



## **SUMMARY OF BENEFITS**

# **Sierra Spectrum PPO**

H2905-001

CMS Approval Date: 11/2009 Material ID: H2905\_001\_41NVSHL09243R

## **Introduction to the Summary of Benefits for Sierra Spectrum (PPO)**

**January 1, 2010 – December 31, 2010  
Washington County, UT**

Thank you for your interest in Sierra Spectrum (PPO). Our plan is offered by SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Sierra Spectrum (PPO) 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 Sierra Spectrum (PPO). You may have other options, too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call Sierra Spectrum (PPO) 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 Sierra Spectrum (PPO) 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 Sierra Spectrum (PPO) Available?**

The service area for this plan includes: Washington County, UT. You must live in this area to join the plan.

### **Who is Eligible to Join Sierra Spectrum (PPO)?**

You can join Sierra Spectrum (PPO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Sierra Spectrum (PPO) unless they are members of our organization and have been since their dialysis began.

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### **Can I Choose My Doctors?**

Sierra Spectrum (PPO) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside 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.sierraspectrumppo.com](http://www.sierraspectrumppo.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?**

You can go to doctors, specialists, or hospitals in or out-of-network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out-of-network. For more information, please call the customer service number at the end of this introduction.

### **Does My Plan Cover Medicare Part B or Part D Drugs?**

Sierra Spectrum (PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

### **Where Can I Get My Prescriptions If I Join This Plan?**

Sierra Spectrum (PPO) 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.sierraspectrumppo.com](http://www.sierraspectrumppo.com). Our customer service number is listed at the end of this introduction.

### **What Is A Prescription Drug Formulary?**

Sierra Spectrum (PPO) 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 <http://www.sierraspectrumppo.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.

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### **How Can I Get Extra Help With Prescription Drug Plan Costs?**

You may be able to get extra help to pay for your prescription drug premium and 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;
- 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 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Sierra Spectrum (PPO), 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, Health Insight, (801) 892-0155 or Toll Free (800) 748-6773.

As a member of Sierra Spectrum (PPO), 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

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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, Health Insight, (801) 892-0155 or Toll Free (800) 748-6773.

### **What is a Medication Therapy Management (MTM) Program?**

A Medication Therapy Management (MTM) Program is a free service we may 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 Sierra Spectrum (PPO) 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 Sierra Spectrum (PPO) 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.

### **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](http://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 at (877) 559-4512 to obtain a copy of the plan ratings for this plan. TTY users call (800) 349-3538.

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Please call Sierra Health and Life Insurance Company, Inc. for more information about .  
Sierra Spectrum (PPO).

Visit us at [www.sierraspectrumppo.com](http://www.sierraspectrumppo.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 (877) 559-4512 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program.  
(TTY/TDD (800) 349-3538)

Prospective members should call toll-free (800) 274-6648 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program.  
(TTY/TDD (800) 349-3538)

Current members should call locally (702) 562-8021 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program.  
(TTY/TDD (702) 242-9214)

Prospective members should call locally (702) 821-2300 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program.  
(TTY/TDD (702) 242-9214)

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](http://www.medicare.gov) on the web.

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 Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
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<b>IMPORTANT INFORMATION</b>		
<p>1-Premium and Other Important Information</p>	<p>In 2010 the monthly Part B Premium is \$96.40 and the yearly Part B deductible amount is \$155.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, 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 Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p><b>General</b> \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p><b>In Network</b> \$3,350 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services: Medicare Services: -Doctor Office Visits -Chiropractic Services -Podiatry Services -Outpatient Mental Health Care -Outpatient Substance Abuse Care -Dental Services -Hearing Services -Vision Services -Other Health Care Professional</p> <p>This limit includes only Medicare-covered services.</p> <p><b>Out-of-Network</b> \$3,350 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services: Medicare Services: -Doctor Office Visits -Chiropractic Services -Podiatry Services -Outpatient Mental Health Care -Outpatient Substance Abuse Care -Dental Services -Hearing Services -Vision Services -Other Health Care Professional</p> <p>This limit includes only Medicare-covered services</p>
<p>2-Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists, and hospitals.</p>

