

Summary of Benefits

January 1, 2011 - December 31, 2011

CareMore Diabetes (HMO SNP) H2593

Arizona: Maricopa (PARTIAL) County



SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in CareMore Diabetes (HMO SNP). Our plan is offered by CAREMORE HEALTH PLAN OF ARIZONA, INC., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria.

If you have been diagnosed with Diabetes mellitus you may be eligible to join this plan.

Please call CareMore Diabetes (HMO SNP) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call CareMore Diabetes (HMO SNP) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES 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 CareMore Diabetes (HMO SNP). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you have one or more of the listed diseases you may enroll in the plan at any time but you may only leave the plan at certain times.

Please call CareMore Diabetes (HMO SNP) at the 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 CareMore Diabetes (HMO SNP) 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 CareMore Diabetes (HMO SNP) AVAILABLE?

The service area for this plan includes: Maricopa* County, AZ. You must live in this area to join the plan.

Maricopa County

85003	85029	85208	85303			
85004	85031	85209	85304			
85006	85032	85210	85305			
85008	85033	85213	85306			
85009	85034	85215	85308			
85012	85035	85216	85345			
85013	85037	85250	85381			
85014	85046	85251				
85015	85050	85253				
85016	85051	85254				
85017	85053	85257				
85018	85054	85258				
85019	85068	85260				
85020	85071	85267				
85021	85201	85271				
85022	85202	85277				
85023	85203	85281				
85024	85204	85282				
85026	85205	85299				
85027	85206	85301				
85028	85207	85302				

* denotes partial county

WHO IS ELIGIBLE TO JOIN CareMore Diabetes (HMO SNP)?

You can join CareMore Diabetes (HMO SNP) 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 generally are not eligible to enroll in CareMore Diabetes (HMO SNP) unless they are members of our organization and have been since their dialysis began.

You must have been diagnosed by your doctor with Diabetes mellitus to join this plan.

Please call plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

CareMore Diabetes (HMO SNP) has 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.caremore.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?

CareMore Diabetes (HMO SNP) has 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.caremore.com. Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

CareMore Diabetes (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

CareMore Diabetes (HMO SNP) uses 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.caremore.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 COSTS 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 a.m. and 7 p.m., 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 plans decide 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 CareMore Diabetes (HMO SNP), 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 CareMore Diabetes (HMO SNP), 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 CareMore Diabetes (HMO SNP) 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 CareMore Diabetes (HMO SNP) 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 alpha 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 this plan. Our customer service number is listed below.

Please call CareMore Health Plan of Arizona, Inc. for more information about CareMore Diabetes (HMO SNP).

Visit us at <http://www.caremore.com> or, call us:

Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Pacific

Current members should call toll-free or locally **(888)-357-4187** for questions related to the Medicare Advantage and/or Medicare Part D Prescription Drug Programs.
(TTY/TDD (800)-577-5586)

Prospective members should call toll-free or locally **(866)-622-2820** for questions related to the Medicare Advantage and/or Medicare Part D Prescription Drug Programs.
(TTY/TDD (800)-577-5586)

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.

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

Este documento puede estar disponible en español.
Para obtener información adicional, llame al departamento de servicio al miembro al número de teléfono indicado anteriormente.

If you have special needs, this document may be available in other formats.

If you have any questions about this plan's benefits or costs, please contact CareMore Health Plan of Arizona, Inc. for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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IMPORTANT INFORMATION

<p>① Premium and 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 at 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>This limit includes only Medicare-covered services.</p>
<p>② Doctor and Hospital Choice (For more information, see Emergency Care - #15 and 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 hospitals and specialists (for certain benefits).</p>

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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INPATIENT CARE

