

Section 1

Providence Medicare Extra



Providence | Health Plan

A caring difference you can feel

Introduction to the Summary of Benefits for **Providence Medicare Extra Group Plan A + RX (20/40)**

Contract #H9047

January 1, 2007 - December 31, 2007
Portland Metro, Willamette Valley and Clark County

Thank you for your interest in Providence Medicare Extra Group Plan A + RX. Our plan is offered by PROVIDENCE HEALTH PLAN, a Medicare Advantage Health Maintenance Organization (HMO). 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 Providence Medicare Extra Group Plan A + RX 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 Providence Medicare Extra Group Plan A + RX. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Providence Medicare Extra Group Plan A + RX at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY 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 Providence Medicare Extra Group Plan A + RX 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 PROVIDENCE MEDICARE EXTRA GROUP PLAN A + RX AVAILABLE?

The service area for this plan includes the following counties: Benton, Clackamas, Columbia, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill Counties, OR; and Clark County, WA. You must live in one of these places to join the plan.

WHO IS ELIGIBLE TO JOIN PROVIDENCE MEDICARE EXTRA GROUP PLAN A + RX?

You can join Providence Medicare Extra Group Plan A + RX 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 not eligible to enroll in Providence Medicare Extra Group Plan A + RX.

CAN I CHOOSE MY DOCTORS?

Providence Medicare Extra Group Plan A + RX 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 up-to-date list or visit us at www.providence.org/healthplans. Our customer service number is listed at the end of this introduction.

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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. Neither Providence Health Plan nor the Original Medicare Plan will pay for these services.

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

Providence Medicare Extra Group Plan A + RX 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?

Providence Medicare Extra Group Plan A + RX 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 current Pharmacy Network List or visit us at www.providence.org/healthplans. Our customer service number is listed at the end of this introduction.

Providence Health Plan has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Providence Medicare Extra Group Plan A + RX uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, 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.providence.org/healthplans.

If you are currently taking a drug that is not on our formulary or subject to additional requirement 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 PRESCRIPTION DRUG PLAN COSTS?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Providence Medicare Extra Group Plan A + RX, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-Medicare (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Providence Medicare Extra Group Plan A + RX, 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.

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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 Providence Medicare Extra Group Plan A + RX for more details.

Please call Providence Health Plan for more information about this plan.

Visit us at www.providence.org/healthplans or, call us: Customer Service assistance is available Monday through Friday, between 8 a.m. and 5 p.m. for questions about your medical plan (Part C) and seven days a week, between 8 a.m. and 8 p.m. for questions about your prescription plan (Part D).

Current members should call (800)-603-2340 for questions related to the Medicare Advantage program. (TTY/TDD (888)-244-6642)

Prospective members should call (800)-988-0088 for questions related to the Medicare Advantage program. (TTY/TDD (888)-244-6642)

Current members should call (800)-603-2340 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (888)-244-6642)

Prospective members should call (800)-988-0088 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (888)-244-6642)

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.

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

SUMMARY OF BENEFITS

<p>If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.</p>		
<p>Benefit Category</p>	<p>Original Medicare</p>	<p>Providence Medicare Extra Group Plan A + RX</p>
<p>IMPORTANT INFORMATION</p>		
<p>1 - Premium and Other Important Information</p>	<p>You pay the Medicare Part B premium of \$93.50 each month.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2007, some people will have to pay a higher premium because of their yearly income (over \$80,000 for singles, \$160,000 for married couples). For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>Your employer's retiree benefits plan pays your premium. Check with your retiree plan for any amount you may pay.</p> <p>You also continue to pay the Medicare Part B premium of \$93.50 each month.</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>You must go to network doctors, specialists, and hospitals.</p> <p>You need a referral to go to network hospitals and certain doctors, including specialists for certain services.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>

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SUMMARY OF BENEFITS

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

Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A+ RX
INPATIENT CARE		
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	You pay for each benefit period (3): Days 1 - 60: an initial deductible of \$992 Days 61 - 90: \$248 each day Days 91 - 150: \$496 each lifetime reserve day (4) Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)	You pay \$250 for each Medicare-covered stay at a network hospital. There is no copayment for additional days received at a network hospital. There is a \$500 maximum out of pocket limit every year. You are covered for unlimited days each benefit period. (3) Except in an emergency, your provider must obtain authorization from Providence Health Plan.
4 - Inpatient Mental Health Care	You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.	You pay \$250 for each Medicare-covered stay at a network hospital. The maximum out of pocket limit is covered under Inpatient Hospital Care. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your provider must obtain authorization from Providence Health Plan.
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	You pay for each benefit period (3), following at least a 3-day covered hospital stay: Days 1 - 20: \$0 for each day Days 21 - 100: \$124 for each day There is a limit of 100 days for each benefit period. (3)	There is no copayment for services received at a Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. (3) Authorization rules may apply for services. Contact plan for details.

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

(4) Lifetime reserve days can only be used once

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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A+ RX
INPATIENT CARE (Continued)		
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no copayment for all covered home health visits.	There is no copayment for Medicare-covered home health visits.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.
OUTPATIENT CARE		
8 - Doctor Office Visits	You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$15 for each primary care doctor office visit for Medicare-covered services. You pay \$15 for each specialist visit for Medicare-covered services. See 32 - Physical Exams for more information.
9 - Chiropractic Services	You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care. You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).