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
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<b>SUMMARY OF BENEFITS</b>		
<b>INPATIENT CARE</b>		
<p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2010 the amounts for each benefit period<sup>(3)</sup> are:            Days 1 - 60: \$1100 deductible            Days 61 - 90: \$275 per day            Days 91 - 150: \$550 per lifetime reserve day.<sup>(4)</sup></p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.<sup>(4)</sup></p>	<p><b>In-Network</b>            For Medicare-covered hospital stays:            Days 1 - 20: \$175 copay per day            Days 21 - 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>Out-of-Network</b>            For hospital stays:            Days 1 - 15: \$225 copay per day            Days 16 and beyond: \$0 copay per day</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><b>In-Network</b>            For Medicare-covered hospital stays:            Days 1 - 11: \$175 copay per day            Days 12 - 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</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> <p><b>Out-of-Network</b>            For hospital stays:            Days 1 - 15: \$225 copay per day            Days 16 and beyond: \$0 copay per day</p>

<sup>3</sup> 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.

<sup>4</sup> Lifetime reserve days can only be used once.

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<p>5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>In 2010 the amounts for each benefit period<sup>(3)</sup> after at least a 3-day covered hospital stay are:  Days 1 - 20: \$0 per day  Days 21 - 100: \$137.50 per day</p> <p>100 days for each benefit period.<sup>(3)</sup></p>	<p><b>General</b>  Authorization rules may apply.</p> <p><b>In-Network</b>  For SNF stays:  Days 1 - 10: \$0 copay per day.  Days 11 - 40: \$50 copay per day.  Days 41 – 100: \$0 copay per day.</p> <p>Plan covers up to 100 days each benefit period.</p> <p>3-day prior hospital stay is required.</p> <p><b>Out-of-Network</b>  40% of the cost for each SNF stay.</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><b>General</b>  Authorization rules may apply.</p> <p><b>In-Network</b>  \$0 copay for Medicare-covered home health visits.</p> <p><b>Out-of-Network</b>  40% for 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><b>General</b>  You must get care from a Medicare-certified hospice.</p>

<sup>3</sup> 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.

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Benefit Category	Original Medicare	Sierra Spectrum (PPO)
<b>OUTPATIENT CARE</b>		
8 - Doctor Office Visits	20% coinsurance. <sup>(1)(2)</sup>	<p><b>General</b> See "Physical Exams," for more information.</p> <p>Authorization rules may apply.</p> <p><b>In-Network</b> \$5 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p> <p><b>Out-of-Network</b> \$10 copay for each primary care doctor visit.</p> <p>\$30 copay for each specialist visit.</p>
9 - Chiropractic Services	<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.<sup>(1)(2)</sup></p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$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><b>Out-of-Network</b> \$30 copay for chiropractic benefits.</p>

<sup>1</sup> Each year, you pay a total of one \$155 deductible.

<sup>2</sup> If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
10 - Podiatry Services	<p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.<sup>(1)(2)</sup></p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$25 copay for each Medicare-covered visit.</p> <p>\$25 copay for up to 6 routine visits every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p><b>Out-of-Network</b> \$30 copay for podiatry benefits.</p> <p>(See page 27 for additional information about Podiatry Services.)</p>
11 - Outpatient Mental Health Care	<p>45% coinsurance for most outpatient mental health services.<sup>(1)(2)</sup></p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$25 copay for each Medicare-covered individual or group therapy visit.</p> <p><b>Out-of-Network</b> \$30 copay for Mental Health benefits.</p> <p>\$30 copay for Mental Health benefits with a psychiatrist.</p>
12 - Outpatient Substance Abuse Care	<p>20% coinsurance.<sup>(1)(2)</sup></p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$25 copay for Medicare-covered individual or group visits.</p> <p><b>Out-of-Network</b> \$30 copay for outpatient substance abuse benefits</p>

<sup>1</sup> Each year, you pay a total of one \$155 deductible.

<sup>2</sup> If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
13 - Outpatient Services/Surgery	<p>20% coinsurance for the doctor.<sup>(1)(2)</sup></p> <p>20% of outpatient facility charges.<sup>(1)(2)</sup></p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$150 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$150 copay for each Medicare-covered outpatient hospital facility visit.</p> <p><b>Out-of-Network</b> 20% of the cost for ambulatory surgical center benefits.</p> <p>20% of the cost for outpatient hospital facility benefits.</p>
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance. <sup>(1)(2)</sup>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$100 copay for Medicare-covered ambulance benefits.</p> <p><b>Out-of-Network</b> \$100 copay (or 40% of the cost) for ambulance benefits.</p> <p>(See pages 27-28 for additional information about Ambulance Services)</p>
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	<p>20% coinsurance for the doctor.<sup>(1)(2)</sup></p> <p>20% of facility charge, or a set copay per emergency room visit.<sup>(1)(2)</sup></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.<sup>(1)(2)</sup></p>	<p><b>General</b> \$50 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p>

<sup>1</sup> Each year, you pay a total of one \$155 deductible.