<p>3 Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2010 the amounts for each benefit period were:</p> <ul style="list-style-type: none"> • Days 1-60: \$1100 deductible • Days 61-90: \$275 per day • Days 91-150: \$550 per lifetime reserve day <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. There is no limit to the number of benefit periods you can have.</p>	<p>In-Network Plan covers 165 days each benefit period.</p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> • Days 1-5: \$100 copay per day • Days 6-90: \$0 copay per day <p>\$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>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 Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days.</p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> • Days 1-5: \$100 copay per day • Days 6-90: \$0 copay per day <p>\$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	Original Medicare	CareMore Diabetes (HMO SNP)
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INPATIENT CARE (CONTINUED)

<p>5 Skilled Nursing Facility (SNF) (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> <ul style="list-style-type: none"> • Days 1-20: \$0 per day • Days 21-100: \$137.50 per day <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. 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> <ul style="list-style-type: none"> • Days 1-31: \$0 copay per day • Days 32-100: \$75 copay per day
<p>6 Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and 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>

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
OUTPATIENT CARE		
<p>⑧ Doctor Office Visits</p>	<p>20% coinsurance</p>	<p>General See “Welcome to Medicare; and Annual Wellness Visit”, for more information.</p> <p>Authorization rules may apply.</p> <p>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for the cost of each in-area, network urgent care Medicare-covered visit.</p> <p>\$25 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 \$25 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 \$0 copay for Medicare-covered podiatry visits</p> <p>up to 12 routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
OUTPATIENT CARE (CONTINUED)		
⑪ Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	<p>General Authorization rules may apply.</p> <p>In-Network For Medicare-covered individual or group therapy:</p> <ul style="list-style-type: none"> • Visit(s) 1-10: \$0 copay per visit • Visit(s) 11 and beyond: \$25 copay per visit <p>\$25 copay for each Medicare-covered individual or group therapy visit with a psychiatrist.</p>
⑫ Outpatient Substance Abuse Care	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual or group visits.</p>
⑬ Outpatient Services/ Surgery	<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 \$50 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$100 copay for each Medicare-covered outpatient hospital facility visit.</p>
⑭ Ambulance Services (medically necessary ambulance services)	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$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	Original Medicare	CareMore Diabetes (HMO SNP)
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OUTPATIENT CARE (CONTINUED)

<p>15 Emergency Care (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 hospital 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>\$10,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit</p>
<p>16 Urgently Needed Care (This is NOT emergency care, and 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>\$25 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the urgently-needed care visit.</p>

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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OUTPATIENT CARE (CONTINUED)

<p>17 Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/Psychological Services, and more)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$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>\$25 copay for Medicare-covered Cardiac Rehab services.</p>
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OUTPATIENT MEDICAL SERVICES AND SUPPLIES

<p>18 Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$250 copay for Medicare-covered items.</p>
<p>19 Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$250 copay for Medicare-covered items.</p>

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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OUTPATIENT MEDICAL SERVICES AND SUPPLIES (CONTINUED)

<p>20 Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies 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>General Authorization rules 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 \$25 may apply.</p>
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<p>21 Diagnostic Tests, X-Rays, Lab Services, and 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:</p> <ul style="list-style-type: none"> • lab services • diagnostic procedures and tests <p>\$0 copay for Medicare-covered X-rays.</p> <p>\$150 copay for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p> <p>Separate Office Visit cost sharing of \$0 to \$25 may apply for Outpatient Diagnostic Procedures, Tests and Lab Services.</p> <p>Separate Office Visit cost sharing of \$0 to \$25 may apply for Outpatient Diagnostic and Therapeutic Radiological Services.</p>
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Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
PREVENTIVE SERVICES		
<p>22 Bone Mass Measurement (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>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered bone mass measurement</p> <p>Separate Office Visit cost sharing of \$0 to \$25 may apply.</p>
<p>23 Colorectal Screening Exams (for people with Medicare age 50 and 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>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Separate Office Visit cost sharing of \$0 to \$25 may apply.</p>
<p>24 Immunizations (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) (for women with Medicare age 40 and 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 Medicare-covered screening mammograms.</p> <p>Separate Office Visit cost sharing of \$0 to \$25 may apply.</p>

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

<p>26 Pap Smears and Pelvic Exams (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 \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>Separate Office Visit cost sharing of \$0 to \$25 may apply.</p>
<p>27 Prostate Cancer Screening Exams (for men with Medicare age 50 and 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 \$0 copay for Medicare-covered prostate cancer screening</p> <p>Separate Office Visit cost sharing of \$0 to \$25 may apply.</p>
<p>28 End-Stage Renal Disease</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 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	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

29 Prescription Drugs

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.

