

Summary of Benefits

January 1, 2012 - December 31, 2012

CareMore Touch (HMO SNP) H0544

California: Los Angeles & Orange Counties (PARTIAL)



SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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

If you reside in a nursing home or you are living in the community but require the same level of care as someone in a nursing home, you may be eligible to join this plan.

Please call CareMore Touch (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 Touch (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 Touch (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 are living in a nursing home or you live in the community or in an assisted living facility and require the same level of care as someone in a nursing home, you may join or leave a plan at any time.

Please call CareMore Touch (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 Touch (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 Touch (HMO SNP) AVAILABLE?

The service area for this plan includes: Los Angeles*, Orange* Counties, CA. You must live in one of these areas to join the plan.

Los Angeles County

90001	90022	90046	90070	90097	90241	90291
90002	90023	90047	90071	90099	90242	90292
90003	90026	90048	90072	90101	90245	90293
90004	90027	90050	90074	90102	90247	90294
90005	90028	90051	90075	90103	90248	90295
90006	90029	90052	90076	90174	90249	90296
90007	90030	90053	90078	90185	90250	90301
90008	90031	90054	90079	90189	90251	90302
90009	90032	90055	90080	90201	90254	90303
90010	90033	90056	90081	90202	90255	90304
90011	90034	90057	90082	90220	90260	90305
90012	90036	90058	90083	90221	90261	90306
90013	90037	90059	90084	90222	90262	90307
90014	90038	90060	90086	90223	90266	90308
90015	90039	90061	90087	90224	90267	90309
90016	90040	90062	90088	90230	90270	90310
90017	90041	90063	90089	90231	90274	90311
90018	90042	90065	90091	90232	90275	90312
90019	90043	90066	90093	90233	90277	90313
90020	90044	90068	90094	90239	90278	90397
90021	90045	90069	90096	90240	90280	90398

* denotes partial county

Los Angeles County

90501	90637	90712	90804	90847	91031	91115
90502	90638	90713	90805	90848	91040	91116
90503	90639	90714	90806	90853	91041	91117
90504	90640	90715	90807	90888	91042	91118
90505	90650	90716	90808	90895	91043	91121
90506	90651	90717	90809	90899	91046	91123
90507	90652	90723	90810	91001	91050	91124
90508	90659	90731	90813	91003	91051	91125
90509	90660	90732	90814	91006	91066	91126
90510	90661	90733	90815	91007	91077	91129
90601	90662	90734	90822	91009	91101	91131
90602	90665	90744	90831	91010	91102	91175
90603	90670	90745	90832	91011	91103	91182
90604	90671	90746	90833	91012	91104	91184
90605	90701	90747	90834	91016	91105	91185
90606	90702	90748	90835	91017	91106	91186
90607	90703	90749	90840	91020	91107	91187
90608	90706	90755	90842	91021	91108	91188
90609	90707	90801	90844	91024	91109	91189
90610	90710	90802	90845	91025	91110	91191
90612	90711	90803	90846	91030	91114	91199

* denotes partial county

Los Angeles County

91201	91328	91401	91506	91615	91745	91780
91202	91329	91402	91507	91616	91746	91788
91203	91330	91403	91508	91617	91747	91789
91204	91331	91404	91510	91618	91748	91790
91205	91333	91405	91521	91702	91749	91791
91206	91334	91406	91522	91706	91750	91792
91207	91335	91407	91523	91711	91754	91793
91208	91337	91408	91526	91714	91755	91795
91209	91340	91409	91601	91715	91756	91797
91210	91341	91411	91602	91716	91765	91799
91214	91343	91412	91603	91722	91766	91801
91221	91344	91413	91604	91723	91767	91802
91222	91345	91416	91605	91724	91768	91803
91224	91346	91423	91606	91731	91769	91804
91225	91352	91426	91607	91732	91770	91841
91226	91353	91436	91608	91733	91771	91896
91316	91356	91501	91609	91734	91772	91899
91324	91357	91502	91610	91735	91773	
91325	91393	91503	91611	91740	91775	
91326	91394	91504	91612	91741	91776	
91327	91395	91505	91614	91744	91778	