<sup>2</sup> If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
	NOT covered outside the U.S. except under limited circumstances.	
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay. <sup>(1)(2)</sup>  NOT covered outside the U.S. except under limited circumstances.	<b>General</b> \$30 copay for Medicare-covered urgently needed care visits.
17 - Outpatient Rehabilitation Services. (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance. <sup>(1)(2)</sup>	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$25 copay for Medicare-covered Occupational Therapy visits.  \$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.  <b>Out-of-Network</b> \$30 copay for Occupational Therapy benefits.  \$30 copay for Physical and/or Speech/Language Therapy visits.
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>		
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance. <sup>(1)(2)</sup>	<b>General</b> Authorization rules may apply.  <b>In-Network</b> 20% of the cost for Medicare-covered items.  <b>Out-of-Network</b> 30% of the cost for durable medical equipment.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance. <sup>(1)(2)</sup>	<b>General</b> Authorization rules may apply.  <b>In-Network</b> 20% of the cost for Medicare-covered

<sup>1</sup> Each year, you pay a total of one \$155 deductible.

<sup>2</sup> If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

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Benefit Category	Original Medicare	Sierra Spectrum (PPO)
		<p>items.</p> <p><b>Out-of-Network</b> 30% of the cost for prosthetic devices.</p>
<p>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance. <sup>(1)(2)</sup></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><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$25 copay for Diabetes self-monitoring training. \$5 to \$25 copay for Nutrition Therapy for Diabetes. 0% to 20% of the cost for Diabetes supplies.</p> <p><b>Out-of-Network</b> \$30 copay for Diabetes self-monitoring training. 30% of the cost for Diabetes supplies. \$10 to \$30 copay for Nutrition Therapy for Diabetes.</p> <p>(See page 28 for additional information about Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies.)</p>

<sup>1</sup> Each year, you pay a total of one \$155 deductible.

<sup>2</sup> If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
<p>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>20% coinsurance for diagnostic tests and x-rays.<sup>(1)(2)</sup></p> <p>\$0 copay for Medicare-covered lab services.<sup>(1)(2)</sup></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><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$10 copay for Medicare-covered lab services.</p> <p>\$15 copay for Medicare-covered diagnostic procedures and tests.</p> <p>\$15 copay for Medicare-covered x-rays.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p> <p><b>Out-of-Network</b> 30% of the cost for diagnostic procedures, tests, and lab services.</p> <p>30% of the cost for therapeutic radiology services.</p> <p>30% of the cost for outpatient x-rays.</p> <p>30% of the cost for diagnostic radiology services.</p>

<b>PREVENTIVE SERVICES</b>		
<p>22 - Bone Mass Measurement (for people with Medicare who are at risk)</p>	<p>20% coinsurance.<sup>(1)(2)</sup></p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement.</p> <p><b>Out-of-Network</b> \$30 copay for Medicare-covered bone mass measurement.</p>

<sup>1</sup> Each year, you pay a total of one \$155 deductible.

<sup>2</sup> If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance. <sup>(1)(2)</sup>  Covered when you are high risk or when you are age 50 and older.	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$5 to \$150 copay (or 20% of the cost) for Medicare-covered colorectal screenings.</p> <p>Separate Office Visit cost sharing of \$5 copay may apply.</p> <p><b>Out-of-Network</b> \$10 to \$30 copay (or 20% to 30% of the cost) for colorectal screenings.</p> <p>(See page 29 for additional information about Colorectal Screening Exams.)</p>
24 – Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	<p>\$0 copay for Flu and Pneumonia vaccines.<sup>(1)(2)</sup></p> <p>20% coinsurance for Hepatitis B vaccine.<sup>(1)(2)</sup></p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p><b>In-Network</b> \$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><b>Out-of-Network</b> \$30 copay for immunizations.</p> <p>(See page 29 for additional information about Immunizations.)</p>
25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance. <sup>(1)(2)</sup>  No referral needed.  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><b>In-Network</b> \$0 copay for Medicare-covered screening mammograms.</p> <p><b>Out-of-Network</b> \$30 copay for screening mammograms.</p>

<sup>1</sup> Each year, you pay a total of one \$155 deductible.

