2018 Summary of Benefits

Vibra Health Plan Essential Coverage PPO (H9408-001)
Vibra Health Plan Enhanced Coverage PPO (H9408-002)

Vibra Health Plan is a PPO with a Medicare contract. Enrollment in **Vibra Health Plan** depends on contract renewal. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

The benefit information provided is a summary of what we cover and what you pay. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. To get a complete list of services we cover, please request the "Evidence of Coverage" by visiting our website, www.vibrahealthplan.com or calling Member Services at 1-844-388-8268 (TTY users call 711).

Summary of Benefits
January 1, 2018 – December 31, 2018

This document gives you a summary of covered benefits and what you pay for the **Vibra Health Plan Essential Coverage PPO** and **Vibra Health Plan Enhanced Coverage PPO** plans. **There are no deductibles and referrals** to see physicians. Both plans include copays and coinsurance for various services. A *copayment* is a set amount you pay each time a service is provided. *Coinsurance* is the percentage you pay as your share of the cost for a service. *Maximum Out-of-Pocket* is the total amount you will spend this year on copayments and coinsurance for covered or eligible medical services, this does not include prescription drugs or emergency care outside the United States.

Topics covered in this document

Vibra Health Plan is a Medicare Advantage PPO plan. (PPO stands for Preferred Provider Organization). To join, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Pennsylvania: **Adams, Berks, Carbon, Cumberland, Dauphin, Franklin, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Northampton, Perry, Schuylkill, Wyoming, and York.**

For more information, please call **Member Services:** Toll-free **1-844-388-8268** (TTY users should call 711) or visit us at www.vibrahealthplan.com. We are available with extended hours from 8 a.m. to 8 p.m., 7 days a week, from October 1st – February 14th. From February 15 to September 30, we use a secure messaging system on Saturdays, Sundays, and Federal holidays. If you leave a message, please include your name, phone number and the time you called. A Member Service representative will return your call no later than one business day after you leave your message.

Vibra Health Plan covers all services covered by Original Medicare. In addition, our plans also cover some extra services not covered by Original Medicare, such as:

- Annual physical exam
- Shingles Vaccine at no cost when administered in a doctor's office
- Preventive Dental Services (Enhanced plan only)
- Preventive Vision Services including a bi-annual allowance for glasses and contact lenses
- Health & Wellness (Enhanced plan only)
- Transportation (Enhanced plan only)
- Worldwide Urgent/Emergency Services

These services are described in the document below.

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know
Monthly Plan Premium	You pay $0	You pay $55.00	You must continue to pay your Medicare Part B premium in addition to any plan premium.
Deductible	You pay $0; deductible does not apply	You pay $0; deductible does not apply	**This plan does not have a deductible**. For information on cost sharing, please see below.
Maximum Out-of-Pocket Responsibility (MOOP)	$5,900 annually (includes both In-Network and Out-of-Network cost sharing)	$4,800 annually (includes both In-Network and Out-of-Network cost sharing)	**This is not a deductible.** Members of this plan are responsible for cost sharing (copays and coinsurances) when accessing services, and the plan pays the rest. The MOOP is the maximum limit you pay out of pocket for copays, coinsurance and other costs for medical services for calendar year 2018. Cost sharing for prescription drugs, emergency care received outside the U.S., and non-medical (accident) dental, routine vision and hearing services does **not** count towards this amount.