Drugs covered under Medicare Part B

General

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

Home Infusion Drugs, Supplies and Services

General

\$0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these 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.caremore.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).

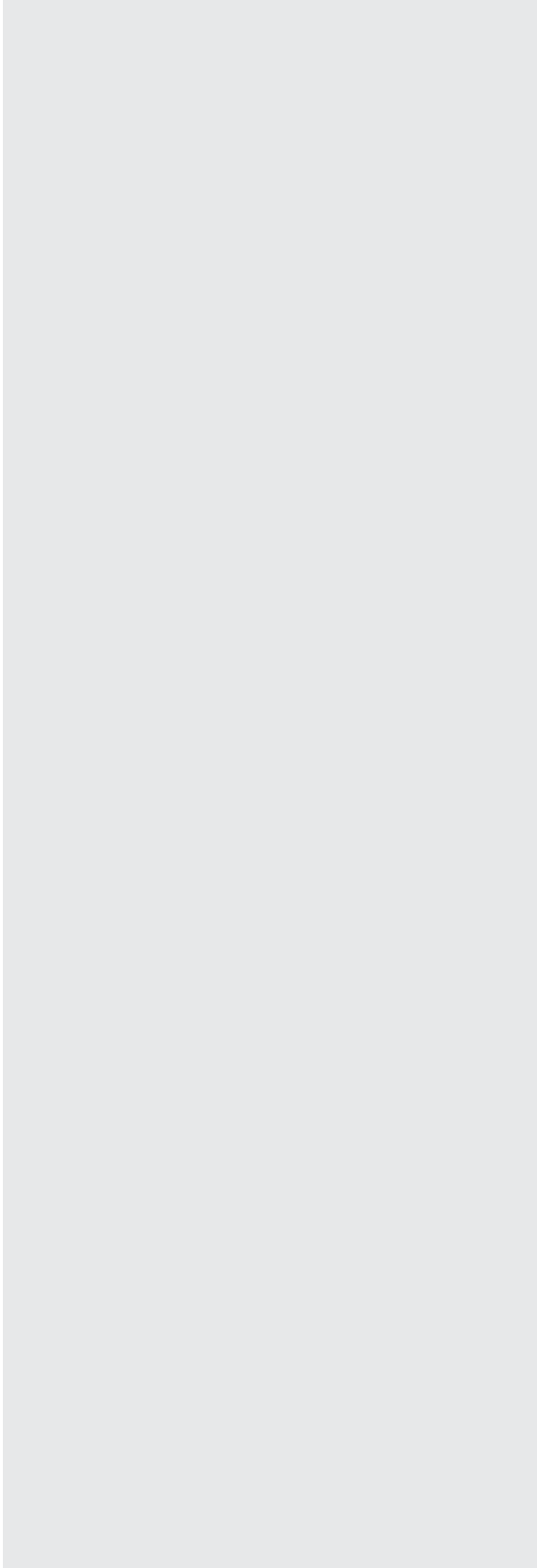
The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

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

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

29 Prescription Drugs
(continued)



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 CareMore Diabetes (HMO SNP) 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.

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.