<sup>2</sup> If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
26 - Pap Smears and Pelvic Exams (for women with Medicare)	<p>\$0 copay for Pap smears.</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.<sup>(2)</sup></p> <p>20% coinsurance for Pelvic exams.<sup>(2)</sup></p>	<p><b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p><b>Out-of-Network</b> \$30 copay for pap smears and pelvic exams.</p>
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	<p>20% coinsurance for the digital rectal exam.<sup>(2)</sup></p> <p>\$0 for the PSA test; 20% coinsurance for other related services.<sup>(2)</sup></p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered prostate cancer screening.</p> <p><b>Out-of-Network</b> \$30 copay for prostate cancer screening.</p>
28 - End-Stage Renal Disease	<p>20% coinsurance for renal dialysis.<sup>(1)(2)</sup></p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease.<sup>(1)(2)</sup></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><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 20% of the cost for renal dialysis. \$5 to \$25 copay for Nutrition Therapy for End-Stage Renal Disease.</p> <p><b>Out-of-Network</b> 20% of the cost for renal dialysis \$10 to \$30 copay for Nutrition Therapy for End-Stage Renal Disease.</p> <p>(See pages 28 &amp; 29 for additional information about End Stage Renal Disease.)</p>

<sup>1</sup> Each year, you pay a total of one \$155 deductible.

<sup>2</sup> If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
29 - Prescription Drugs	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b>            20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>20% of the cost for Part B drugs out-of-network.</p> <p><b>Drugs covered under Medicare Part D</b></p> <p><b>General</b>            This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.sierraspectrumppo.com">www.sierraspectrumppo.com</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>● have limited incomes.</li> <li>● live in long term care facilities, or</li> <li>● have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details.</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p>

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
		<p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Sierra Spectrum (PPO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Sierra Spectrum (PPO) approves the exception, you will pay Non-Preferred cost sharing for that drug.</p> <p><b>In Network</b> \$0 deductible.</p> <p><b>Initial Coverage</b> You pay the following until total yearly drug costs reach \$2,830:</p> <p><b>Retail Pharmacy</b> Preferred Generic/Some Brand Maintenance</p> <ul style="list-style-type: none"> <li>• \$10 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$30 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Preferred Brand</p> <ul style="list-style-type: none"> <li>• \$40 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$120 copay for a three-month (90-day) supply of drugs in this tier</li> </ul>

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
		<p>Non-Preferred</p> <ul style="list-style-type: none"> <li>• \$85 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Specialty</p> <ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>• 33% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Long Term Care Pharmacy</b> Preferred Generic/Some Brand Maintenance</p> <ul style="list-style-type: none"> <li>• \$10 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <p>Preferred Brand</p> <ul style="list-style-type: none"> <li>• \$40 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>• \$85 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <p>Specialty</p> <ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (31-day) supply of drugs in this tier</li> </ul> <p><b>Mail Order Pharmacy</b> Preferred Generic/Some Brand Maintenance</p> <ul style="list-style-type: none"> <li>• \$20 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Preferred Brand</p> <ul style="list-style-type: none"> <li>• \$80 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Specialty</p> <ul style="list-style-type: none"> <li>• 33% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Coverage Gap</b> The plan covers many generics (65%-99% of formulary generic drugs) and few brands (less than 10% of formulary</p>

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
		<p>brand drugs) through the coverage gap. You pay the following:</p> <p><b>Retail Pharmacy</b> Preferred Generic/Some Brand Maintenance</p> <ul style="list-style-type: none"> <li>• \$10 copay for a one-month (30-day) supply of all drugs in this tier</li> <li>• \$30 copay for a three-month (90-day) supply of all drugs in this tier</li> </ul> <p><b>Long Term Care Pharmacy</b> Preferred Generic/Some Brand Maintenance</p> <ul style="list-style-type: none"> <li>• \$10 copay for a one-month (31-day) supply of all drugs covered in this tier</li> </ul> <p><b>Mail Order Pharmacy</b> Preferred Generic/Some Brand Maintenance</p> <ul style="list-style-type: none"> <li>• \$20 copay for a three-month (90-day) supply of all drugs covered in this tier</li> </ul> <p>For all other covered drugs, after your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach \$4,550 you pay the greater of a:</p> <ul style="list-style-type: none"> <li>• \$2.50 copay for generic (including brand drugs treated as generic) and a</li> <li>• \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance.</li> </ul> <p><b>Out-of-Network</b></p> <p>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</p>

