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

Member Service Hours:
8am – 8pm, 7 days a week

You may receive a messaging service on weekends and holidays from March 2 through November 14. Please leave a message and your call will be returned the next business day.

Current & Prospective Members

Call toll-free **1-866-789-7747** for questions related to the Medicare Advantage Program and questions related to Medicare Part D Prescription. (TTY/TDD 1-866-264-4141).

Call locally **253-779-8830** for questions related to the Medicare Advantage Program and questions related to Medicare Part D Prescription. (TTY/TDD 253-284-3900).

For more information about Medicare Please call Medicare at **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

Section II - 2011 Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
IMPORTANT INFORMATION		
<p>1. Premium & Other Important Information</p>	<p>In 2010 the monthly Part B Premium was \$96.40 and may change for 2011 and the yearly Part B deductible amount was \$155 and may change for 2011.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. (Over \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Medicare @ 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>This plan covers all Medicare-covered preventive services with zero cost sharing.</p> <p>In-Network \$3,400 out-of-pocket limit.</p> <p>All plan services included.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. (Over \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Medicare @ 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>

IMPORTANT INFORMATION

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

General

\$79 monthly plan premium in addition to your monthly Medicare Part B premium.

This plan covers all Medicare-covered preventive services with zero cost sharing.

In-Network

\$2,250 out-of-pocket limit.

All plan services included.

Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. (Over \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Medicare @ 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

General

\$152 monthly plan premium in addition to your monthly Medicare Part B premium.

\$162 monthly plan premium in addition to your monthly Medicare Part B premium for King County.

This plan covers all Medicare-covered preventive services with zero cost sharing.

In-Network

\$1,200 out-of-pocket limit.

All plan services included.

Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. (Over \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Medicare @ 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

General

\$190 monthly plan premium in addition to your monthly Medicare Part B premium.

This plan covers all Medicare-covered preventive services with zero cost sharing.

In-Network

\$1,200 out-of-pocket limit.

All plan services included.

Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. (Over \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Medicare @ 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>2. Doctor & Hospital Choice</p> <p>(For more information, see Emergency – #15 & Urgently Needed Care – #16)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network specialists (for certain benefits).</p>
<p>INPATIENT CARE</p>		
<p>3. Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2010 the amounts for each benefit period were: Days 1 - 60: \$1100 deductible Days 61 - 90: \$275 per day Days 91 - 150: \$550 per lifetime reserve day</p> <p>These amounts will change for 2011.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period.</p> <p>There is no limit to the number of benefit periods you can have.</p>	<p>In-Network No limit to the number of days covered by the plan each benefit period.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 8: \$275 copay per day Days 9 - 90: \$0 copay per day \$0 copay for additional hospital days.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

CHARTER+RX (HMO)	APEX+RX (HMO)	SUMMIT+RX (HMO-POS)
<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network specialists (for certain benefits).</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network specialists (for certain benefits).</p>	<p>In-Network Referral required for network specialists (for certain benefits).</p>
<p>In-Network No limit to the number of days covered by the plan each benefit period.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$200 copay per day Days 6 - 90: \$0 copay per day \$0 copay for additional hospital days.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network No limit to the number of days covered by the plan each benefit period.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$125 copay per day Days 6 - 90: \$0 copay per day \$0 copay for additional hospital days.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network No limit to the number of days covered by the plan each benefit period.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$125 copay per day Days 6 - 90: \$0 copay per day \$0 copay for additional hospital days.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>4. Inpatient Mental Health Care</p>	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p>In-Network You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>For Medicare-covered hospital stays</p> <p>Days 1 - 7: \$300 copay per day Days 8 - 90: \$0 copay per day</p> <p>Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:</p> <p>Days 1 - 7 : \$300 copay per day Days 8 - 60: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

In-Network

You get up to 190 days in a Psychiatric Hospital in a lifetime.

For Medicare-covered hospital stays

Days 1 - 5: \$200 copay per day

Days 6 - 90: \$0 copay per day

Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:

Days 1 - 5: \$200 copay per day

Days 6 - 60: \$0 copay per day

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

In-Network

You get up to 190 days in a Psychiatric Hospital in a lifetime.

For Medicare-covered hospital stays

Days 1 - 5: \$125 copay per day

Days 6 - 90: \$0 copay per day

Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:

Days 1 - 5: \$125 copay per day

Days 6 - 60: \$0 copay per day

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

In-Network

You get up to 190 days in a Psychiatric Hospital in a lifetime.