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know
Inpatient Hospital Coverage (requires authorization)	**Inpatient Acute Care** • In-Network: You pay $210 copay per day for days 1-8; $0 for days 9+ • Out-of-Network: You pay 40% coinsurance **Inpatient Rehabilitation** • In-Network: You pay $210 copay per day for days 1-8; $0 for days 9+ • Out-of-Network: You pay 40% coinsurance **Long Term Acute Care** • In-Network: You pay $210 copay per day for days 1-8; $0 for days 9+ • Out-of-Network: You pay 40% coinsurance **Inpatient Mental Health** • Please see page **9** under Mental Health Services for benefit information.	**Inpatient Acute Care** • In-Network: You pay $195 copay per day for days 1-8; $0 for days 9+ • Out-of-Network: You pay 25% coinsurance **Inpatient Rehabilitation** • In-Network: You pay $195 copay per day for days 1-8; $0 for days 9+ • Out-of-Network: You pay 25% coinsurance **Long Term Acute Care** • In-Network: You pay $195 copay per day for days 1-8; $0 for days 9+ • Out-of-network: You pay 25% coinsurance **Inpatient Mental Health** • Please see page **9** under Mental Health Services for benefit information.	This benefit will begin on day one each time you are admitted to an inpatient facility type. A transfer to a different inpatient facility type is considered a new admission. This copay or coinsurance covers all services rendered during the stay. If you are billed separately for services incurred during your inpatient stay, please contact **Vibra Health Plan** before taking any action.
Outpatient Hospital Coverage (surgery)	**Ambulatory Surgery Center (ASC):** • You pay $250 copay per visit • Out-of-Network: You pay 40% coinsurance per visit **Outpatient Facility:** • You pay $325 copay per visit • Out-of-Network: You pay 40% coinsurance per visit	**Ambulatory Surgery Center (ASC):** • You pay $225 copay per visit • Out-of-Network: You pay 30% coinsurance per visit **Outpatient Facility:** • You pay $300 copay per visit • Out-of-Network: You pay 30% coinsurance per visit	

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know
Doctor Visits (Primary Care Providers and Specialists)	**Primary Care Physician (Family Doctor) Visit:** • In-Network: You pay $5 copay per visit • Out-of-Network: You pay $35 copay per visit **Specialist Visit (e.g., Cardiologist, Neurologist):** • In-Network: You pay $40 copay per visit • Out-of-Network: You pay $75 copay per visit	**Primary Care Physician (Family Doctor) Visit:** • In-Network: You pay $5 copay per visit • Out-of-Network: You pay 30% coinsurance **Specialist Visit (e.g., Cardiologist, Neurologist):** • In-Network: You pay $35 copay per visit • Out-of-Network: You pay 30% coinsurance	Most physician offices will ask you to pay the applicable copay at time of service.
Preventive Care	**Annual Wellness Visit** (performed by your Primary Care Physician) • In-Network: You pay $0 • Out-of-Network: You pay 40% coinsurance **Comprehensive Physical Exam** (performed by your Primary Care Physician) • In-Network: You pay $0 • Out-of-Network: You pay 40% coinsurance **Glaucoma Screening, Diabetes Self-Management Training** • In-Network: You pay $0 • Out-of-Network: You pay 40% coinsurance **Kidney Disease Education Services** • In-Network: You pay $0 • Out-of-Network: You pay 40% coinsurance	**Annual Wellness Visit** (performed by your Primary Care Physician) • In-Network: You pay $0 • Out-of-Network: You pay 30% coinsurance **Comprehensive Physical Exam** (performed by your Primary Care Physician) • In-Network: You pay $0 • Out-of-Network: You pay 30% coinsurance **Glaucoma Screening, Diabetes Self-Management Training** • In-Network: You pay $0 • Out-of-Network: You pay 30% coinsurance **Kidney Disease Education Services** • In-Network: You pay $0 • Out-of-Network: You pay 30% coinsurance	Preventive care also includes colorectal cancer screenings, breast cancer screenings, cervical/vaginal cancer screenings (pap smears), and additional preventive services approved by Medicare during the contract year. There is no cost sharing associated with these services when performed by an In-Network provider. However, cost sharing may apply if other, non-preventive services are performed during the same visit.