* denotes partial county

Orange County

90620	92647	92780	92823	92861		
90621	92648	92781	92825	92862		
90622	92649	92782	92831	92863		
90623	92655	92799	92832	92864		
90624	92683	92801	92833	92865		
90630	92684	92802	92834	92866		
90631	92685	92803	92835	92867		
90632	92701	92804	92836	92868		
90633	92702	92805	92837	92869		
90680	92703	92806	92838	92870		
90720	92704	92807	92840	92871		
90721	92705	92808	92841	92885		
90740	92706	92809	92842	92886		
90742	92707	92811	92843	92887		
90743	92708	92812	92844	92899		
92605	92710	92814	92845			
92615	92711	92815	92846			
92626	92712	92816	92850			
92627	92725	92817	92856			
92628	92728	92821	92857			
92646	92735	92822	92859			

* denotes partial county

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

You can join CareMore Touch (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 Touch (HMO SNP) unless they are members of our organization and have been since their dialysis began.

If you are a resident of a nursing home you may be eligible to join the plan or if you reside or agree to reside in a nursing home that has a contract with this health plan.

You must live in one of the following facilities to join this plan: Alamitos West Healthcare Center, Alexandria Care Center, Amberwood Convalescent Hospital, Anaheim Healthcare Center, Bay Crest Care Center, Bel Tooren Villa Convalescent Hospital, Brookfield Healthcare Center, Buena Park Nursing Center, Catered Manor Nursing Center, Chandler Convalescent Hospital, Chapman Care Center, Del Amo Gardens Convalescent Center, Del Mar Convalescent Hospital, Downey Care Center, Downey Community Health Center, Ensign Facility Services, French Park Care Center, Garden Park Care Center, Gardena Convalescent Hospital, Hollenbeck Palms, Harbor Villa Care Center, Gordon Lane Convalescent Hospital, Heritage Manor Healthcare, Huntington Park Nursing Center, Imperial Convalescent Hospital, La Habra Convalescent Hospital, Leisure Court Nursing Center, Mission Care & Rehab Center, Mirada Hills Rehabilitation & Convalescent Hospital, Monterey Park Convalescent Hospital, North Walk Villa Convalescent Hospital, Orangegrove Rehabilitation Hospital, Paramount Convalescent Hospital, Park Regency Care Center, Regency Oaks Care Center, Riviera Health Care Center, Rose Villa Healthcare Center, Royal Court Healthcare, Royal Park Skilled Nursing Center, Royalwood Convalescent Hospital, Shoreline Healthcare Center, Southland, Sorenson Convalescent Hospital, St. Edna Sub-Acute & Rehabilitation, Sun Mar Nursing Center, Sunset Manor Convalescent Hospital, Sycamore Park Care Center, The Earlwood, Whittier Hills Health Care Center, Windsor Gardens Care Center of Fullerton, Windsor Gardens Convalescent Center of Anaheim, Windsor Gardens Convalescent Center of Long Beach, Windsor Palms Care Center of Artesia, Woodland Care Center or Woodruff Convalescent Hospital

or

You must require the same amount of care as someone in a nursing home but reside in your home or another community residence to join this plan.

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

CAN I CHOOSE MY DOCTORS?

CareMore Touch (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. For an updated 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 Touch (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 Touch (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

CareMore Touch (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 calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, 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 Touch (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 Touch (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 Touch (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 Touch (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 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 administered 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 “Health and Drug Plans” then “Compare Drug and Health Plans” 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 for more information about CareMore Touch (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 **(800)-589-3147** 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 other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento puede estar disponible en otro formatos, por ejemplo braille, con letra grande o otro alterno formatos.