For Medicare-covered hospital stays

Days 1-5: \$125 copay per day

Days 6 -90: \$0 copay per day

Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:

Days 1 - 5: \$125 copay per day

Days 6 - 60: \$0 copay per day

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>5. Skilled Nursing Facility (SNF)</p> <p>(in a Medicare-certified skilled nursing facility)</p>	<p>In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p>Days 1 - 20: \$0 per day Days 21 - 100: \$137.50 per day</p> <p>These amounts will change for 2011.</p> <p>100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care.</p> <p>If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1 - 30: \$100 copay per day Days 31 - 100: \$0 copay per day</p>
<p>6. Home Health Care</p> <p>(includes medically necessary intermittent skilled nursing care, home health aide services, & rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>
<p>7. Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>

CHARTER+RX (HMO)	APEX+RX (HMO)	SUMMIT+RX (HMO-POS)
<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1 - 10: \$0 copay per day Days 11 - 33: \$100 copay per day Days 34 - 100: \$0 copay per day</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1 - 10: \$0 copay per day Days 11 - 22: \$100 copay per day Days 23 - 100: \$0 copay per day</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1 - 10: \$0 copay per day Days 11 - 22: \$100 copay per day Days 23 - 100: \$0 copay per day</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>
<p>General You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
OUTPATIENT CARE		
<p>8. Doctor Office Visits</p>	<p>20% coinsurance.</p>	<p>In-Network \$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$40 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$40 copay for each specialist visit for Medicare-covered benefits.</p>
<p>9. Chiropractic Services</p>	<p>Routine care not covered.</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>
<p>10. Podiatry Services</p>	<p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network \$15 to \$40 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>

**CHARTER+RX
(HMO)**

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**SUMMIT+RX
(HMO-POS)**

<p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$30 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$30 copay for each specialist visit for Medicare-covered benefits.</p>	<p>In-Network \$5 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$15 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$15 copay for each specialist visit for Medicare-covered benefits.</p>	<p>In-Network \$5 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$15 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$15 copay for each specialist visit for Medicare-covered benefits.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>
<p>In-Network \$10 to \$30 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>	<p>In-Network \$5 to \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>	<p>In-Network \$5 to \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>11. Outpatient Mental Health Care</p>	<p>45% coinsurance for most outpatient mental health services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$40 copay for each Medicare-covered individual or group therapy visit.</p>
<p>12. Outpatient Substance Abuse Care</p>	<p>20% coinsurance.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$40 copay for Medicare-covered individual or group visits.</p>
<p>13. Outpatient Services/ Surgery</p>	<p>20% coinsurance for the doctor.</p> <p>Specified copayment for outpatient hospital facility charges. Copay cannot exceed Part A inpatient hospital deductible.</p> <p>20% coinsurance for ambulatory surgical center facility charges.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$300 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$40 to \$300 copay for each Medicare-covered outpatient hospital facility visit.</p>
<p>14. Ambulance Services (medically necessary ambulance services)</p>	<p>20% coinsurance.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$200 copay for Medicare-covered ambulance benefits.</p> <p>If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.</p>

CHARTER+RX (HMO)	APEX+RX (HMO)	SUMMIT+RX (HMO-POS)
<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for each Medicare-covered individual or group therapy visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered individual or group therapy visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered individual or group therapy visit.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual or group visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for Medicare-covered individual or group visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for Medicare-covered individual or group visits.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$30 to \$150 copay for each Medicare-covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$50 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$15 to \$50 copay for each Medicare-covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$50 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$15 to \$50 copay for each Medicare-covered outpatient hospital facility visit.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for Medicare-covered ambulance benefits.</p> <p>If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay for Medicare-covered ambulance benefits.</p> <p>If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay for Medicare-covered ambulance benefits.</p> <p>If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>15. Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor.</p> <p>Specified copayment for outpatient hospital emergency room (ER) facility charge.</p> <p>ER copay cannot exceed Part A inpatient deductible.</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>\$50 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p>
<p>16. Urgently Needed Care</p> <p>(This is NOT emergency care, & in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>\$40 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the urgently-needed care visit.</p>

CHARTER+RX (HMO)	APEX+RX (HMO)	SUMMIT+RX (HMO-POS)
<p>General \$50 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p>	<p>General \$50 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p>	<p>General \$50 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p>
<p>General \$30 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the urgently-needed care visit.</p>	<p>General \$15 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the urgently-needed care visit.</p>	<p>General \$15 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the urgently-needed care visit.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>17. Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech & Language Therapy, Respiratory Therapy Services, Social/Psychological Service, and more)</p>	<p>20% coinsurance.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$40 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 to \$40 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> <p>\$0 to \$40 copay for Medicare-covered Cardiac Rehab services.</p>
<p>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</p>		
<p>18. Durable Medical Equipment</p> <p>(includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 25% of the cost for Medicare-covered items.</p>

CHARTER+RX (HMO)	APEX+RX (HMO)	SUMMIT+RX (HMO-POS)
<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$30 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 to \$30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> <p>\$0 to \$30 copay for Medicare-covered Cardiac Rehab services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$15 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 to \$15 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> <p>\$0 to \$15 copay for Medicare-covered Cardiac Rehab services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$15 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 to \$15 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> <p>\$0 to \$15 copay for Medicare-covered Cardiac Rehab services.</p>
<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>19. Prosthetic Devices</p> <p>(includes braces, artificial limbs & eyes, etc.)</p>	<p>20% coinsurance.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 25% of the cost for Medicare-covered items.</p>
<p>20. Diabetes Self-Monitoring Training, Nutrition Therapy, & Supplies</p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/ glaucoma test, and foot exam/therapeutic soft shoes)</p>	<p>20% coinsurance.</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply.</p>

