



CARE IMPROVEMENT PLUS

Specialized Care for Medicare Beneficiaries

2012 Summary of Benefits

Wisconsin



The service area for these plans includes: Brown, Dodge, Green, Jefferson, Manitowoc, Ozaukee, Racine, Walworth, Washington, and Waukesha Counties, WI

Section 1

Introduction to the Summary of Benefits Report for CARE IMPROVEMENT PLUS January 1, 2012 - December 31, 2012 WISCONSIN

Thank you for your interest in Care Improvement Plus Medicare Advantage Only (PPO). Our plan is offered by CARE IMPROVEMENT PLUS WISCONSIN INSURANCE COMPANY/Care Improvement Plus, 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 Care Improvement Plus Medicare Advantage Only (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 Care Improvement Plus Medicare Advantage Only (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 Care Improvement Plus Medicare Advantage Only (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 Care Improvement Plus Medicare Advantage Only (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 CARE IMPROVEMENT PLUS MEDICARE ADVANTAGE ONLY (PPO) AVAILABLE?

The service area for this plan includes: Brown, Dodge, Green, Jefferson, Manitowoc, Ozaukee, Racine, Walworth, Washington, and Waukesha Counties, WI. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN CARE IMPROVEMENT PLUS MEDICARE ADVANTAGE ONLY (PPO)?

You can join Care Improvement Plus Medicare Advantage Only (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 Care Improvement Plus Medicare Advantage Only (PPO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Care Improvement Plus Medicare Advantage Only (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. For an updated list, visit us at <http://www.careimprovementplus.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?

Care Improvement Plus Medicare Advantage Only (PPO) does cover Medicare Part B prescription drugs. Care Improvement Plus Medicare Advantage Only (PPO) does NOT cover Medicare Part D prescription drugs.

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 Care Improvement Plus Medicare Advantage Only (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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

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 Care Improvement Plus Medicare Advantage Only (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 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 Care Improvement Plus for more information about Care Improvement Plus Medicare Advantage Only (PPO).

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

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

Current members should call toll-free (800)-204-1002 for questions related to the Medicare Advantage Program. (TTY/TDD (711))

Prospective members should call toll-free (800)-711-1656 for questions related to the Medicare Advantage Program. (TTY/TDD (711))

Current members should call locally (800)-204-1002 for questions related to the Medicare Advantage Program. (TTY/TDD (711))

Prospective members should call locally (800)-711-1656 for questions related to the Medicare Advantage Program. (TTY/TDD (711))

Current members should call toll-free (866)-673-3561 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-673-3563)

Prospective members should call toll-free (800)-711-1656 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-673-3563)

Current members should call locally (866)-673-3561 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-673-3563)

Prospective members should call locally (800)-711-1656 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-673-3563)

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.

If you have any questions about this plan's benefits or costs, please contact Care Improvement Plus for details.

Section II – Summary of Benefits

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
IMPORTANT INFORMATION		
<p>1. Premium and Other Important Information</p>	<p>In 2012 the monthly Part B Premium is \$99.90 and the annual Part B deductible amount is \$140.</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</p> <p>\$35 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 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>Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available</p>

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
<p>1. Premium and Other Important Information <i>(continued)</i></p>		<p>on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type.</p> <p>To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.</p> <p>In-Network \$6,700 out-of-pocket limit for Medicare-covered services.</p> <p>Out-of-Network \$6,700 out-of-pocket limit for Medicare-covered services.</p> <p>In and Out-of-Network \$6,700 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 No referral required for network doctors, specialists, and hospitals.</p> <p>In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.</p>

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
INPATIENT CARE		
3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2012 the amounts for each benefit period are: Days 1 - 60: \$1156 deductible Days 61 - 90: \$289 per day Days 91 - 150: \$578 per lifetime reserve day Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. 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.	In-Network Plan covers 90 days each benefit period. For Medicare-covered hospital stays: Days 1 - 15: \$175 copay per day Days 16 - 90: \$0 copay per day Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: Days 1 - 60: \$0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network For hospital stays: Days 1 - 15: \$175 copay per day Days 16 - 90: \$0 copay per day
4. Inpatient Mental Health Care	In 2012 the amounts for each benefit period are: Days 1 - 60: \$1156 deductible Days 61 - 90: \$289 per day Days 91 - 150: \$578 per lifetime reserve day 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.	In-Network 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. \$1,000 copay for each Medicare-covered hospital stay. Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: Days 1 - 60: \$0 copay per day