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

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

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	CareMore Touch (HMO SNP)
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IMPORTANT INFORMATION

<p>① Premium and Other Important Information</p>	<p>In 2011 the monthly Part B Premium was \$96.40 and may change for 2012 and the annual Part B deductible amount was \$162 and may change for 2012.</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>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D 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>In-Network \$3,400 out-of-pocket limit for 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>

SUMMARY OF BENEFITS

INPATIENT CARE

<p>③ Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2011 the amounts for each benefit period were:</p> <ul style="list-style-type: none"> • Days 1 - 60: \$1132 deductible • Days 61 - 90: \$283 per day • Days 91 - 150: \$566 per lifetime reserve day <p>These amounts may change for 2012.</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 No limit to the number of days covered by the plan each hospital stay.</p> <p>\$0 copay</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>In 2011 the amounts for each benefit period were:</p> <ul style="list-style-type: none"> • Days 1 - 60: \$1132 deductible • Days 61 - 90: \$283 per day • Days 91 - 150: \$566 per lifetime reserve day <p>These amounts may change for 2012.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p>	<p>In-Network \$0 copay</p> <p>Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 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 Touch (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 2011 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: \$141.50 per day <p>These amounts may change for 2012.</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 150 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>\$0 copay for SNF services</p>
<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. Your plan will pay for a consultative visit before you select hospice.</p>

Benefit	Original Medicare	CareMore Touch (HMO SNP)
OUTPATIENT CARE		
8 Doctor Office Visits	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$0 copay for the cost of each in-area, network urgent care Medicare-covered visit.</p> <p>\$0 copay for each specialist doctor visit for Medicare-covered benefits.</p>
9 Chiropractic Services	<p>Supplemental 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 \$0 copay for Medicare-covered chiropractic visits</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>
10 Podiatry Services	<p>Supplemental routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered podiatry visits</p> <p>Up to 6 supplemental routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>

Benefit	Original Medicare	CareMore Touch (HMO SNP)
OUTPATIENT CARE (CONTINUED)		
<p>11 Outpatient Mental Health Care</p>	<p>40% coinsurance for most outpatient mental health services</p> <p>Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>“Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered Mental Health visits</p> <p>\$0 copay for Medicare-covered partial hospitalization program services</p>
<p>12 Outpatient Substance Abuse Care</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered visits</p>
<p>13 Outpatient Services/ Surgery</p>	<p>20% coinsurance for the doctor’s services</p> <p>Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>20% coinsurance for ambulatory surgical center facility services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit</p>

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

<p>14 Ambulance Services (medically necessary ambulance services)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$50 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>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's services</p> <p>Specified copayment for outpatient hospital facility emergency services.</p> <p>Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient 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 \$65 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 \$0 copay for Medicare-covered urgently-needed-care visits</p>

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

<p>17 Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered Occupational Therapy visits</p> <p>\$0 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</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 20% of the cost 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 copay for Medicare-covered items</p>
<p>20 Diabetes Programs and Supplies</p>	<p>20% coinsurance for diabetes self-management training</p> <p>20% coinsurance for diabetes supplies</p> <p>20% coinsurance for diabetic therapeutic shoes or inserts</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • Diabetes monitoring supplies • Therapeutic shoes or inserts

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

<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 supplemental 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 • X-rays • diagnostic radiology services (not including X-rays) • therapeutic radiology services
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<p>22 Cardiac and Pulmonary Rehabilitation Services</p>	<p>20% coinsurance Cardiac Rehabilitation services</p> <p>20% coinsurance for Pulmonary Rehabilitation services</p> <p>20% coinsurance for Intensive Cardiac Rehabilitation services</p> <p>This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services
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Benefit	Original Medicare	CareMore Touch (HMO SNP)
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PREVENTIVE SERVICES

23 Preventive Services and Wellness/ Education Programs

No coinsurance, copayment or deductible for the following:

- Abdominal Aortic Aneurysm Screening
- Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.
- Cardiovascular Screening
- Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk.
- Colorectal Cancer Screening
- Diabetes Screening
- Influenza Vaccine
- Hepatitis B Vaccine for people with Medicare who are at risk
- HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor’s visit. 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.
- Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39.
- Medical Nutrition Therapy Services. 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 and may

General

\$0 copay for all preventive services covered under Original Medicare at zero cost sharing:

- Abdominal Aortic Aneurysm screening
- Bone Mass Measurement
- Cardiovascular Screening
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)
- Colorectal Cancer Screening
- Diabetes Screening
- Influenza Vaccine
- Hepatitis B Vaccine
- HIV Screening
- Breast Cancer Screening (Mammogram)
- Medical Nutrition Therapy Services
- Personalized Prevention Plan Services (Annual Wellness Visits)
- Pneumococcal Vaccine
- Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only)
- Smoking Cessation (Counseling to stop smoking)
- Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)

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

<p>23 Preventive Services and Wellness/ Education Programs (continued)</p>	<p>include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p> <ul style="list-style-type: none"> • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. • Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Welcome to Medicare Physical Exam (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. 	<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>Authorization rules may apply.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Additional Smoking Cessation
<p>24 Kidney Disease and Conditions</p>	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for kidney disease education services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for renal dialysis</p> <p>\$0 copay for kidney disease education services</p>

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

25 Outpatient 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

0% to 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) providers.