CHARTER+RX (HMO)	APEX+RX (HMO)	SUMMIT+RX (HMO-POS)
<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>
<p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply.</p>	<p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Separate Office Visit cost sharing of \$0 to \$15 may apply.</p>	<p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Separate Office Visit cost sharing of \$0 to \$15 may apply.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>21. Diagnostic Tests, X-Rays, Lab Services, & Radiology Services</p>	<p>20% coinsurance for diagnostic tests and x-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered lab services.</p> <p>\$0 copay for Medicare-covered diagnostic procedures and tests.</p> <p>\$0 copay for Medicare-covered X-rays.</p> <p>\$0 to \$250 copay for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>\$40 copay for Medicare-covered therapeutic radiology services.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply for Outpatient Diagnostic Procedures, Tests and Lab Services.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply for Outpatient Diagnostic and Therapeutic Radiological Services.</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered lab services.

\$0 copay for Medicare-covered diagnostic procedures and tests.

\$0 copay for Medicare-covered X-rays.

\$0 to \$130 copay for Medicare-covered diagnostic radiology services (not including x-rays).

\$30 copay for Medicare-covered therapeutic radiology services.

Separate Office Visit cost sharing of \$0 to \$30 may apply for Outpatient Diagnostic Procedures, Tests and Lab Services.

Separate Office Visit cost sharing of \$0 to \$30 may apply for Outpatient Diagnostic and Therapeutic Radiological Services.

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered lab services.

\$0 copay for Medicare-covered diagnostic procedures and tests.

\$0 copay for Medicare-covered X-rays.

\$0 to \$130 copay for Medicare-covered diagnostic radiology services (not including x-rays).

\$15 copay for Medicare-covered therapeutic radiology services.

Separate Office Visit cost sharing of \$0 to \$15 may apply for Outpatient Diagnostic Procedures, Tests and Lab Services.

Separate Office Visit cost sharing of \$0 to \$15 may apply for Outpatient Diagnostic and Therapeutic Radiological Services.

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered lab services.

\$0 copay for Medicare-covered diagnostic procedures and tests.

\$0 copay for Medicare-covered X-rays.

\$0 to \$130 copay for Medicare-covered diagnostic radiology services (not including x-rays).

\$15 copay for Medicare-covered therapeutic radiology services.

Separate Office Visit cost sharing of \$0 to \$15 may apply for Outpatient Diagnostic Procedures, Tests and Lab Services.

Separate Office Visit cost sharing of \$0 to \$15 may apply for Outpatient Diagnostic and Therapeutic Radiological Services.

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
PREVENTIVE SERVICES		
<p>22. Bone Mass Measurement</p> <p>(for people with Medicare who are at risk)</p>	<p>No coinsurance, copayment or deductible.</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>In-Network \$0 copay for Medicare-covered bone mass measurement.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply.</p>
<p>23. Colorectal Screening Exams</p> <p>(for people with Medicare age 50 & older)</p>	<p>No coinsurance, copayment or deductible for screening colonoscopy or screening flexible sigmoidoscopy.</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply.</p>
<p>24. Immunizations</p> <p>(Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 copay for Flu, Pneumonia and Hepatitis B vaccines.</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and Pneumonia vaccines.</p>
<p>25. Mammograms (Annual Screening)</p> <p>(for women with Medicare age 40 & older)</p>	<p>No coinsurance, copayment or deductible.</p> <p>No referral needed.</p> <p>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p>In-Network \$0 copay for additional screening mammograms.</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

<p>In-Network \$0 copay for Medicare-covered bone mass measurement.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered bone mass measurement.</p> <p>Separate Office Visit cost sharing of \$0 to \$15 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered bone mass measurement.</p> <p>Separate Office Visit cost sharing of \$0 to \$15 may apply.</p>
<p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Separate Office Visit cost sharing of \$0 to \$15 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Separate Office Visit cost sharing of \$0 to \$15 may apply.</p>
<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and Pneumonia vaccines.</p>	<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and Pneumonia vaccines.</p>	<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and Pneumonia vaccines.</p>
<p>In-Network \$0 copay for additional screening mammograms.</p>	<p>In-Network \$0 copay for additional screening mammograms.</p>	<p>In-Network \$0 copay for additional screening mammograms.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>26. Pap Smears & Pelvic Exams</p> <p>(for women with Medicare)</p>	<p>No coinsurance, copayment or deductible for Pap smears.</p> <p>No coinsurance, copayment or deductible for Pelvic and clinical breast exams.</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>- up to 1 additional pap smear and pelvic exam every year.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply.</p>
<p>27. Prostate Cancer Screening Exams</p> <p>(for men with Medicare age 50 & older)</p>	<p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered prostate cancer screening.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply.</p>
<p>28. End-Stage Renal Disease (ESRD)</p>	<p>20% coinsurance for renal dialysis.</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease.</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>23% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