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
4. Inpatient Mental Health Care <i>(continued)</i>		Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network \$1,000 copay for each hospital stay.
5. Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: \$0 per day Days 21 - 100: \$144.50 per day 100 days for each benefit period. 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.	General Authorization rules may apply. In-Network Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1 - 20: \$0 copay per day Days 21 - 100: \$130 copay per day Out-of-Network For each SNF stay: Days 1 - 20: \$0 copay per SNF day Days 21 - 100: \$130 copay per SNF day
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	General Authorization rules may apply. In-Network 0% of the cost for each Medicare-covered home health visit. Out-of-Network 35% of the cost for home health visits.

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
7. Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE		
8. Doctor Office Visits	20% coinsurance	In-Network \$35 copay for each primary care doctor visit for Medicare-covered benefits. \$35 copay for each in-area, network urgent care Medicare-covered visit. \$50 copay for each specialist visit for Medicare-covered benefits. Out-of-Network \$35 copay for each primary care doctor visit. \$50 copay for each specialist visit.
9. Chiropractic Services	Supplemental routine care not covered 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.	In-Network \$20 copay for each Medicare-covered visit . 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. Out-of-Network \$20 copay for chiropractic benefits.

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
10. Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	In-Network \$50 copay for each Medicare-covered visit. \$0 copay for up to 6 supplemental routine visit(s) every year. Medicare-covered podiatry benefits are for medically-necessary foot care. Out-of-Network \$0 to \$50 copay for podiatry benefits.
11. Outpatient Mental Health Care	40% coinsurance for most outpatient mental health services 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. "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.	General Authorization rules may apply. In-Network \$40 copay for each Medicare-covered individual therapy visit \$35 copay for each Medicare-covered group therapy visit \$40 copay for each Medicare-covered individual therapy visit with a psychiatrist \$35 copay for each Medicare-covered group therapy visit with a psychiatrist \$40 copay for Medicare-covered partial hospitalization program services Out-of-Network \$35 to \$40 copay for Mental Health benefits with a psychiatrist \$35 to \$40 copay for Mental Health benefits \$40 copay for partial hospitalization program services
12. Outpatient Substance Abuse Care	20% coinsurance	In-Network \$40 copay for Medicare-covered individual visits. \$35 copay for Medicare-covered group visits. Out-of-Network \$35 to \$40 copay for outpatient substance abuse benefits.

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
13. Outpatient Services/Surgery	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	General Authorization rules may apply. In-Network \$150 copay for each Medicare-covered ambulatory surgical center visit. \$150 copay for each Medicare-covered outpatient hospital facility visit. Out-of-Network \$150 copay for outpatient hospital facility benefits. \$150 copay for ambulatory surgical center benefits.
14. Ambulance Services (medically necessary ambulance services)	20% coinsurance	In-Network \$150 copay for Medicare-covered ambulance benefits. Out-of-Network \$150 copay for ambulance benefits.
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. 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. Not covered outside the U.S. except under limited circumstances.	General \$65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
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 NOT covered outside the U.S. except under limited circumstances.	General \$35 copay for Medicare-covered urgently-needed-care visits.
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	General Authorization rules may apply. In-Network There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits. \$50 copay for Medicare-covered Occupational Therapy visits. \$50 copay for Medicare-covered Physical and/or Speech and Language Therapy visits. Out-of-Network \$50 copay for Physical and/or Speech and Language Therapy visits. \$50 copay for Occupational Therapy benefits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items. Out-of-Network 30% of the cost for durable medical equipment.