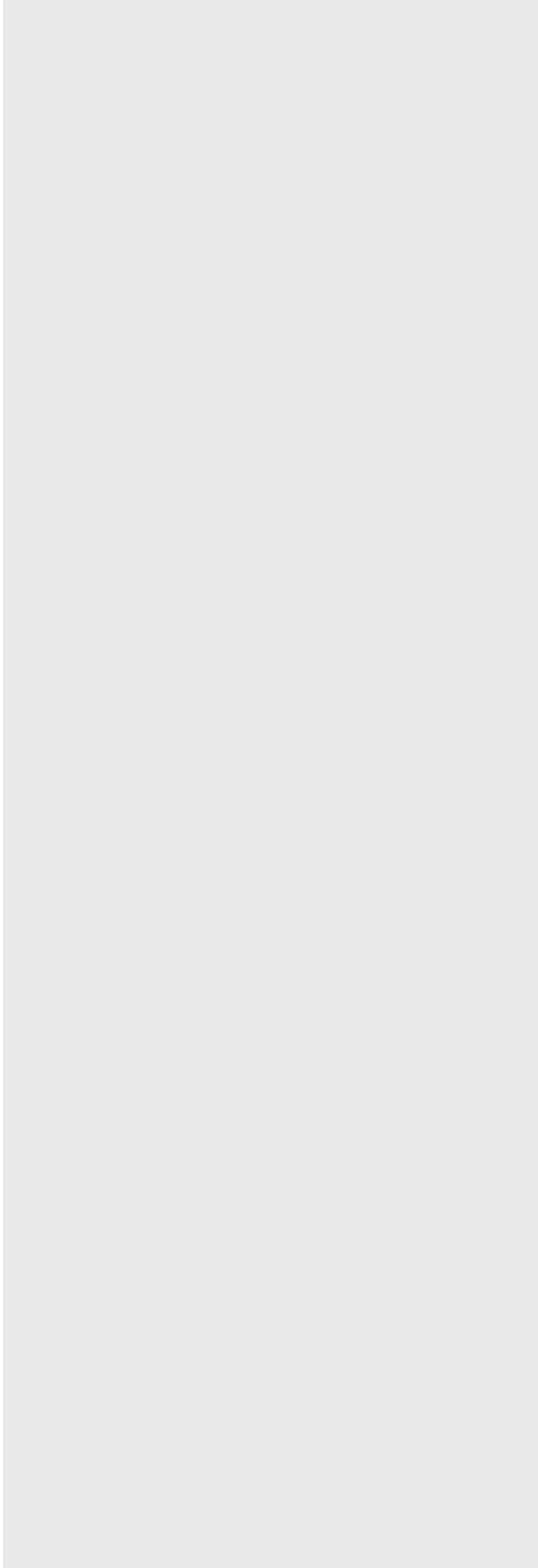
The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance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

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

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

25 Outpatient 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 Touch (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 Touch (HMO SNP) approves the exception, you will pay Tier 4: Non-Preferred Brand Drugs cost sharing for that drug.

In-Network
\$0 deductible.