CHARTER+RX (HMO)	APEX+RX (HMO)	SUMMIT+RX (HMO-POS)
<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>- up to 1 additional pap smear and pelvic exam every year.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>- up to 1 additional pap smear and pelvic exam every year.</p> <p>Separate Office Visit cost sharing of \$0 to \$15 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>- up to 1 additional pap smear and pelvic exam every year.</p> <p>Separate Office Visit cost sharing of \$0 to \$15 may apply.</p>
<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p> <p>Separate Office Visit cost sharing of \$0 to \$15 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p> <p>Separate Office Visit cost sharing of \$0 to \$15 may apply.</p>
<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>29. Prescription Drugs</p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General 20% of the cost for Part B-covered chemotherapy drugs.</p> <p>20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.OurPSHP.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, <p>or</p> <ul style="list-style-type: none"> -have access to Indian/ Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

**Drugs covered under
Medicare Part B**

General

20% of the cost for Part B-covered chemotherapy drugs.

20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).

**Drugs Covered under
Medicare Part D**

General

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.OurPSHP.com on the web.

Different out-of-pocket costs may apply for people who -have limited incomes,

-live in long term care facilities,

or

-have access to Indian/Tribal/Urban (Indian Health Service).

The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy

**Drugs covered under
Medicare Part B**

General

20% of the cost for Part B-covered chemotherapy drugs.

20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).

**Drugs Covered under
Medicare Part D**

General

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.OurPSHP.com on the web.

Different out-of-pocket costs may apply for people who -have limited incomes,

-live in long term care facilities,

or

-have access to Indian/Tribal/Urban (Indian Health Service).

The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy

**Drugs covered under
Medicare Part B**

General

20% of the cost for Part B-covered chemotherapy drugs.

20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).

**Drugs Covered under
Medicare Part D**

General

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.OurPSHP.com on the web.

Different out-of-pocket costs may apply for people who -have limited incomes,

-live in long term care facilities,

or

-have access to Indian/Tribal/Urban (Indian Health Service).

The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>29. Prescription Drugs (cont.)</p>		<p>outside of the plan’s service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Sound Plus Rx (HMO) for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from Charter Plus Rx (HMO) for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from Apex Plus Rx (HMO) for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from Summit Plus Rx (HMO-POS) for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>29. Prescription Drugs (cont.)</p>		<p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Sound Plus Rx (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.</p> <p>The cost sharing for a partial fill of a new prescription will be prorated based on the cost sharing for a full fill of the same prescription.</p> <p>In-Network \$310 deductible on all drugs except Tier 1: Generic Drugs.</p> <p>Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,840:</p> <p>Retail Pharmacy Tier 1: Generic Drugs - \$7 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$17.50 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Tier 2: Brand Drugs - \$32 copay for a one-month (30-day) supply of drugs in this tier.</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

If you request a formulary exception for a drug and Charter Plus Rx (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.

The cost sharing for a partial fill of a new prescription will be prorated based on the cost sharing for a full fill of the same prescription.

In-Network

\$0 deductible.

Initial Coverage

You pay the following until total yearly drug costs reach \$2,840:

Retail Pharmacy

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of drugs in this tier.

- \$20 copay for a three-month (90-day) supply of drugs in this tier.

Tier 2: Brand Drugs
- \$32 copay for a one-month (30-day) supply of drugs in this tier.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

If you request a formulary exception for a drug and Apex Plus Rx (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.

The cost sharing for a partial fill of a new prescription will be prorated based on the cost sharing for a full fill of the same prescription.

In-Network

\$0 deductible.

Initial Coverage

You pay the following until total yearly drug costs reach \$2,840:

Retail Pharmacy

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of drugs in this tier.

- \$20 copay for a three-month (90-day) supply of drugs in this tier.

Tier 2: Brand Drugs
- \$32 copay for a one-month (30-day) supply of drugs in this tier.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

If you request a formulary exception for a drug and Summit Plus Rx (HMO-POS) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.

The cost sharing for a partial fill of a new prescription will be prorated based on the cost sharing for a full fill of the same prescription.

In-Network

\$0 deductible.

Initial Coverage

You pay the following until total yearly drug costs reach \$2,840:

Retail Pharmacy

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of drugs in this tier.

- \$20 copay for a three-month (90-day) supply of drugs in this tier.

Tier 2: Brand Drugs
- \$32 copay for a one-month (30-day) supply of drugs in this tier.

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>29. Prescription Drugs (cont.)</p>		<ul style="list-style-type: none"> - \$80 copay for a three-month (90-day) supply of drugs in this tier. Tier 3: Non-Preferred Brand Drugs <ul style="list-style-type: none"> - \$64 copay for a one-month (30-day) supply of drugs in this tier. - \$160 copay for a three-month (90-day) supply of drugs in this tier. Tier 4: Specialty Tier Drugs <ul style="list-style-type: none"> - 25% coinsurance for a one-month (30-day) supply of drugs in this tier. - 25% coinsurance for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy Tier 1: Generic Drugs <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier. Tier 2: Brand Drugs <ul style="list-style-type: none"> - \$32 copay for a one-month (31-day) supply of drugs in this tier. Tier 3: Non-Preferred Brand Drugs <ul style="list-style-type: none"> - \$64 copay for a one-month (31-day) supply of drugs in this tier.