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know
Worldwide Emergency Coverage	You pay $80 copay per visit (within the U.S.) **Worldwide Emergency/Urgent Care Coverage:** • Emergency Care - You pay $80 copay per visit • Urgent Care - You pay $65 copay per visit $2,500 maximum annual benefit – Combined for Emergency and Urgent Care Coverage	You pay $80 copay per visit (within the U.S.) **Worldwide Emergency/Urgent Care Coverage:** • Emergency Care - You pay $80 copay per visit • Urgent Care - You pay $65 copay per visit $5,000 maximum annual benefit – Combined for Emergency and Urgent Care Coverage	ER copay is waived if admitted to the hospital within 48 hours for the same diagnosis. Worldwide ER/Urgent Coverage only applies outside the U.S. and its territories.
Urgently Needed Services	**Urgent Coverage:** • You pay $50 copay per visit (within the U.S.)	**Urgent Coverage:** • You pay $50 copay per visit (within the U.S.)	Urgently needed services treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical care. These services can be provided by primary care physicians or urgent care facilities.
Diagnostic Services/Labs/ Imaging - Outpatient (may require authorization)	**Diagnostic Tests & Procedures:** • In-Network: You pay $25 copay per service • Out-of-Network: You pay 20% coinsurance **Lab Services (e.g., complete blood count, chemistry profile):** • In-Network: You pay $15 copay per service • Out-of-Network: You pay 20% coinsurance	**Diagnostic Tests & Procedures:** • In-Network: You pay $15 copay per service • Out-of-Network: You pay 30% coinsurance **Lab Services (e.g., complete blood count, chemistry profile):** • In-Network: You pay $15 copay per service • Out-of-Network: You pay 30% coinsurance	Diagnostic tests and procedures are performed by your physician to help identify health issues.

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know
Diagnostic Services/Labs/ Imaging - Outpatient (may require authorization) continued	**Outpatient X-Rays:** • In-Network: You pay $35 copay • Out-of-Network: You pay 40% coinsurance **Diagnostic Radiology Services (e.g. MRI, CT Scan)** • In-Network: You pay $275 copay • Out-of-Network: You pay 40% coinsurance **Therapeutic Radiology (e.g. radiation treatment for cancer):** • In-Network: You pay $60 copay • Out-of-Network: You pay 40% coinsurance	**Outpatient X-Rays:** • In-Network: You pay $30 copay • Out-of-Network: You pay 30% coinsurance **Diagnostic Radiology Services (e.g. MRI, CT Scan)** • In-Network: You pay $225 copay • Out-of-Network: You pay 30% coinsurance **Therapeutic Radiology (e.g. radiation treatment for cancer):** • In-Network: You pay 20% coinsurance • Out-of-Network: You pay 30% coinsurance	Prior authorization is required for coverage on some services, including MRIs, CT Scans and therapeutic radiology.
Hearing Services	**Exam to diagnose and treat hearing and balance issues:** • In-Network: You pay $40 copay per visit • Out-of-Network: You pay $75 copay per visit **Routine Hearing Exam:** • In-Network: You pay $0 copay per visit • Out-of-Network: You pay $75 copay per visit **Hearing Aid Fitting/Evaluation:** • In-Network: You pay $0 copay per visit • Out-of-Network: You pay $75 copay per visit **Hearing Aids:** • $300 allowance	**Exam to diagnose and treat hearing and balance issues:** • In-Network: You pay $35 copay per visit • Out-of-Network: You pay 30% coinsurance **Routine Hearing Exam:** • In-Network: You pay $0 copay per visit • Out-of-Network: You pay 30% coinsurance **Hearing Aid Fitting/Evaluation:** • In-Network: You pay $0 copay per visit • Out-of-Network: You pay 30% coinsurance **Hearing Aids:** • $300 allowance	Limit one routine hearing exam visit per calendar year. Limit one fitting/evaluation for hearing aid visit per three calendar years. Limit one hearing aid, both ears combined per three calendar years.

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know
Medical (Accident) Dental Services	**Dental Specialist Visit (Medicare-covered)** • In-Network: You pay a $40 copay per visit • Out-of-Network: You pay $75 copay per visit	**Dental Specialist Visit (Medicare-covered)** • In-Network: You pay $35 copay per visit • Out-of-Network: You pay 30% coinsurance	Medical (Accident) Dental services cover non-routine dental treatment resulting from an underlying medical condition. **Please see below for benefit information on preventive dental services.**

Preventive Dental Services	Not covered	• In-Network:
		  • 2 cleanings per year: You pay $0 per cleaning
		  • 2 exams per year: You pay $20 per exam
		  • Dental X-Rays have a copay range of $10 to $30 depending on X-Ray performed.
		
