Fallon Medicare Plus Premier HMO
Schedule of Benefits

This *Schedule of Benefits* is part of your
2020 Fallon Medicare Plus Premier HMO Evidence of Coverage.
It describes your costs for health care.

You are a member of Fallon Medicare Plus through an employer group. Under this group plan, you have copayments that are different from those shown in your *2020 Fallon Medicare Plus Premier HMO Evidence of Coverage*. The information in this document replaces any information in your *Evidence of Coverage* that conflicts with it. If you have any questions about your benefits, please call Customer Service at 1-800-325-5669 (TRS 711), Monday-Friday, 8 a.m.-8 p.m. (From Oct. 1-March 31, seven days a week.) Calls to these numbers are free.

The following changes apply to the Benefits Chart in *Chapter 4: Medical Benefits Chart (what is covered and what you pay)* of your *2020 Fallon Medicare Plus Premier HMO Evidence of Coverage*:

Services that are covered for you	What you must pay when you get these services
Ambulance services *For non-emergency ambulance services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	You pay a $50 copayment for for Medicare-covered ambulance transport (one-way). Ambulance services covered worldwide.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	You pay a $10 copayment for each Medicare-covered office visit for chiropractic services.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. As explained in Chapter 3, you can get routine dental services on your own, without a referral from your PCP as long as you get the services from a plan network dentist: We cover:	You pay a $25 copayment for each preventive dental visit. You pay copayments varying from $0 to $990 for comprehensive non-orthodontic dental care. See your "Addendum: Dental

Services that are covered for you	What you must pay when you get these services
• Preventive dental care including exam, cleaning, fluoride treatment and X-rays. Limited to twice a year. • Minor restorative (fillings); major restorative (crowns); endodontics (root canals); periodontics (gum disease procedures); oral surgery (simple extractions) and prosthodontics (dentures). There are plan exclusions, for example, full mouth debridement is limited to once every 36 months; periodontal maintenance after active therapy is limited to twice within 12 months after osseous surgery, or root planning and scaling. Reline dentures are limited to once per 36 months. Certain X-rays are allowed once per 36 months. See your "Dental Services Copayments and Fees" addendum for more information. • Emergency medical care, such as to relieve pain or to stop bleeding as a result of injury to the sound natural teeth or tissue, provided in the office of a physician or dentists as soon as possible after the injury. This does not include restorative or other dental care. Go to the closest provider, you do not need a referral from your PCP. • Additional dental services as part of your Benefit Bank. For information on the additional covered dental services, see the "Benefit Bank" section in this chart. *For oral surgery services (with the exception of the removal or exposure of impacted teeth) to be covered in a provider's office, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* • Non-routine dental care covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician. There is a provider network for non-routine dental care.	Services Copayments and Fees" addendum for more information. You pay a $15 copayment for emergency medical care of the sound natural teeth or tissue. You pay a $15 copayment for each office visit for oral surgery services. For information on the additional covered dental services, see the "Benefit Bank" section in this chart.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition	You pay a $50 copayment for each Medicare-covered emergency room visit in-network and out-of-network. If you are admitted to the hospital within 72 hours for the same condition, you do not pay the emergency room copayment. If you receive emergency care at an out-of-network hospital