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

- \$80 copay for a three-month (90-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs

- \$64 copay for a one-month (30-day) supply of drugs in this tier.

- \$160 copay for a three-month (90-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs

- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.

- 33% coinsurance for a three-month (90-day) supply of drugs in this tier.

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

**Long Term Care
Pharmacy**

Tier 1: Generic Drugs

- \$8 copay for a one-month (31-day) supply of drugs in this tier.

Tier 2: Brand Drugs

- \$32 copay for a one-month (31-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs

- \$64 copay for a one-month (31-day) supply of drugs in this tier.

- \$80 copay for a three-month (90-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs

- \$64 copay for a one-month (30-day) supply of drugs in this tier.

- \$160 copay for a three-month (90-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs

- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.

- 33% coinsurance for a three-month (90-day) supply of drugs in this tier.

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

**Long Term Care
Pharmacy**

Tier 1: Generic Drugs

- \$8 copay for a one-month (31-day) supply of drugs in this tier.

Tier 2: Brand Drugs

- \$32 copay for a one-month (31-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs

- \$64 copay for a one-month (31-day) supply of drugs in this tier.

- \$80 copay for a three-month (90-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs

- \$64 copay for a one-month (30-day) supply of drugs in this tier.

- \$160 copay for a three-month (90-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs

- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.

- 33% coinsurance for a three-month (90-day) supply of drugs in this tier.

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

**Long Term Care
Pharmacy**

Tier 1: Generic Drugs

- \$8 copay for a one-month (31-day) supply of drugs in this tier.

Tier 2: Brand Drugs

- \$32 copay for a one-month (31-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs

- \$64 copay for a one-month (31-day) supply of drugs in this tier.

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>29. Prescription Drugs (cont.)</p>		<p>Tier 4: Specialty Tier Drugs - 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Mail Order</p> <p>Tier 1: Generic Drugs - \$7 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$14 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Tier 2: Brand Drugs - \$32 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$64 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Tier 3: Non-Preferred Brand Drugs - \$64 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$128 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Tier 4: Specialty Tier Drugs - 25% coinsurance for a one-month (30-day) supply of drugs in this tier.</p> <p>- 25% coinsurance for a three-month (90-day) supply of drugs in this tier.</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

Tier 4: Specialty Tier Drugs
- 33% coinsurance for a one-month (31-day) supply of drugs in this tier

Mail Order

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of drugs in this tier.

- \$16 copay for a three-month (90-day) supply of drugs in this tier.

Tier 2: Brand Drugs
- \$32 copay for a one-month (30-day) supply of drugs in this tier.

- \$64 copay for a three-month (90-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs
- \$64 copay for a one-month (30-day) supply of drugs in this tier.

- \$128 copay for a three-month (90-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs
- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.

- 33% coinsurance for a three-month (90-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs
- 33% coinsurance for a one-month (31-day) supply of drugs in this tier

Mail Order

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of drugs in this tier.

- \$16 copay for a three-month (90-day) supply of drugs in this tier.

Tier 2: Brand Drugs
- \$32 copay for a one-month (30-day) supply of drugs in this tier.

- \$64 copay for a three-month (90-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs
- \$64 copay for a one-month (30-day) supply of drugs in this tier.

- \$128 copay for a three-month (90-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs
- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.

- 33% coinsurance for a three-month (90-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs
- 33% coinsurance for a one-month (31-day) supply of drugs in this tier

Mail Order

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of drugs in this tier.

- \$16 copay for a three-month (90-day) supply of drugs in this tier.

Tier 2: Brand Drugs
- \$32 copay for a one-month (30-day) supply of drugs in this tier.

- \$64 copay for a three-month (90-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs
- \$64 copay for a one-month (30-day) supply of drugs in this tier.

- \$128 copay for a three-month (90-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs
- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.

- 33% coinsurance for a three-month (90-day) supply of drugs in this tier.

BENEFIT CATEGORY**ORIGINAL MEDICARE****SOUND+RX
(HMO)****29. Prescription Drugs
(cont.)**

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Coverage Gap

After your total yearly drug costs reach \$2,840, you receive a discount on brand name drugs and pay 93% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,550.

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Coverage Gap

After your total yearly drug costs reach \$2,840, you receive a discount on brand name drugs and pay 93% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,550.

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Coverage Gap

You pay the following:

Retail Pharmacy

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of all drugs covered in this tier.

- \$20 copay for a three-month (90-day) supply of all drugs covered in this tier.

Long Term Care Pharmacy

Tier 1: Generic Drugs
- \$8 copay for a one-month (31-day) supply of all drugs covered in this tier.

Mail Order

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of all drugs covered in this tier.

- \$16 copay for a three-month (90-day) supply of all drugs covered in this tier.