(1) Each year, you pay a total of one \$131 deductible. *NOTE: The Medicare Part B deductible may change each year.*

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

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SUMMARY OF BENEFITS

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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A+ RX
OUTPATIENT CARE (Continued)		
10 - Podiatry Services	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p> <p>You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>You pay 100% for routine care.</p>	<p>You pay \$15 for each Medicare-covered visit (medically necessary foot care).</p>
11 - Outpatient Mental Health Care	<p>You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)</p>	<p>For Medicare-covered Mental Health services, you pay \$15 for each individual/group therapy visit.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
12 - Outpatient Substance Abuse Care	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p>	<p>For Medicare-covered services, you pay \$15 for each individual/group visit.</p> <p>Except in emergency, your provider must obtain authorization from Providence Health Plan.</p>
13 - Outpatient Services/Surgery	<p>You pay 20% of Medicare-approved amounts for the doctor. (1)(2)</p> <p>You pay 20% of outpatient facility charges. (1)(2)</p>	<p>There is no copayment for each Medicare-covered visit to an ambulatory surgical center.</p> <p>There is no copayment for each Medicare-covered visit to an outpatient hospital facility.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>

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SUMMARY OF BENEFITS

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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A+ RX
OUTPATIENT CARE (continued)		
14 - Ambulance Services (medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)	You pay \$50 for Medicare-covered ambulance services.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2) You pay 20% of doctor charges. (1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay \$50 for each Medicare-covered emergency room visit; You do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition. Worldwide coverage.
16 – Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay \$25 for each Medicare-covered urgently needed care visit; You do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition. Worldwide coverage.
17 – Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$15 for each Medicare-covered Occupational Therapy visit. You pay \$15 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.

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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A+ RX
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 – Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Medicare-covered items. Authorization rules may apply for services. Contact plan for details.
19 – Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Medicare-covered items.
20 – Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self-management training)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$15 for Medicare-covered Diabetes self-monitoring training. There is no copayment for Diabetes supplies.
21 – Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2) There is no copayment for Medicare-approved lab services.	There is no copayment for the following Medicare-covered service(s): <ul style="list-style-type: none"> ▪ clinical/diagnostic lab services ▪ radiation therapy ▪ X-ray visits
PREVENTIVE SERVICES		
22 – Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for each Medicare-covered Bone Mass Measurement.
23 – Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Medicare-covered Colorectal Screening Exams.

(1) Each year, you pay a total of one \$131 deductible. *NOTE: The Medicare Part B deductible may change each year.*

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SUMMARY OF BENEFITS

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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A+ RX
PREVENTIVE SERVICES (Continued)		
24 – Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	There is no copayment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2) You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for Medicare-covered influenza and pneumococcal vaccines. Referral required for other immunizations. Please check with your plan for details. There is no copayment for the Hepatitis B vaccine.
25 – Mammograms (Annual Screening) (for women with Medicare age 40 and older)	You pay 20% of Medicare-approved amounts. (2) No referral necessary for Medicare-covered screenings.	There is no copayment for Medicare-covered Screening Mammograms. No referral necessary for Medicare-covered screenings.
26 – Pap Smears and Pelvic Exams (for women with Medicare)	There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2) You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)	There is no copayment for <ul style="list-style-type: none"> ▪ Medicare-covered Pap Smear and Pelvic Exam ▪ additional Pap Smear and Pelvic Exam up to 1 Pap Smear(s) and Pelvic Exam(s) every year
27 – Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (1)(2)	There is no copayment for Medicare-covered Prostate Cancer Screening Exams.

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SUMMARY OF BENEFITS

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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A+ RX
ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER)		
<p>28 –Prescription Drugs</p> <p>Drugs covered under Medicare Part B (Original Medicare)</p> <p>Drugs covered under Medicare Part D (Prescription Drug Benefit)</p>	<p>You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program</p>	<p>This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified, in writing, before the change. To view the plan's formulary, go to www.providence.org on the web.</p> <p>People who have low incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact the plan for details.</p> <p>Generic drugs: \$20 copayment for up to a 30-day supply purchased at a participating retail pharmacy.</p> <p>Brand-name drugs: \$40 copayment for up to a 30-day supply purchased at a participating retail pharmacy. (when a generic equivalent is not available)</p> <p>One copayment applies for each 30-day supply.</p> <p>Compounded prescription drugs: 50% copayment for each 30-day supply purchased at a participating retail pharmacy.</p> <p>You may receive drugs from an In-Network Preferred Pharmacy for a three month (90 day) supply.</p> <p>You may receive drugs from an In-Network Non-Preferred Pharmacy for a three month (90 day) supply.</p>

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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A+ RX
ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER) Continued		
28 –Prescription Drugs (Continued)		<p>Covered Part D drugs are available at out of network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy.</p> <p>In addition to paying the co-payments/co-insurances listed below, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of network pharmacy charged for your prescriptions.</p> <p>You may receive drugs from an In-Network or participating Mail Order Pharmacy for a three month (90 day) supply.</p> <p>Certain prescription drugs will have maximum quantity limits. Contact plan for details.</p> <p>Your provider must get prior authorization from Providence Medicare Extra Group Plan A + RX for certain prescription drugs. Contact plan for details.</p>

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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A+ RX
ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER) Continued		
29 – Dental Services	In general, you pay 100% for preventive dental services.	In general, you pay 100% for preventive dental services. You pay \$15 for each Medicare-covered dental benefit. Authorization rules may apply. Contact plan for details.
30 – Hearing Services	<p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)</p>	<p>In general, you pay 100% for routine hearing exams and hearing aids.</p> <p>You pay:</p> <ul style="list-style-type: none"> ▪ \$15 for each Medicare-covered hearing exam (diagnostic hearing exams).
31 – Vision Services	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)</p> <p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)</p> <p>You pay 100% for routine eye exams and glasses.</p>	<p>There is no copayment for the following items:</p> <ul style="list-style-type: none"> ▪ Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) ▪ You pay: \$15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) ▪ \$15 for each Routine eye exam, limited to 1 exam(s) every two years

(1) Each year, you pay a total of one \$131 deductible. *NOTE: The Medicare Part B deductible may change each year.*

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