		• Out-of-Network:
		  • Out-of-Network dental services will be reimbursed by the plan at the In-Network rate. The member will be responsible for the in-network cost share plus any difference in cost between the In-Network reimbursement rate and the amount charged by the Out-of-Network provider.
			Preventive dental covers routine cleanings, exams and x-rays.
			
			"Per year" refers to calendar year.
			
			Optional supplemental dental is available for both plans at an additional monthly cost. Please see page **17** for more information.

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know

Vision Services	**Routine Eye Examination:**
	• In-Network: You pay $20 copay
	• Out-of-Network: You pay 50% coinsurance
	
	Eyeglass Frames:
	One frame every 2 calendar years.
	• In-Network: Members pay the balance of charges after $40 allowance is applied.
	• Out-of-Network: Member pays the total charges in full at the time of purchase. Plan reimburses the member $40 of the providers billed amount.
	
	Standard Eyeglass Lenses:
	One pair of lenses every 2 calendar years
	• In-Network: $0 copay
	• Out-of-Network: Member pays the total charges in full at the time of purchase. Plan reimburses the member up to the allowances listed below:
	  • Single vision $36
	  • Bi-focal $48
	  • Tri-focal $58
	
	Contact Lenses:
	One order every 2 calendar years
	• In-Network: Members pay the balance of charges after a $40 allowance is applied.
	• Out-of-Network: Member pays the total charges in full at the time of purchase. Plan reimburses the member $40 of the providers billed amount.
		Routine Eye Examination:
		• In-Network: You pay $20 copay
		• Out-of-Network: You pay 30% coinsurance
		
		Eyeglasses Frames:
		One frame every 2 calendar years.
		• In-Network: Members pay the balance of charges after $40 allowance is applied.
		• Out-of-Network: Member pays the total charges in full at the time of purchase. Plan reimburses the member $40 of the providers billed amount.
		
		Standard Eyeglass Lenses:
		One pair of lenses every 2 calendar years
		• In-Network: $0 copay
		• Out-of-Network: Member pays the total charges in full at the time of purchase. Plan reimburses the member up to the allowances listed below:
		  • Single vision $36
		  • Bi-focal $48
		  • Tri-focal $58
		
		Contact Lenses:
		One order every 2 calendar years
		• In-Network: Members pay the balance of charges after a $40 allowance is applied.
		• Out-of-Network: Member pays the total charges in full at the time of purchase. Plan reimburses the member $40 of the providers billed amount.
			Routine eye exams to determine visual acuity are limited to one per calendar year.
			
			Limit one set of eyeglass lenses and eyeglass frames or contacts every two calendar years $0 copay.
			
			Eye exams to diagnose and treat eye problems do not have an annual limit.

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know
Vision Services continued	**Exam to diagnose and treat eye issues (performed by Primary Care Physician)** • In-Network: You pay $5 copay • Out-of-Network: You pay $35 copay **Exam to diagnose and treat eye issues (performed by Specialist)** • In-Network: You pay $40 copay • Out-of-Network: You pay $75 copay	**Exam to diagnose and treat eye issues (performed by Primary Care Physician)** • In-Network: You pay $5 copay Out-of-Network: You pay 30% coinsurance **Exam to diagnose and treat eye issues (performed by Specialist)** • In-Network: You pay $35 copay • Out-of-Network: You pay 30% coinsurance	
Mental Health Services (may require authorization)	**Inpatient Hospital Stay:** • In-Network: You pay $200 copay per day for days 1-8; $0 for days 9+ • Out-of-Network: You pay 40% coinsurance for the stay **Outpatient Group Therapy Visit:** • In-Network: You pay $40 copay per visit • Out-of-Network: You pay 40% coinsurance for the visit **Outpatient Individual Therapy Visit:** • In-Network: You pay $40 copay per visit • Out-of-Network: You pay 40% coinsurance for the visit	**Inpatient Hospital Stay:** • In-Network: You pay $200 copay per day for days 1-8; $0 for days 9+ • Out-of-Network: You pay 25% coinsurance for the stay **Outpatient Group Therapy Visit:** • In-Network: You pay $40 copay per visit • Out-of-Network: You pay 30% coinsurance for the visit **Outpatient Individual Therapy Visit:** • In-Network: You pay $40 copay per visit • Out-of-Network: You pay 30% coinsurance for the visit	Prior authorization is required for coverage on inpatient mental health stays. The cost sharing on the inpatient hospital stay covers all services rendered during the stay. If you are billed separately for services incurred during your inpatient stay, please contact **Vibra Health Plan** before taking any action. Medicare limits inpatient stays at psychiatric only hospitals to 190 days per lifetime.