Additional Coverage Gap

After your total yearly drug costs reach \$2,840, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 93% of the plan's

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Coverage Gap

You pay the following:

Retail Pharmacy

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of all drugs covered in this tier.

- \$20 copay for a three-month (90-day) supply of all drugs covered in this tier.

Long Term Care Pharmacy

Tier 1: Generic Drugs
- \$8 copay for a one-month (31-day) supply of all drugs covered in this tier.

Mail Order

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of all drugs covered in this tier.

- \$16 copay for a three-month (90-day) supply of all drugs covered in this tier.

Additional Coverage Gap

After your total yearly drug costs reach \$2,840, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 93% of the plan's

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>29. Prescription Drugs (cont.)</p>		<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or - 5% coinsurance. <p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy.</p> <p>In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Sound Plus Rx (HMO).</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs,
- or
- 5% coinsurance.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy.

In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Charter Plus Rx (HMO).

costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,550.

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs,
- or
- 5% coinsurance.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy.

In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Apex Plus Rx (HMO).

costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,550.

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs,
- or
- 5% coinsurance.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy.

In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Summit Plus Rx (HMO-POS).

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>29. Prescription Drugs (cont.)</p>		<p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,840:</p> <p>Tier 1: Generic Drugs - \$7 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Tier 2: Brand Drugs - \$32 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Tier 3: Non-Preferred Brand Drugs - \$64 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Tier 4: Specialty Tier Drugs - 25% coinsurance for a one-month (30-day) supply of drugs in this tier.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

Out-of-Network Initial Coverage

You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,840:

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of drugs in this tier.

Tier 2: Brand Drugs
- \$32 copay for a one-month (30-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs
- \$64 copay for a one-month (30-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs
- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Out-of-Network Initial Coverage

You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,840:

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of drugs in this tier.

Tier 2: Brand Drugs
- \$32 copay for a one-month (30-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs
- \$64 copay for a one-month (30-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs
- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Out-of-Network Initial Coverage

You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,840:

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of drugs in this tier.

Tier 2: Brand Drugs
- \$32 copay for a one-month (30-day) supply of drugs in this tier.

Tier 3: Non-Preferred Brand Drugs
- \$64 copay for a one-month (30-day) supply of drugs in this tier.

Tier 4: Specialty Tier Drugs
- 33% coinsurance for a one-month (30-day) supply of drugs in this tier.

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

BENEFIT CATEGORY**ORIGINAL MEDICARE****SOUND+RX
(HMO)****29. Prescription Drugs
(cont.)****Out-of-Network Coverage
Gap**

You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

Out-of-Network Coverage Gap

You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

Out-of-Network Coverage Gap

You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of all drugs covered in this tier

Additional Out-of-Network Coverage Gap

Tier 2: Brand Drugs
Tier 3: Non-Preferred Brand Drugs, and
Tier 4: Specialty Tier Drugs
- You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

- You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

Out-of-Network Coverage Gap

You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:

Tier 1: Generic Drugs
- \$8 copay for a one-month (30-day) supply of all drugs covered in this tier

Additional Out-of-Network Coverage Gap

Tier 2: Brand Drugs
Tier 3: Non-Preferred Brand Drugs, and
Tier 4: Specialty Tier Drugs
- You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

- You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>29. Prescription Drugs (cont.)</p>		<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> - 5% coinsurance. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

**Out-of-Network
Catastrophic Coverage**

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:

- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs,

or

- 5% coinsurance.

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

**Out-of-Network
Catastrophic Coverage**

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:

- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs,

or

- 5% coinsurance.

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

**Out-of-Network
Catastrophic Coverage**

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:

- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs,

or

- 5% coinsurance.

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>30. Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")</p> <p>\$40 copay for Medicare-covered dental benefits.</p>
<p>31. Hearing Services</p>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network</p> <ul style="list-style-type: none"> - \$0 to \$40 copay for Medicare-covered diagnostic hearing exams. - \$0 to \$40 copay for up to 1 routine hearing test every year. <p>Hearing aids not covered.</p>

CHARTER+RX (HMO)	APEX+RX (HMO)	SUMMIT+RX (HMO-POS)
<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")</p> <p>\$30 copay for Medicare-covered dental benefits.</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")</p> <p>\$15 copay for Medicare-covered dental benefits</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")</p> <p>\$15 copay for Medicare-covered dental benefits.</p>
<p>In-Network - \$0 to \$30 copay for Medicare-covered diagnostic hearing exams.</p> <p>- \$0 to \$30 copay for up to 1 routine hearing test every year.</p> <p>Hearing aids not covered.</p>	<p>In-Network - \$0 to \$15 copay for Medicare-covered diagnostic hearing exams.</p> <p>- \$0 to \$15 copay for up to 1 routine hearing test every year.</p> <p>Hearing aids not covered.</p>	<p>In-Network - \$0 to \$15 copay for Medicare-covered diagnostic hearing exams.</p> <p>- \$0 to \$15 copay for up to 1 routine hearing test every year.</p> <p>Hearing aids not covered.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>32. Vision Services</p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network</p> <ul style="list-style-type: none"> - \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$0 to \$40 copay for exams to diagnose and treat diseases and conditions of the eye. - \$0 copay for up to 1 routine eye exam every year. - \$15 copay for up to 1 pair of glasses every year. - \$15 copay for up to 1 pair of contacts every year. - \$15 copay for up to 1 pair of lenses every year. - \$15 copay for up to 1 frame every year. <p>\$120 plan coverage limit for eye wear every year.</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