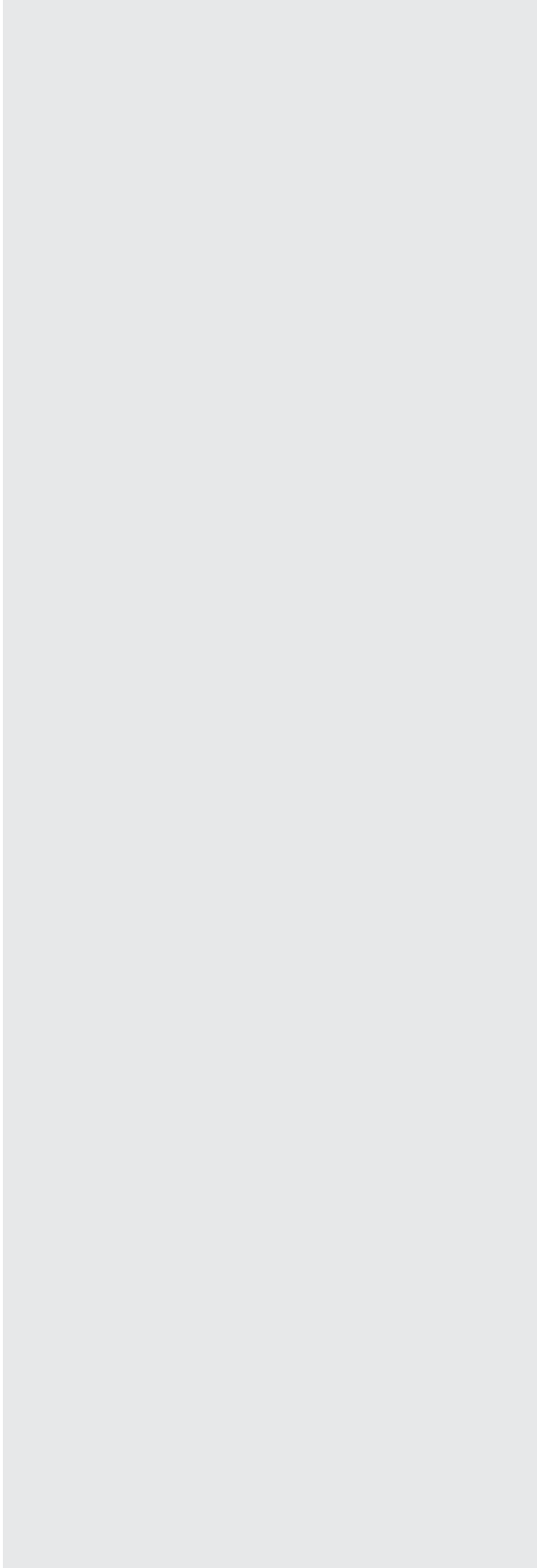
If you request a formulary exception for a drug and CareMore Diabetes (HMO SNP) approves the exception, you will pay Tier 5: Non-Preferred Generic and Non-Preferred Brand Drugs cost sharing for that drug.

In-Network
\$0 deductible.

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

29 Prescription Drugs
(continued)



Initial Coverage
You pay the following until total yearly drug costs reach \$3,000:

Retail Pharmacy
Tier 1: Preferred Generic Drugs

- \$0 copay for a one-month (31-day) supply of drugs in this tier
- \$0 copay for a three-month (93-day) supply of drugs in this tier

Tier 2: Generic Drugs

- \$5 copay for a one-month (31-day) supply of drugs in this tier
- \$15 copay for a three-month (93-day) supply of drugs in this tier

Tier 3: Brand Drugs

- \$0 copay for a one-month (31-day) supply of drugs in this tier
- \$0 copay for a three-month (93-day) supply of drugs in this tier

Tier 4: Preferred Brand Drugs

- \$35 copay for a one-month (31-day) supply of drugs in this tier
- \$105 copay for a three-month (93-day) supply of drugs in this tier

Tier 5: Non-Preferred Generic and Non-Preferred Brand Drugs

- \$75 copay for a one-month (31-day) supply of drugs in this tier
- \$225 copay for a three-month (93-day) supply of drugs in this tier