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
		<p>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 Sierra Spectrum (PPO).</p> <p><b>Out-of-Network Initial Coverage</b></p> <p>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830:</p> <p>Preferred Generic/Some Brand Maintenance</p> <ul style="list-style-type: none"> <li>• \$10 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Preferred Brand</p> <ul style="list-style-type: none"> <li>• \$40 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>• \$85 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Specialty</p> <ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul> <p><b>Out-of-Network Coverage Gap</b></p> <p>You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p>Preferred Generic/Some Brand Maintenance</p> <ul style="list-style-type: none"> <li>• \$10 copay for a one-month (30-day) supply of all drugs covered in this tier</li> </ul> <p>Preferred Brand</p> <p>After your total yearly drug costs reach \$2,830, you pay 100% of the</p>

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
		<p>pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Sierra Spectrum (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Sierra Spectrum (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Non-Preferred</p> <p>After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Sierra Spectrum (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Sierra Spectrum (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Specialty</p> <p>After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Sierra Spectrum (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Sierra Spectrum (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
		<p><b>Out-of-Network Catastrophic Coverage</b></p> <p>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 the following:</p> <ul style="list-style-type: none"> <li>• A \$2.50 copay for generic (including brand drugs treated as generic) and</li> <li>• \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance.</li> </ul> <p>(See page 29-30 for additional information about Prescription Drugs.)</p>
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$25 copay for Medicare-covered dental benefits.</p> <p><b>Out-of-Network</b> \$30 copay for comprehensive dental benefits.</p>
31 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.<sup>(1) (2)</sup></p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> In general, routine hearing exams and hearing aids not covered.</p> <p>\$25 copay for Medicare-covered diagnostic hearing exams.</p> <p><b>Out-of-Network</b> \$30 copay for hearing exams.</p>

<sup>1</sup> Each year, you pay a total of one \$155 deductible.

<sup>2</sup> If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about this plan's benefits or costs, please contact Member Services.

Benefit Category	Original Medicare	Sierra Spectrum (PPO)
32 - Vision Services	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. <sup>(1)(2)</sup></p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. <sup>(1)(2)</sup></p> <p>Annual glaucoma screenings covered for people at risk. <sup>(1)(2)</sup></p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> Non-Medicare-covered eye exams and glasses not covered.</p> <p>20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>\$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p><b>Out-of-Network</b> \$30 copay for eye exams. 40% of the cost for eye wear.</p>
33 - Physical Exams	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. <sup>(1)(2)</sup></p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><b>In-Network</b> \$0 copay for routine exams.</p> <p>Limited to 1 exam every year.</p> <p><b>Out-of-Network</b> \$30 copay for routine exams.</p>
34 - Health/Wellness Education	<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><b>In-Network</b> The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletters</li> <li>- Nursing Hotline</li> </ul> <p>\$5 to \$25 copay for each Medicare-covered smoking cessation counseling session.</p>

<sup>1</sup> Each year, you pay a total of one \$155 deductible.

<sup>2</sup> If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about this plan's benefits or costs, please contact Member Services.

<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Sierra Spectrum (PPO)</b>
		<p><b>Out-of-Network</b>                      \$0 to \$30 copay for Health and Wellness services.</p> <p>(See page 30 for additional information about Health/Wellness Education.)</p>
Transportation (Routine)	Not covered.	<p><b>In-Network</b>                      This plan does not cover routine transportation.</p>
Acupuncture	Not covered.	<p><b>In-Network</b>                      This plan does not cover Acupuncture.</p>

If you have any questions about this plan's benefits or costs, please contact Member Services.

## The Advantages of Being a Sierra Spectrum (PPO) Member

### Your Very Own Personal Assistant Team

When you have questions or concerns about your plan or benefits, call our Member Services Department. You will be connected to a Personal Assistant. He or she can find answers to your claims questions, help you select a physician, assist with community resources, and assist you in any way they can with your Sierra Spectrum (PPO) benefits and services.