Services that are covered for you	What you must pay when you get these services
that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Coverage is worldwide.	and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.
Health and wellness education programs **Membership in Health Club/Fitness Classes** • SilverSneakers Fitness is a complete wellness program that includes access to fitness locations* nationwide, exercise equipment, group exercise classes, a support network and online resources. Classes designed for all fitness levels and abilities include the signature SilverSneakers Classic, Circuit, CardioFit, Splash and Stability; SilverSneakers FLEX™ classes such as Latin dance, yoga and tai chi; and BOOM® MIND, MUSCLE and MOVE IT classes for more athletic participants. (*At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.) Members may visit silversneakers.com to obtain a personal SilverSneakers ID number and find their closest participating fitness location. SilverSneakers members may use any participating location just by showing their SilverSneakers ID number. To find fitness locations, call 1-888-423-4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. • We cover membership in Health Club/Fitness Classes as part of your Benefit Bank. For information on the additional covered membership in Health Club/Fitness Classes, see the "Benefit Bank" section in this chart. **Nutritional Benefit** • Unlimited group or individual nutritional therapy counseling is available to all members when provided by a registered dietician or other nutrition professional in the network. Members must receive services from network providers. **Health Education** • A communication that is filled with information to help keep you well. • Weight Watchers® – Members are entitled to a coupon book which gives them one 13-consecutive-week membership,	You pay $0 for: - SilverSneakers® Fitness program or SilverSneakers Steps - Nutritional Benefit - Newsletter - Weight Watchers® - Case Management and Disease Case Management programs - Infusion Drug program You may pay a $10 copayment for each health/wellness education class. For information on the additional covered membership in Health Club/Fitness Classes, see the "Benefit Bank" section in this chart.

Services that are covered for you	What you must pay when you get these services
including registration fee, per calendar year. Meals are not covered. Replacement of lost or stolen coupons is not included. • Health/wellness education classes – Members must receive services from network providers and may pay a copayment depending on the type of class and its location. • Case Management and Disease Case Management programs are available for members with chronic conditions such as diabetes, coronary artery disease and asthma. • An Infusion Drug program is available for members with infusion drug therapies to help ensure that infusion drugs are administered in the most appropriate and convenient setting for the member. For more information on any of these health and wellness education programs, call Customer Service at the number on the back cover of this booklet.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. We cover: • 1 supplemental routine hearing exam every year. • Hearing aids covered for certain manufacturers through Amplifon only. Limit of two hearing aids per member per year.	You pay a $15 specialist office visit copayment for each Medicare-covered diagnostic hearing exam. There is no copayment for 1 supplemental routine hearing exam every year. You pay copayments varying from $695 to $995 for covered hearing aids from Amplifon. See the "List of Covered Hearing Aids and Copayments" for details on the specific hearing aid coverage through Amplifon on fallonhealth.org/medicare or call Customer Service (phone numbers are printed on the back cover of this booklet).
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Fallon Medicare Plus Premier

Services that are covered for you	What you must pay when you get these services
Covered services include: • Drugs for symptom control and pain relief • Short-term respite care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by Fallon Medicare Plus Premier HMO but are not covered by Medicare Part A or B: Fallon Medicare Plus Premier HMO will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	HMO. You pay a $10 primary care doctor or a $15 specialist office visit copayment for hospice consultation services.
Inpatient hospital care *For inpatient hospital care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.*	You pay a $300 copayment for your first inpatient admission each year; this includes medical, surgical and rehabilitation services.

Services that are covered for you	What you must pay when you get these services
Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. You are covered for an unlimited number of days in an acute care hospital. This includes substance abuse services, but it does not include rehabilitation services. You are covered for up to 90 days of care in each benefit period in an inpatient rehabilitation facility or rehabilitation unit of an acute care hospital. If you exceed the 90-day limit in a benefit period, you may use your lifetime reserve days for additional coverage. See Chapter 12 for an explanation of "benefit period." Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Fallon Medicare Plus Premier HMO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain	You pay a $0 copayment for additional admissions. There is no copay for substance abuse inpatient admissions when the primary reason is substance detoxification and/or rehabilitation. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Physician services Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient mental health care *For inpatient mental health care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include mental health care services that require a hospital stay. • There is a 190-day lifetime limit on mental health care in a psychiatric hospital. You may use your lifetime reserve days for additional coverage once you have used the initial 90 days, if you have not reached your 190-day limit. See Chapter 12 for an explanation of "benefit period." • You are covered for an unlimited number of days of inpatient mental health care in an acute care hospital.	You pay a $300 copayment for your first inpatient mental health care admission each year. You pay a $0 copayment for additional admissions.
Medicare Part B prescription drugs For Medicare Part B prescription drugs to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:	There is no coinsurance, copayment, or deductible for drugs that are administered by a health care professional. You pay a $10 primary care doctor or a $15 specialist office copayment. For prescription drugs that are