Initial Coverage
You pay the following:

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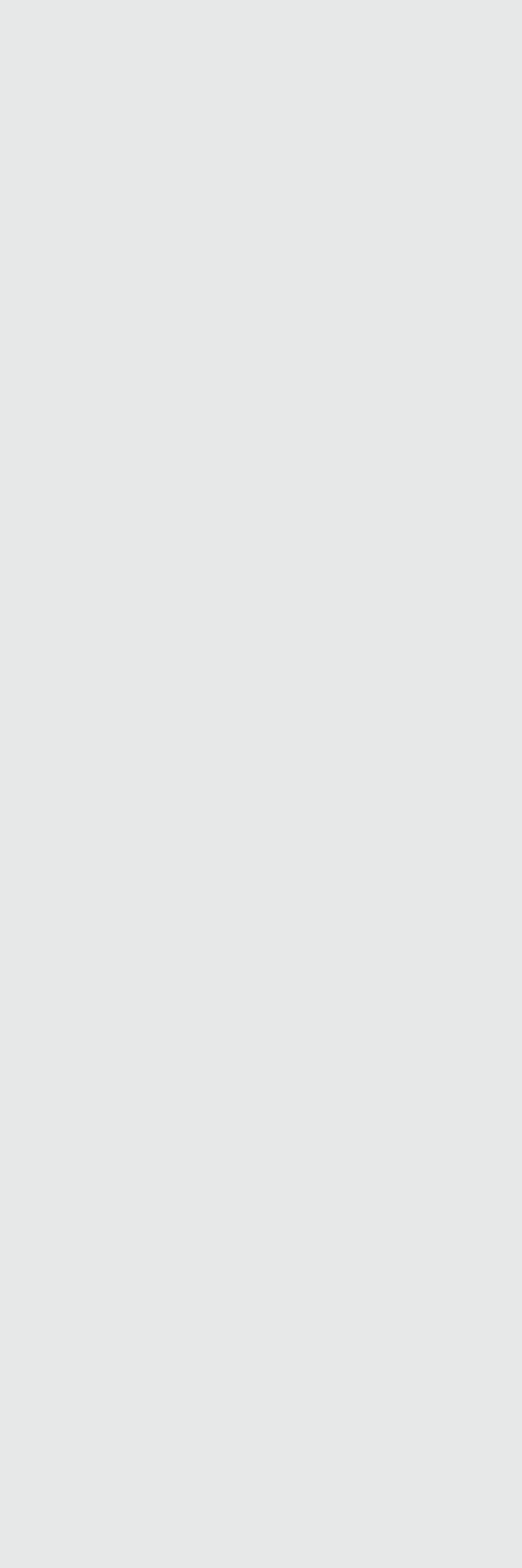
PREVENTIVE SERVICES (CONTINUED)

<p>25 Outpatient Prescription Drugs (continued)</p>		<p>Retail Pharmacy</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 • \$0 copay for a three-month (93-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$25 copay for a one-month (31-day) supply of drugs in this tier • \$75 copay for a three-month (93-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$50 copay for a one-month (31-day) supply of drugs in this tier • \$150 copay for a three-month (93-day) supply of drugs in this tier <p>Tier 5: 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>Tier 6: Select Care Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Long Term Care Pharmacy</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: Non-Preferred 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: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$25 copay for a one-month (31-day) supply of drugs in this tier
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Benefit	Original Medicare	CareMore Touch (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

25 Outpatient Prescription Drugs
(continued)



Tier 4: Non-Preferred Brand Drugs

- \$50 copay for a one-month (31-day) supply of drugs in this tier

Tier 5: Specialty Tier Drugs

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

Tier 6: Select Care Drugs

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

Mail Order

Tier 1: Preferred Generic Drugs

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

Tier 2: Non-Preferred Generic Drugs

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

Tier 3: Preferred Brand Drugs

- \$62.50 copay for a three-month (93-day) supply of drugs in this tier

Tier 4: Non-Preferred Brand Drugs

- \$125 copay for a three-month (93-day) supply of drugs in this tier

Tier 5: Specialty Tier Drugs

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

Tier 6: Select Care Drugs

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

Coverage Gap

The plan covers all formulary drugs through the coverage gap.

Additional Coverage Gap

The plan covers all formulary generics (100% of formulary generic drugs), all formulary brands (100% of formulary brand drugs) through the coverage gap.