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items. Out-of-Network 20% of the cost for prosthetic devices.
20. Diabetes Programs and Supplies	20% coinsurance for Diabetes self-management training 20% coinsurance for Diabetes supplies 20% coinsurance for Diabetic therapeutic shoes or inserts	In-Network \$0 copay for Diabetes self-management training \$0 copay for Diabetes monitoring supplies \$0 copay for Therapeutic shoes or inserts Out-of-Network \$0 copay for Diabetes self-management training \$0 copay for Diabetes monitoring supplies \$0 copay for Therapeutic shoes or inserts
21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and X-rays \$0 copay for Medicare-covered lab services 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.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered lab services 20% of the cost for Medicare-covered diagnostic procedures and tests 20% of the cost for Medicare-covered X-rays 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays) 20% of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services <i>(continued)</i>	20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.	sharing of \$35 to \$50 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$35 to \$50 may apply Out-of-Network 20% of the cost for therapeutic radiology services 20% of the cost for outpatient X-rays 20% of the cost for diagnostic radiology services 20% of the cost for diagnostic procedures, tests, and lab services
22. Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	General Authorization rules may apply. In-Network \$50 copay for Medicare-covered Cardiac Rehabilitation Services \$50 copay for Medicare-covered Intensive Cardiac Rehabilitation Services \$50 copay for Medicare-covered Pulmonary Rehabilitation Services Out-of-Network \$50 copay for Cardiac Rehabilitation Services \$50 copay for Intensive Cardiac Rehabilitation Services \$50 copay for Pulmonary Rehabilitation Services

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
PREVENTIVE SERVICES		
23. Preventive Services and Wellness/Education Programs	No coinsurance, copayment or deductible for the following: <ul style="list-style-type: none"> - 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. 	General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> - 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) 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.

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
23. Preventive Services and Wellness/Education Programs <i>(continued)</i>	<ul style="list-style-type: none"> - 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 include a nutritional assessment and counseling to help you manage your diabetes or kidney disease - 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. 	In-Network The plan covers the following supplemental education/wellness programs: <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Additional Smoking Cessation - Nursing Hotline Out-of-Network \$0 copay for Medicare-covered preventive services \$0 copay for supplemental education/wellness programs

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
24. Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	In-Network 20% of the cost for renal dialysis \$0 copay for kidney disease education services Out-of-Network \$0 copay for kidney disease education services 20% of the cost for renal dialysis
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 Most drugs not covered 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 20% of the cost for Part B drugs out-of-network. Drugs Covered under Medicare Part D General This plan does not offer prescription drug coverage.
26. Dental Services	Preventive dental services (such as cleaning) not covered.	In-Network \$0 copay for Medicare-covered dental benefits \$10 copay for an office visit that includes: - up to 1 oral exam(s) every year - up to 1 cleaning(s) every year - up to 1 dental X-ray(s) every year Out-of-Network \$0 copay for comprehensive dental benefits \$10 copay for preventive dental benefits

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
27. Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	In-Network In general, supplemental routine hearing exams and hearing aids not covered. - \$50 copay for Medicare-covered diagnostic hearing exams. Out-of-Network \$50 copay for hearing exams.
28. Vision Services	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.	In-Network - \$50 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$50 copay for exams to diagnose and treat diseases and conditions of the eye. - \$10 copay for up to 1 supplemental routine eye exam(s) every year. - \$0 copay for glasses. - \$0 copay for contacts. Out-of-Network \$0 to \$50 copay for eye wear. \$10 to \$50 copay for eye exams. In and Out-of-Network \$150 plan coverage limit for eye wear every year. This limit applies to both in-network and out-of-network benefits.
Over-the-Counter Items	Not covered.	General The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	General Authorization rules may apply. In-Network \$0 copay for up to 12 one-way trip(s) to plan approved location every year. Out-of-Network \$0 copay for transportation.

Benefit	Original Medicare	Care Improvement Plus Medicare Advantage Only (PPO)
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Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.
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CARE IMPROVEMENT PLUS

Specialized Care for Medicare Beneficiaries

351 W Camden Street, Suite 100
Baltimore, MD 21201

For Full information on Care Improvement Plus benefits, call:

Current Members

7 days a week, 8 am – 8 pm

1-800-204-1002 (TTY: 1-800-713-1603)

Prospective Members

7 days a week, 8 am – 8 pm

1-800-711-1656 (TTY: 1-800-713-1603)

Visit us on the web www.careimprovementplus.com