Tier 6: Specialty Tier Drugs

- 33% coinsurance for a one-month (31-day) supply of drugs in this tier

Long Term Care Pharmacy
Tier 1: Preferred Generic Drugs

- \$0 copay for a one-month (31-day) supply of drugs in this tier

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

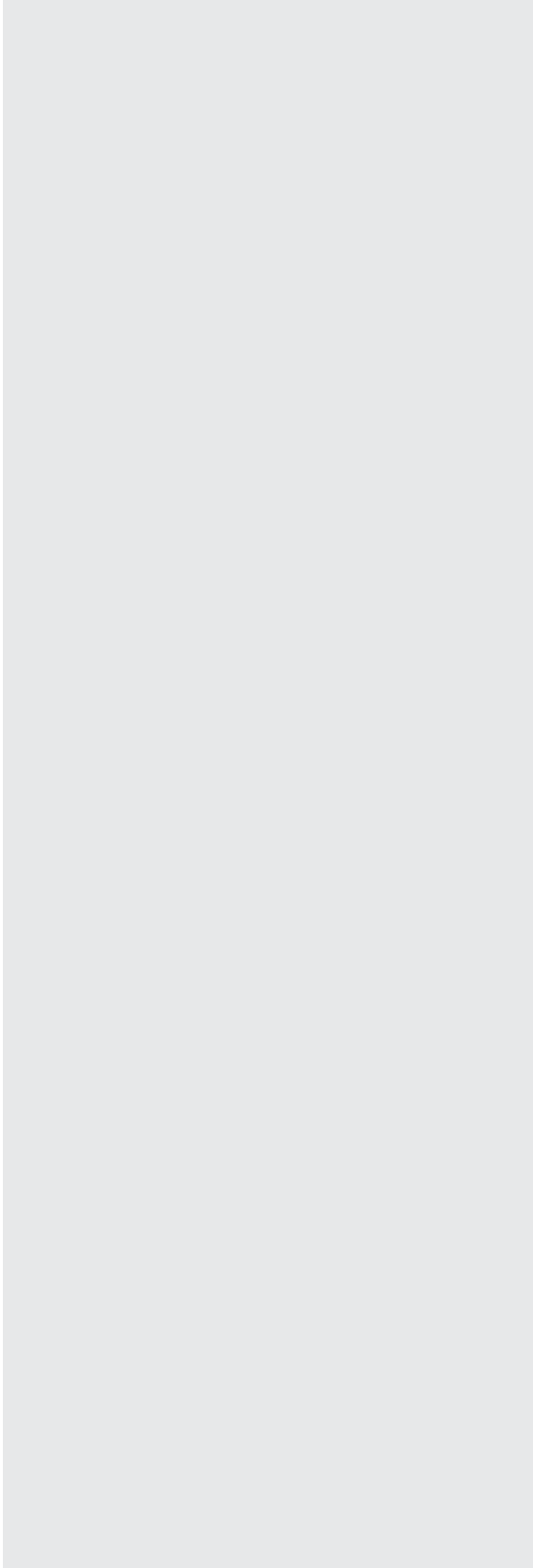
29 Prescription Drugs
(continued)

	<p>Tier 2: Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Brand Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$35 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 5: Non-Preferred Generic and Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$75 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 6: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a three-month (93-day) supply of drugs in this tier <p>Tier 2: Generic Drugs</p> <ul style="list-style-type: none"> • \$12.50 copay for a three-month (93-day) supply of drugs in this tier <p>Tier 3: Brand Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a three-month (93-day) supply of drugs in this tier <p>Tier 4: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$87.50 copay for a three-month (93-day) supply of drugs in this tier <p>Tier 5: Non-Preferred Generic and Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$187.50 copay for a three-month (93-day) supply of drugs in this tier <p>Tier 6: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier
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Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

29 Prescription Drugs
(continued)



Additional Coverage Gap
The plan covers all formulary generics (100% of formulary generic drugs), few formulary brands (less than 10% of formulary brand drugs) through the coverage gap.