Services that are covered for you	What you must pay when you get these services
• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	covered under Original Medicare you pay: *Retail Cost-Sharing:* Tier 1: $10 copayment for up to a 30-day supply; $20 copayment for up to a 60-day supply; $30 copayment for up to a 90-day supply Tier 2: $10 copayment for up to a 30-day supply; $20 copayment for up to a 60-day supply; $30 copayment for up to a 90-day supply Tier 3: $25 copayment for up to a 30-day supply; $50 copayment for up to a 60-day supply; $75 copayment for up to a 90-day supply Tier 4: $50 copayment for up to a 30-day supply; $100 copayment for up to a 60-day supply; $150 copayment for up to a 90-day supply Tier 5: $50 copayment for up to a 30-day supply; $100 copayment for up to a 60-day supply; $150 copayment for up to a 90-day supply Tier 6:

Services that are covered for you	What you must pay when you get these services
	$0 copayment for up to a 30-day supply *Mail-order Cost-Sharing:* Tier 1: $10 copayment for up to a 30-day supply; $20 copayment for up to a 60-day supply; $20 copayment for up to a 90-day supply Tier 2: $10 copayment for up to a 30-day supply; $20 copayment for up to a 60-day supply; $20 copayment for up to a 90-day supply Tier 3: $25 copayment for up to a 30-day supply; $50 copayment for up to a 60-day supply; $50 copayment for up to a 90-day supply Tier 4: $50 copayment for up to a 30-day supply; $100 copayment for up to a 60-day supply; $100 copayment for up to a 90-day supply Tier 5: $50 copayment for up to a 30-day supply; $100 copayment for up to a 60-day supply; $100 copayment for up to a 90-day supply Tier 6:

Services that are covered for you	What you must pay when you get these services
	$0 copayment for up to a 30-day supply There is no benefit limit on Medicare Part B covered drugs.
Opioid Treatment Program Services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	You pay a $10 copayment for each Medicare-covered opioid use disorder treatment services visit.
Outpatient mental health care *For outpatient mental health care beyond the eighth visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	You pay a $10 copayment for each Medicare-covered individual or group therapy visit without a psychiatrist. You pay a $15 copayment for each Medicare-covered individual or group therapy visit with a psychiatrist.
Outpatient rehabilitation services *For physical therapy visits beyond the 60th visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* *For occupational therapy visits beyond the 60th visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* *For speech language therapy visits beyond the 35th visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient	You pay a $10 copayment for each Medicare-covered physical, occupational or speech language therapy visit.

Services that are covered for you	What you must pay when you get these services
settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	
Outpatient substance abuse services Medicare-covered outpatient substance abuse treatment services are covered when provided in a clinic or hospital outpatient by a psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, and physician assistant department. Covered services include, but are not limited to: • Psychotherapy • Member education regarding diagnosis and treatment	You pay a $10 copayment for Medicare-covered individual or group therapy visits.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers *For outpatient surgery to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	You pay a $50 copayment for each Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility. You do not pay the outpatient surgery copayment in a hospital outpatient facility if you are admitted to the hospital on the same day of the surgery.
Physician/Practitioner services, including doctor's office visits *For some outpatient services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. For more information, see Chapter 3.* Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Diagnostic Hearing Exams • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including for: acute and psychiatric inpatient hospital; skilled nursing facility; emergency/urgently needed care; partial hospitalization; primary care; specialist care; outpatient mental health; opioid treatment; outpatient substance abuse; and diabetes self-management training. You have the option	You pay a $10 copayment for each primary care doctor visit for Medicare-covered benefits. You pay a $15 copayment for each specialist visit for Medicare-covered benefits. You pay a $15 copayment for each Medicare-covered diagnostic hearing exam. You pay a $10 primary care doctor or $15 specialist copayment for telehealth services. You pay a $15 copayment for Medicare-covered dental