You can call your Personal Assistant at (702) 562-8021 or (877) 559-4512 (TTY/TDD: (702) 242-9214 or (800) 349-3538):

- From November 15, 2009 through March 1, 2010, 7 days/week from 8am to 8pm
- From March 2, 2010 through November 14, 2010 - Monday through Friday from 8am to 8pm

Calls on Saturday, Sunday and holidays will be received by our automated phone system (where you can leave a detailed message, and a representative will return your call as soon as possible).

Si usted habla español y necesita asistencia con esta forma o tiene alguna pregunta acerca de su cobertura con Sierra Spectrum tenemos representantes disponibles para asistirle. Puede llamarnos al servicio del cliente de Sierra Spectrum al (702) 562-8021 o (877) 559-4512 (TTY/TDD: (702) 242-9214 o (800) 349-3538):

- De noviembre 15, 2009 hasta marzo 1, 2010 - 7 días de la semana de 8:00am-8:00pm.
- Comenzando en marzo 2, 2010 hasta noviembre 14, 2010 - lunes a viernes de 8:00am-8:00pm.

Llamadas recibidas los sábados, domingos y los días festivos serán contestadas por nuestro sistema de teléfono automatizado (donde usted podrá dejar un mensaje detallado, y un representante le regresará su llamada lo más pronto posible.)

### Additional Information

#### Premium & Other Important Information

All office visit cost-sharing is excluded from the annual Out-of-Pocket Maximum.

#### Podiatry

- Routine Podiatry - Treatment of the foot which is generally considered preventative, i.e. cutting or removal of corns, warts, calluses or nails. Up to 6 podiatry visits per year are allowed for routine foot care.
- Non-routine podiatry - Medicare-covered, medically necessary treatment of the foot and foot conditions.

#### Ambulance Services

In-Network:

- \$100 for a one-way ambulance trip

If you have any questions about this plan's benefits or costs, please contact Member Services.

Out-of-Network:

- \$100 or 40% of the cost, whichever is greater, for a one-way ambulance trip

No authorization is required for emergency transport. However, Medicare-covered, non-emergency transport requires an authorization.

### **Medical Supplies**

There should be no cost for medical supplies routinely used in the course of an office visit (such as bandages, cotton swabs, etc.) However, there is a 20% coinsurance for supplies for which an appropriate separate charge is made for services by a network provider, and a 30% coinsurance for these supplies for services by an out-of-network provider. An example of this type of medical supply would be chemical agents used in certain diagnostic procedures.

### **Diabetes Self-Monitoring Training and Supplies**

- Diabetes self-monitoring training (this is Medicare-covered training to help you understand what diabetes is and how to manage it)
  - \$25 copay for in-network
  - \$30 copay for out-of-network.
- Part B diabetic supplies (Part B diabetic supplies include test strips/agents, lancets/lancet devices and glucose solutions.)
  - \$0 copay/Part B diabetic supplies obtained through the Plan's DME mail order vendor for up to a 90-day supply.
  - 20% of the cost/Part B diabetic supplies purchased at a plan retail pharmacy for a 30-day supply.
  - 30% of the cost/Part B diabetic supplies when purchased from an out-of-network pharmacy.
- Blood sugar (glucose) monitors (this is DME available through the Plan's DME vendor)
  - 20% coinsurance from the plan's DME vendor
  - 30% coinsurance when purchased out-of-network
- Part D diabetic supplies (Part D diabetic supplies include insulin, syringes, needles, alcohol swabs and gauze. Part D diabetic supplies are available from network pharmacies and the plan's Part D pharmacy mail order vendor.)
  - \$10/preferred generic 30-day supply from a network pharmacy
  - \$40/preferred brand-name 30-day supply from a network pharmacy
  - \$20/preferred generic 90-day supply from the plan's mail order vendor
  - \$80/preferred brand-name 90-day supply from the plan's mail order vendor

If you need assistance with ordering Part D diabetic supplies via mail order, please call your Personal Assistant before ordering and they will be glad to help.

### **Nutrition Training for people with End-Stage Renal Disease (ESRD) or Diabetes**

In-Network:

- \$5 copay/PCP.
- \$25 copay/specialist.

If you have any questions about this plan's benefits or costs, please contact Member Services.

Out-of-Network:

- \$10 copay/PCP.
- \$30 copay/specialist.