In-Network

- \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.
- \$0 to \$30 copay for exams to diagnose and treat diseases and conditions of the eye.
- \$0 copay for up to 1 routine eye exam every year.
- \$15 copay for up to 1 pair of glasses every year.
- \$15 copay for up to 1 pair of contacts every year.
- \$15 copay for up to 1 pair of lenses every year.
- \$15 copay for up to 1 frame every year.
- \$120 plan coverage limit for eye wear every year.

In-Network

- \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.
- \$0 to \$15 copay for exams to diagnose and treat diseases and conditions of the eye.
- \$0 copay for up to 1 routine eye exam every year.
- \$15 copay for up to 1 pair of glasses every year.
- \$15 copay for up to 1 pair of contacts every year.
- \$15 copay for up to 1 pair of lenses every year.
- \$15 copay for up to 1 frame every year.
- \$120 plan coverage limit for eye wear every year.

In-Network

- \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.
- \$0 to \$15 copay for exams to diagnose and treat diseases and conditions of the eye.
- \$0 copay for up to 1 routine eye exam every year.
- \$15 copay for up to 1 pair of glasses every year.
- \$15 copay for up to 1 pair of contacts every year.
- \$15 copay for up to 1 pair of lenses every year.
- \$15 copay for up to 1 frame every year.
- \$120 plan coverage limit for eye wear every year.

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>33. Welcome to Medicare; and Annual Wellness Visit</p>	<p>When you join Medicare Part B, then you are eligible as follows:</p> <p>During the first 12 months of your new Medicare Part B coverage, you can get either a Welcome to Medicare exam or an Annual Wellness visit.</p> <p>After your first 12 months, you can get one Annual Wellness visit every 12 months.</p> <p>There is no coinsurance, copayment or deductible for either the Welcome to Medicare exam or the Annual Wellness visit.</p> <p>The Welcome to Medicare exam does not include lab tests.</p>	<p>In-Network \$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p>

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

In-Network

\$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.

In-Network

\$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.

In-Network

\$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
<p>34. Health/Wellness Education</p>	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p> <p>\$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months of up to three times during a pregnancy.</p>	<p>In-Network The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Health Club Membership/ Fitness Classes - Other Wellness Benefits <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>General HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p>In-Network \$0 copay for each Medicare-covered HIV screening.</p>
<p>Transportation (Routine)</p>	<p>Not covered.</p>	<p>In-Network This plan does not cover routine transportation.</p>

CHARTER+RX (HMO)	APEX+RX (HMO)	SUMMIT+RX (HMO-POS)
<p>In-Network The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Health Club Membership/ Fitness Classes - Other Wellness Benefits <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p>	<p>In-Network The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Health Club Membership/ Fitness Classes - Other Wellness Benefits <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p>	<p>In-Network The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Health Club Membership/ Fitness Classes - Other Wellness Benefits <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for up to 20 one-way trips to plan-approved location every year.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for up to 20 one-way trips to plan-approved location every year.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for up to 20 one-way trips to plan-approved location every year.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	SOUND+RX (HMO)
Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.
Point of Service		

PREVENTIVE SERVICES

CHARTER+RX (HMO)	APEX+RX (HMO)	SUMMIT+RX (HMO-POS)
<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>
		<p>Out-of-Network Point of Service coverage is available for the following benefits:</p> <ul style="list-style-type: none"> - Occupational Therapy Services - Physician Specialist Services - Mental Health Specialty Services - Podiatry Services - Other Health Care Professional - Psychiatric Services - Physical Therapy and Speech/Language Pathology Services - Cardiac Rehabilitation Services <p>\$50 copay for</p> <ul style="list-style-type: none"> - Occupational Therapy Services - Physician Specialist Services - Mental Health Specialty Services - Podiatry Services - Other Health Care Professional - Psychiatric Services - Physical Therapy and Speech/Language Pathology Services - Cardiac Rehabilitation Services

BENEFIT CATEGORY

ORIGINAL MEDICARE

**SOUND+RX
(HMO)**

OPTIONAL BENEFITS

Optional Supplemental Package #1

**Premium & Other
Important Information**

**General
Package: 1 - Partners Dental
Plan:**

\$56 monthly premium, in addition to your \$0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:

- Preventive Dental

- Comprehensive Dental

\$1,500 plan coverage limit every year for these benefits.

Dental Services

General Plan offers additional comprehensive dental benefits.

In-Network

- 0% to 20% of the cost for up to 2 cleanings every year.

- 0% to 20% of the cost for up to 2 fluoride treatments every year.