Services that are covered for you	What you must pay when you get these services
of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth. Covered telehealth services are limited to those that involve both an audio and video component and must be done in real-time over a secure communication method administered by your provider. These services can replace some in-person visits to your provider. • Telehealth services for monthly ESRD-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke • Brief virtual (for example, via telephone or video chat) 5-10 minute check-ins with your doctor—if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment • Consultation your doctor has with other physicians via telephone, internet, or electronic health record assessment—if you are an established patient • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Reconstructive surgery *(For reconstructive surgery to be covered, your PCP or other plan provider must get prior authorization (approval in advance) from the plan.)* o Surgery for post-mastectomy patients for reconstruction of the breast on which the mastectomy was performed. o Surgery and reconstruction of the other breast to produce a symmetrical appearance o Treatment of any physical complications resulting from the mastectomy including lymphedema.	benefits. You pay $50 copayment for each Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility. You do not pay the outpatient surgery copayment in a hospital outpatient facility if you are admitted to the hospital on the same day of surgery.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.	You pay a $10 copayment for each Medicare-covered urgently needed care visit in the United States and its territories. You pay a $50 copayment for

Services that are covered for you	What you must pay when you get these services
Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Coverage is worldwide.	each urgently needed care visit outside of the United States and its territories.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • One supplemental routine eye exam every year. • One pair of routine eyeglasses (prescription lenses and frames) or contact lenses every calendar year. • The $150 plan coverage limit includes new eyeglasses, contact lenses, lens replacement, fitting, adjustment or repair. Must be purchased from an EyeMed network provider. Members pay all charges over $150 per calendar year. The following exclusions apply: o Store promotions or coupons o The one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery o Two pairs of glasses in lieu of bifocals o Non-prescription lenses and/or contact lenses o Non-prescription sunglasses We also cover eyewear as part of your Benefit Bank. For information on additional eyewear coverage, see the "Benefit Bank" section in this chart.	There is no copayment for Medicare-covered glaucoma tests. You pay a $15 copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. You pay a $15 copayment for 1 supplemental routine eye exam every year. There is no copayment for: – One pair of Medicare-covered eyeglasses or contact lenses after cataract surgery – One pair of eyeglasses or contacts every year There is a $150 plan coverage limit for eyewear every year. For information on the additional eyewear coverage, see the "Benefit Bank" section in this chart.

Chapter 6: What you pay for your Part D prescription drugs explains the three cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier.

Section 5.2 A table that shows your costs for a one-month supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be a copayment.

- "Copayment" means that you pay a fixed amount each time you fill a prescription.

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

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

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

	Retail cost-sharing (in-network) (up to a 30-day supply)	**Mail-order cost-sharing** (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred generic drugs)	$10 copay	$10 copay
Cost-Sharing Tier 2 (Generic drugs)	$10 copay	$10 copay
Cost-Sharing Tier 3 (Preferred brand drugs)	$25 copay	$25 copay
Cost-Sharing Tier 4 (Non-preferred brand drugs)	$50 copay	$50 copay
Cost-Sharing Tier 5 (Specialty drugs)	$50 copay	$50 copay
Cost-Sharing Tier 6 (Select care drugs (certain vaccines and anti-opioid drugs))	$0 copay	$0 copay

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

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

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

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

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

	Retail cost-sharing (in-network) (up to a 90-day supply)	**Mail-order cost-sharing** (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred generic drugs)	$30 copay	$20 copay
Cost-Sharing Tier 2 (Generic drugs)	$30 copay	$20 copay
Cost-Sharing Tier 3 (Preferred brand drugs)	$75 copay	$50 copay
Cost-Sharing Tier 4 (Non-preferred brand drugs)	$150 copay	$100 copay
Cost-Sharing Tier 5 (Specialty drugs)	$150 copay	$100 copay
Cost-Sharing Tier 6 (Select care drugs (certain vaccines and anti-opioid drugs))	A long-term supply is not available for drugs in Tier 6.	A long-term supply is not available for drugs in Tier 6.