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

25 **Outpatient Prescription Drugs**
(continued)

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,700, you pay the following:

Tier 1: Preferred Generic Drugs
• \$0 copay for drugs in this tier

Tier 2: Non-Preferred Generic Drugs
• \$2.60 copay or 5% coinsurance whichever costs more for drugs in this tier

Tier 3: Preferred Brand Drugs
• \$6.50 copay or 5% coinsurance whichever costs more for drugs in this tier

Tier 4: Non-Preferred Brand Drugs
• \$6.50 copay or 5% coinsurance whichever costs more for drugs in this tier

Tier 5: Specialty Tier Drugs
• \$6.50 copay or 5% coinsurance whichever costs more for drugs in this tier

Tier 6: Select Care Drugs
• \$0 copay for drugs in this tier

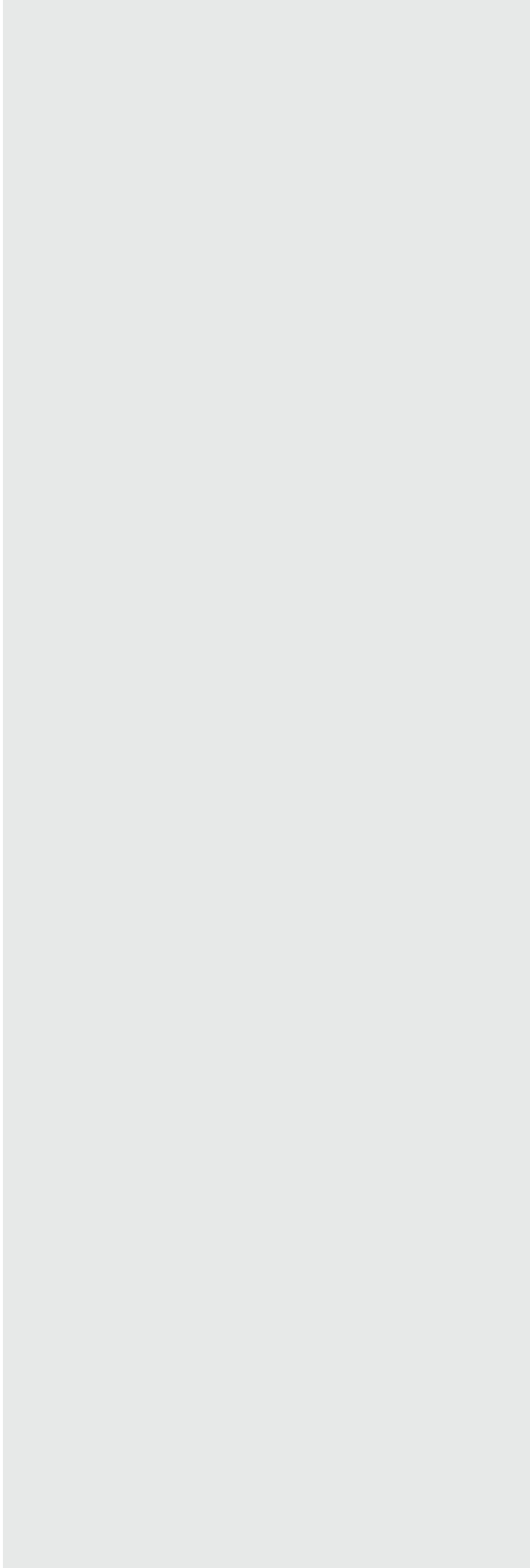
Out-of-Network

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 Touch (HMO SNP).

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

25 **Outpatient Prescription Drugs**
(continued)



Out-of-Network Initial Coverage

You pay the following:

Tier 1: Preferred Generic Drugs

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

Tier 2: Non-Preferred Generic Drugs

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

Tier 3: Preferred Brand Drugs

- \$25 copay for a one-month (31-day) supply of drugs in this tier

Tier 4: Non-Preferred Brand Drugs

- \$50 copay for a one-month (31-day) supply of drugs in this tier

Tier 5: Specialty Tier Drugs

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

Tier 6: Select Care Drugs

- \$0 copay for a one-month (31-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 Coverage Gap

The plan covers all formulary drugs through the gap.