You pay the following:

Retail Pharmacy
Tier 1: Preferred Generic Drugs

- \$0 copay for a one-month (31-day) supply of all drugs covered in this tier
- \$0 copay for a three-month (93-day) supply of all drugs covered in this tier

Tier 2: Generic Drugs

- \$5 copay for a one-month (31-day) supply of all drugs covered in this tier
- \$15 copay for a three-month (93-day) supply of all drugs covered in this tier

Tier 3: Brand Drugs

- \$0 copay for a one-month (31-day) supply of all drugs covered in this tier
- \$0 copay for a three-month (93-day) supply of all drugs covered in this tier

Long Term Care Pharmacy
Tier 1: Preferred Generic Drugs

- \$0 copay for a one-month (31-day) supply of all drugs covered in this tier

Tier 2: Generic Drugs

- \$5 copay for a one-month (31-day) supply of all drugs covered in this tier

Tier 3: Brand Drugs

- \$0 copay for a one-month (31-day) supply of all drugs covered in this tier

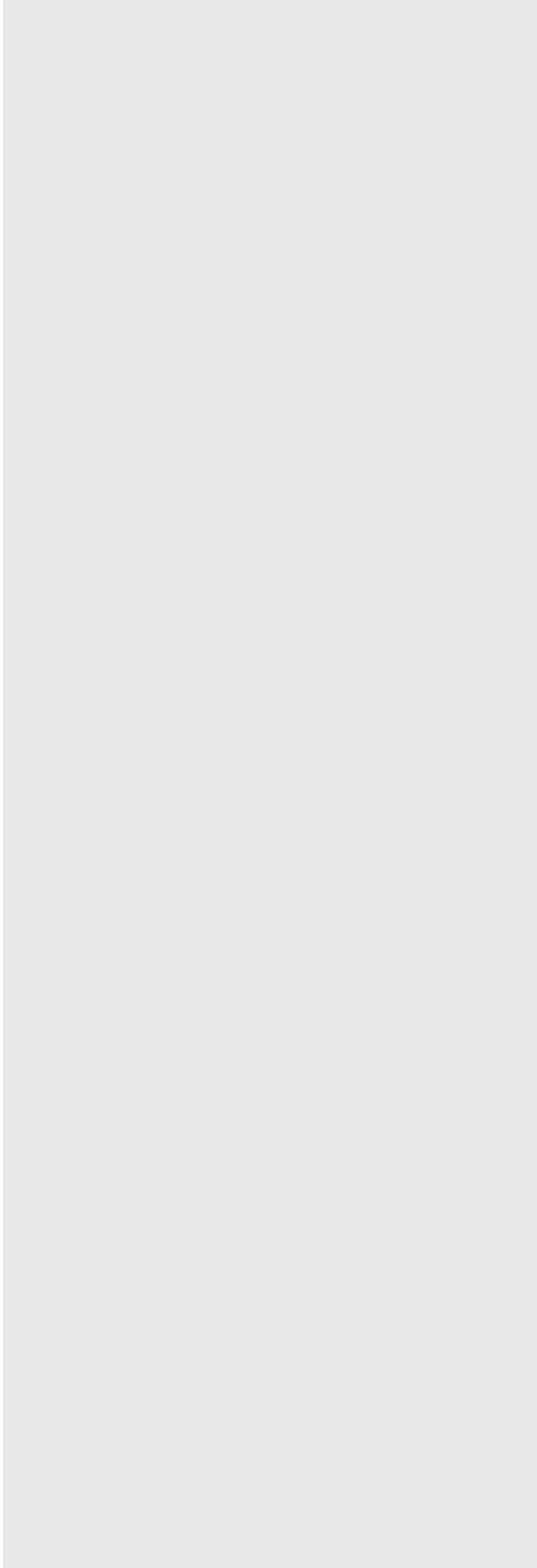
Mail Order
Tier 1: Preferred Generic Drugs

- \$0 copay for a three-month (93-day) supply of all drugs covered in this tier

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

29 Prescription Drugs
(continued)



Tier 2: Generic Drugs

- \$12.50 copay for a three-month (93-day) supply of all drugs covered in this tier

Tier 3: Brand Drugs

- \$0 copay for a three-month (93-day) supply of all drugs covered in this tier

After your total yearly drug costs reach \$3,000, 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 costs for all 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 CareMore Diabetes (HMO SNP).