- 0% to 20% of the cost for up to 2 oral exams every year.

- 0% to 20% of the cost for up to 1 dental x-ray every year.

\$1,500 plan coverage limit for dental benefits every year.

OPTIONAL BENEFITS

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

<p>General Package: 1 - Partners Dental Plan: \$56 monthly premium, in addition to your \$79 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> - Preventive Dental - Comprehensive Dental <p>\$1,500 plan coverage limit every year for these benefits.</p>	<p>General Package: 1 - Partners Dental Plan: \$56 monthly premium, in addition to your \$152 or \$162 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> - Preventive Dental - Comprehensive Dental <p>\$1,500 plan coverage limit every year for these benefits.</p>	<p>General Package: 1 - Partners Dental Plan: \$56 monthly premium, in addition to your \$190 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> - Preventive Dental - Comprehensive Dental <p>\$1,500 plan coverage limit every year for these benefits.</p>
<p>General Plan offers additional comprehensive dental benefits.</p> <p>In-Network</p> <ul style="list-style-type: none"> - 0% to 20% of the cost for up to 2 cleanings every year. - 0% to 20% of the cost for up to 2 fluoride treatments every year. - 0% to 20% of the cost for up to 2 oral exams every year. - 0% to 20% of the cost for up to 1 dental x-ray every year. <p>\$1,500 plan coverage limit for dental benefits every year.</p>	<p>General Plan offers additional comprehensive dental benefits.</p> <p>In-Network</p> <ul style="list-style-type: none"> - 0% to 20% of the cost for up to 2 cleanings every year. - 0% to 20% of the cost for up to 2 fluoride treatments every year. - 0% to 20% of the cost for up to 2 oral exams every year. - 0% to 20% of the cost for up to 1 dental x-ray every year. <p>\$1,500 plan coverage limit for dental benefits every year.</p>	<p>General Plan offers additional comprehensive dental benefits.</p> <p>In-Network</p> <ul style="list-style-type: none"> - 0% to 20% of the cost for up to 2 cleanings every year. - 0% to 20% of the cost for up to 2 fluoride treatments every year. - 0% to 20% of the cost for up to 2 oral exams every year. - 0% to 20% of the cost for up to 1 dental x-ray every year. <p>\$1,500 plan coverage limit for dental benefits every year.</p>

BENEFIT CATEGORY

ORIGINAL MEDICARE

**SOUND+RX
(HMO)**

Optional Supplemental Package #2

**Premium & Other
Important Information**

**General
Package: 2 - Partners
Alternative Care Plan:**

\$5 monthly premium,
in addition to your \$0
monthly plan premium and
the monthly.

Medicare Part B premium,
for the following optional
benefits:

- Chiropractic Services.
- Acupuncture.

In-Network

\$15 copay for up to 20
routine visits every year.

Chiropractic Services

In-Network

\$15 copay for up to 20
routine visits every year

OPTIONAL BENEFITS

**CHARTER+RX
(HMO)**

**APEX+RX
(HMO)**

**SUMMIT+RX
(HMO-POS)**

**General
Package: 2 - Partners
Alternative Care Plan:**

\$5 monthly premium, in addition to your \$79 monthly plan premium and the monthly.

Medicare Part B premium, for the following optional benefits:

- Chiropractic Services.
- Acupuncture.

In-Network

\$15 copay for up to 20 routine visits every year.

**General
Package: 2 - Partners
Alternative Care Plan:**

\$5 monthly premium, in addition to your \$152 or \$162 monthly plan premium and the monthly.

Medicare Part B premium, for the following optional benefits:

- Chiropractic Services.
- Acupuncture.

In-Network

\$15 copay for up to 20 routine visits every year.

**General
Package: 2 - Partners
Alternative Care Plan:**

\$5 monthly premium, in addition to your \$190 monthly plan premium and the monthly.

Medicare Part B premium, for the following optional benefits:

- Chiropractic Services.
- Acupuncture.

In-Network

\$15 copay for up to 20 routine visits every year.

In-Network

\$15 copay for up to 20 routine visits every year

In-Network

\$15 copay for up to 20 routine visits every year

In-Network

\$15 copay for up to 20 routine visits every year

Puget Sound Health Partners Important Phone Numbers

PSHP Member Services

1-866-789-PSHP (7747)
8am-8pm, 7 days a week

You may receive a messaging service on weekends and holidays from March 2 through November 14. Please leave a message and your call will be returned the next business day.

TTY / TDD users call
1-866-264-4141

PSHP Mailing Address

PO Box 4537
Federal Way, WA 98063

PSHP Website

www.OurPSHP.com

Medicare

1-800-MEDICARE (633-4227)
24 hrs a day, 7 days a week

TTY/TTD users call
1-877-486-2048

Social Security Office

1-800-772-1213
7am-7pm, Monday-Friday

TTY/TTD users call
1-800-325-0778

Other Important Phone Numbers:



PUGET SOUND
HEALTH PARTNERS

Puget Sound Health Partners is a Medicare approved HMO.