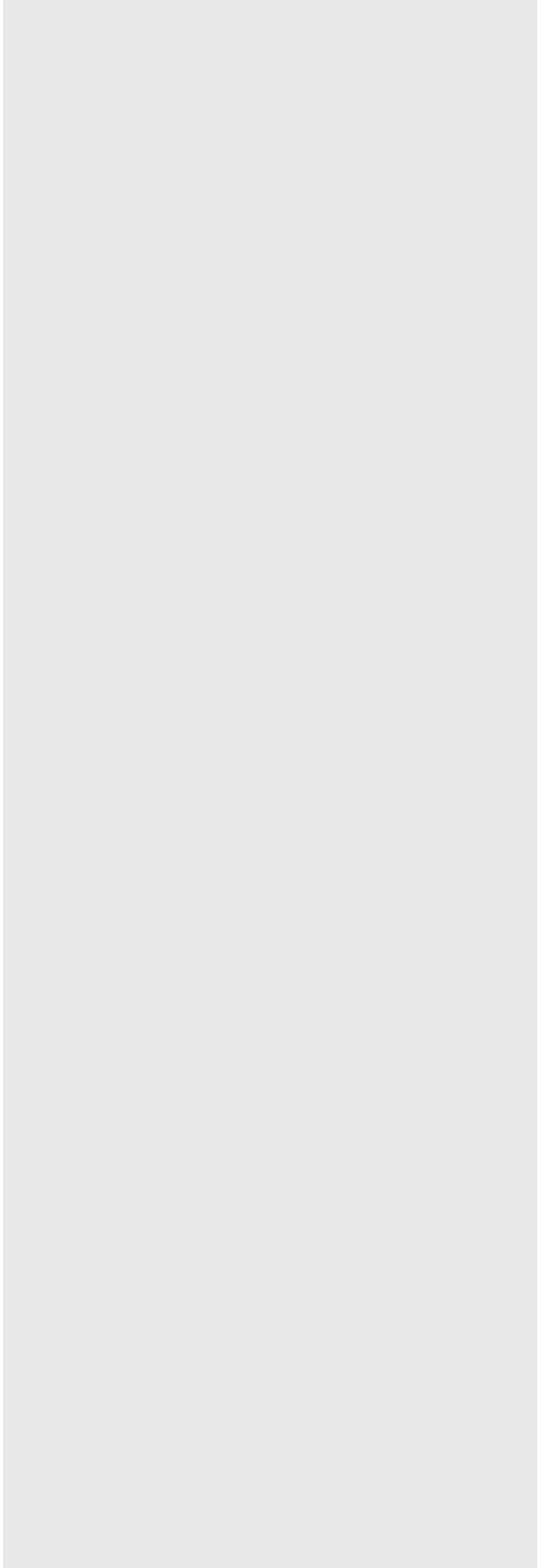
Additional Out-of-Network Coverage Gap

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

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

25 **Outpatient Prescription Drugs**
(continued)



Out-of-Network Catastrophic Coverage
After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus the following:

Tier 1: Preferred Generic Drugs

- \$0 copay for drugs in this tier

Tier 2: Non-Preferred Generic Drugs

- \$2.60 copay or 5% coinsurance whichever costs more for drugs in this tier

Tier 3: Preferred Brand Drugs

- \$6.50 copay or 5% coinsurance whichever costs more for drugs in this tier

Tier 4: Non-Preferred Brand Drugs

- \$6.50 copay or 5% coinsurance whichever costs more for drugs in this tier

Tier 5: Specialty Tier Drugs

- \$6.50 copay or 5% coinsurance whichever costs more for drugs in this tier

Tier 6: Select Care Drugs

- \$0 copay for 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	Original Medicare	CareMore Touch (HMO SNP)
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PREVENTIVE SERVICES (CONTINUED)

<p>26 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.”) \$0 copay for Medicare-covered dental benefits</p>
<p>27 Hearing Services</p>	<p>Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network \$0 copay for Medicare-covered diagnostic hearing exams \$0 copay for <ul style="list-style-type: none"> • up to 1 supplemental routine hearing exam(s) every year • up to 1 fitting-evaluation(s) for a hearing aid every year \$0 copay for hearing aids. \$1,500 plan coverage limit for hearing aids every two years.</p>
<p>28 Vision Services</p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental 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.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for diagnosis and treatment for diseases and conditions of the eye <ul style="list-style-type: none"> • and up to 1 supplemental routine eye exam(s) every year • \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery. • \$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 </p>