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

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

29 Prescription Drugs
(continued)

	<p>until total yearly drug costs reach \$3,000:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Brand Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$35 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 5: Non-Preferred Generic and Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$75 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 6: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier <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> <p>Additional 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:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of all drugs covered in this tier <p>Tier 2: Generic Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of all drugs covered in this tier
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Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

29 Prescription Drugs
(continued)

	<p>Tier 3: Brand Drugs</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of all drugs covered in this tier <p>Tier 4: Preferred Brand 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.</p> <p>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.</p> <p>Tier 5: Non-Preferred Generic and Non-Preferred Brand 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.</p> <p>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.</p> <p>Tier 6: 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.</p> <p>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.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's</p>
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Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

<p>29 Prescription Drugs (continued)</p>		<p>In-Network allowable amount.</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, or • 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>
<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. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")</p> <p>\$0 to \$25 copay for Medicare-covered dental benefits.</p> <p>Separate Office Visit cost sharing of \$7 may apply.</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 Hearing aids not covered.</p> <p>\$0 copay for Medicare-covered diagnostic hearing exams</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> • up to 1 routine hearing test(s) every year • up to 1 fitting-evaluation(s) for a hearing aid every year

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

32 Vision Services

20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.

Routine eye exams and glasses not covered.

Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.

Annual glaucoma screenings covered for people at risk.

General

Authorization rules may apply.

In-Network

- \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.
- \$0 to \$25 copay for exams to diagnose and treat diseases and conditions of the eye.
- \$20 copay for up to 1 routine eye exam(s) every year
- \$25 copay for up to 1 pair(s) of glasses every two years
- \$25 copay for up to 1 pair(s) of contacts every year
- \$0 copay for up to 1 pair(s) of lenses every year
- \$25 copay for up to 1 frame(s) every two years

\$80 plan coverage limit for eye glasses (lenses and frames) every two years.

\$100 plan coverage limit for contact lenses every year.

\$80 plan coverage limit for eye glass frames every two years.

Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

<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 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</p> <p>\$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p> <p>\$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>Separate Office Visit cost sharing of \$0 to \$25 may apply.</p>
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<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 or up to three times during a pregnancy.</p>	<p>General</p> <p>Please visit our plan website to see our list of covered Over-the-Counter items.</p> <p>OTC items may be purchased only for the enrollee. Please contact the plan for specific instructions for using this benefit.</p> <p>In-Network</p> <p>The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Nutritional Training • Additional Smoking Cessation • Nursing Hotline • 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>
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Benefit	Original Medicare	CareMore Diabetes (HMO SNP)
PREVENTIVE SERVICES (CONTINUED)		
34 Health/Wellness Education (continued)		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.
Transportation (Routine)	Not covered.	General Authorization rules may apply. In-Network \$0 copay for each one-way trip to plan-approved location.
Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.

OPTIONAL SUPPLEMENTAL PACKAGE #1

Premium and Other Important Information Dental Services		General Package: 1- Dental: \$14.80 monthly premium in addition to your \$0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: <ul style="list-style-type: none"> • Preventive Dental • Comprehensive Dental General Plan offers additional comprehensive dental benefits. In-Network <ul style="list-style-type: none"> • \$10 to \$17 copay for cleanings • \$0 to \$7 for up to 2 fluoride treatment(s) every year • \$7 to \$55 for oral exams • \$15 to \$22 copay for dental x-rays
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