### **Colorectal Screening Exams**

- In-Network:
  - Colonoscopy/Sigmoidoscopy: \$5 PCP/\$25 Specialist
  - Barium enema: 20% of the cost
  - Fecal occult lab test: \$10 copay
  - Facility fee:
    - \$150 Outpatient Hospital or Ambulatory Surgical Center
- Out-of-Network:
  - Colonoscopy/Sigmoidoscopy: \$10 PCP/\$30 Specialist
  - Barium enema: 30% of the cost
  - Fecal occult lab test: 30% of the cost
  - Facility fee:
    - 20% coinsurance for Outpatient Hospital or Ambulatory Surgical Center

### **Immunizations**

In-Network:

- \$0 copay for Flu and Pneumonia vaccines.
- \$0 copay for Hepatitis B vaccine.

Out-of-Network:

- \$30 copay for immunizations.

Out-of-network cost-sharing does not apply to seasonal flu shots or pneumococcal vaccinations.

### **End-Stage Renal Disease:**

In-Network and Out-of-Network

- 20% of the cost for dialysis

Out of area renal dialysis services do not require prior authorization. However, if you are traveling out of the service area or on vacation and will need renal dialysis services, we recommend that you call your Personal Assistant to help you with your health care arrangements and to assist the plan in monitoring your care.

### **Prescription Drugs**

Generally, drugs obtained at an out-of-network pharmacy are not covered. In rare circumstances, drugs *may* be covered, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement. Please refer to your Evidence of Coverage for more information.

There is a \$0 deductible for Part D Prescription Drugs.

If you have any questions about this plan's benefits or costs, please contact Member Services.

#### Initial Coverage:

- Preferred Generic/Some Brand Maintenance drugs (This tier includes all preferred generics on our formulary and certain brand name maintenance drugs):
  - \$10/30-day supply from a network pharmacy
  - \$30/90-day supply from a network pharmacy
  - \$20/90-day supply from the Plan's mail order vendor
- Preferred Brand drugs:
  - \$40/30-day supply from a network pharmacy
  - \$120/90-day supply from a network pharmacy
  - \$80/90-day supply from the Plan's mail order vendor
- Non-Preferred drugs:
  - \$85/30-day supply from a network pharmacy
- Specialty Drugs:
  - 33% coinsurance (regardless of the supply or whether they were obtained from a network pharmacy or the Plan's mail order vendor). Examples of Specialty drugs include Copaxone, Rebif, Humira, Enbrel, Tarceva, and Neupogen.

Coverage Gap (this is the period between when your drug costs reach \$2,830 and when they reach \$4,550, the catastrophic coverage level):

- When your total yearly drug costs reach \$2,830, the plan will cover all drugs in the following drug tier:
  - Preferred Generic/Some Brand Maintenance

There is no gap coverage for the Preferred Brand, Non-preferred, and Specialty drug tiers.

#### Catastrophic Coverage:

After your yearly total drug expenses (paid by both you and the plan) reach \$4,550\* you pay the greater of:

- \$2.50/generic (including brand drugs treated as generic) and,
- \$6.30/all other drugs, or
- 5% coinsurance

\*There will be further details on the Explanation of Benefits that will be provided to you each month that you access pharmacy benefits.

Drugs that are covered under Part B Medicare benefits have a 20% coinsurance. Medicare-covered Part B drugs do not apply towards the Medicare Part D maximums. Please refer to your Evidence of Coverage for additional information regarding your prescription drug coverage.

#### Health/Wellness Education

In-Network:

- \$0 for written materials/nursing hotline
- \$5 copay for a PCP visit

If you have any questions about this plan's benefits or costs, please contact Member Services.

- \$25 copay for a specialist visit

Out-of-Network:

- \$0 for written materials/nursing hotline
- \$10 copay for a PCP visit
- \$30 copay for a specialist visit

**Refer to the Evidence of Coverage for more information regarding the Sierra Spectrum (PPO) benefits.**

Sierra Spectrum (PPO) is a Medicare Advantage (MA) PPO plan offered by Sierra Health and Life Insurance Company, Inc., a UnitedHealthcare Company. Sierra Health and Life Insurance Company, Inc. is an MA organization with a Medicare contract. Anyone with Medicare Parts A & B may apply. Members must continue to pay Medicare premiums. Prescription coverage subject to limitations.