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

<p>28 Vision Services (continued)</p>		<p>\$100 plan coverage limit for eye glasses (lenses and frames) every two years.</p> <p>\$125 plan coverage limit for contact lenses every year.</p> <p>\$100 plan coverage limit for eye glass frames every two years.</p>
<p>Over-the-Counter Items</p>	<p>Not covered.</p>	<p>General Please visit our plan website to see our list of covered Over-the-Counter items. OTC items may be purchased only for the enrollee. Please contact the plan for specific instructions for using this benefit.</p>
<p>Transportation (Routine)</p>	<p>Not covered.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for up to 12 one-way trip(s) to plan-approved location every year</p>
<p>Acupuncture</p>	<p>Not covered.</p>	<p>In-Network This plan does not cover Acupuncture.</p>

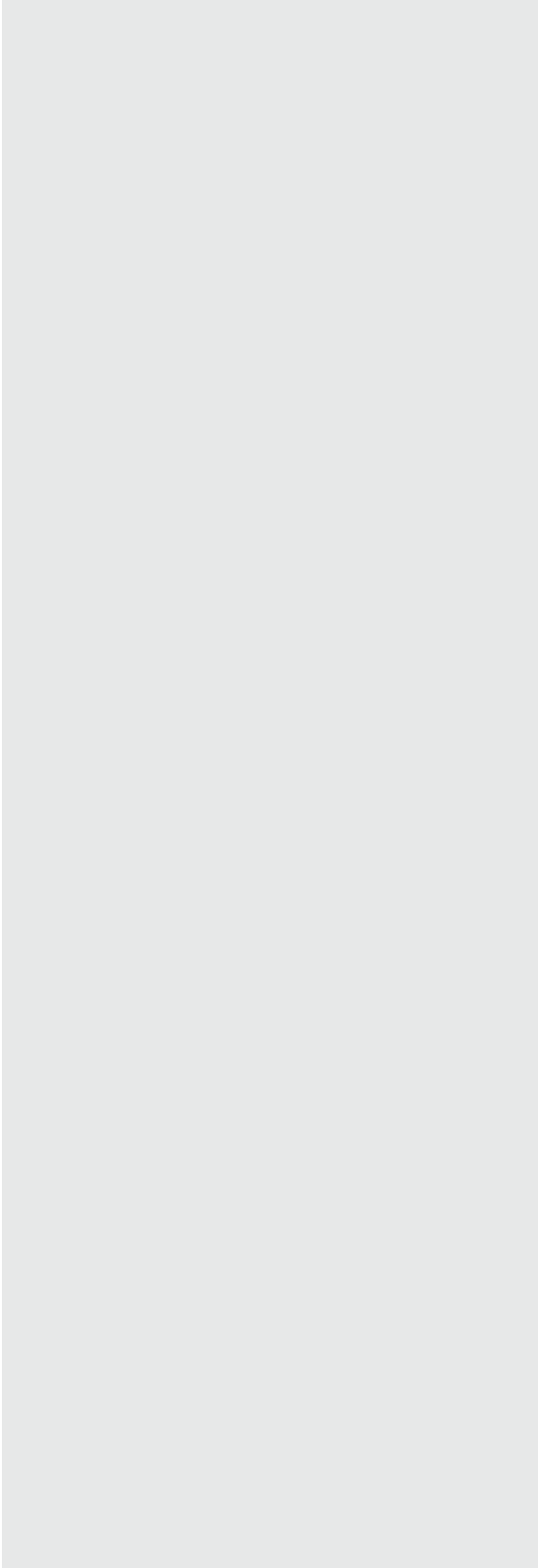
OPTIONAL SUPPLEMENTAL PACKAGE #1

<p>Premium and Other Important Information</p>		<p>General Package: 1 - Optional Dental:</p> <p>\$15.20 monthly premium, in addition to your \$0 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
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Benefit	Original Medicare	CareMore Touch (HMO SNP)
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OPTIONAL SUPPLEMENTAL PACKAGE #1 (CONTINUED)

Dental Services



General
 Plan offers additional comprehensive dental benefits.

In-Network

- \$5 copay for up to 2 cleaning(s) every year
- \$5 copay for up to 2 fluoride treatment(s) every year
- \$5 to \$10 copay for oral exams
- \$5 copay for up to 1 dental x-ray(s) every three years