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know
Skilled Nursing Facility (SNF) (requires authorization)	• In-Network: You pay $0 for days 1-20; $167.50 copay per day for days 21-100 • Out-of-network: You pay 40% coinsurance for the stay	• In-Network: You pay $0 for days 1-20; $165.00 copay per day for days 21-100 • Out-of-Network: You pay 25% coinsurance for the stay	This plan covers up to 100 days per benefit period in a SNF. This benefit is for medically necessary care and is not a substitute for Long Term Care insurance.
Rehabilitation Services Outpatient (requires authorization)	**Cardiac (Heart) Rehabilitation, Intensive Services Cardiac Rehab Services:** • In-Network: You pay $10 copay per visit • Out-of-Network: You pay $75 copay per visit **Occupational Therapy, Physical Therapy and Speech-Language Therapy Visits:** • In-Network: You pay $40 copay per visit • Out-of-Network: You pay $75 copay per visit **Pulmonary (Lung) Rehabilitation Services:** • In-Network: You pay $10 copay per visit • Out-of-Network: You pay $75 copay per visit	**Cardiac (Heart) Rehabilitation, Intensive Services Cardiac Rehab Services:** • In-Network: You pay $15 copay per visit • Out-of-Network: You pay 30% coinsurance **Occupational Therapy, Physical Therapy and Speech-Language Therapy Visits:** • In-Network: You pay $40 copay per visit • Out-of-Network: You pay 30% coinsurance **Pulmonary (Lung) Rehabilitation Services:** • In-Network: You pay $15 copay per visit • Out-of-Network: You pay 30% coinsurance	Cardiac (heart) rehab services have a maximum of 12 one-hour sessions per year. Occupational therapy, physical therapy, speech therapy and pulmonary rehabilitation services do not have annual limits.

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know
Ambulance (may require authorization)	**Emergency Service** • In-Network/Out-of-Network: You pay $225 copay **Non-Emergency Service** • In-Network/Out-of-Network: You pay $225 copay	**Emergency Service** • In-Network/Out-of-Network: You pay $150 copay **Non-Emergency Service** • In-Network/Out-of-Network: You pay $150 copay	This benefit covers emergency and non-emergency ambulance services. Prior authorization is required for non-emergency service coverage.
Transportation	Not Covered	• $30 allowance per round trip • 12 round trips per calendar year • $360 maximum benefit per year	You will need to submit a member reimbursement claim form with a receipt for each trip. Mode of Transport: Taxi, Bus/Subway, Van, Medical Transport; arranged by Plan.

Medicare Part B Drugs (e.g. chemotherapy drugs)	• When administered in a physician's office:
	  • In-Network: You pay 20% coinsurance
	  • Out-of-Network: You pay 40% coinsurance
	• When administered in an outpatient hospital setting:
	  • In-Network: You pay 20% coinsurance
	  • Out-of-Network: You pay 40% coinsurance
		• When administered in a physician's office:
		  • In-Network: You pay 10% coinsurance
		  • Out-of-Network: You pay 30% coinsurance
		• When administered in an outpatient hospital setting:
		  • In-Network: You pay 20% coinsurance
		  • Out-of-Network: You pay 30% coinsurance
			Part B drugs include drugs that are usually injected or infused while you are receiving physician, outpatient or ambulatory surgical center services.
			These drugs are covered under Part B of Original Medicare.
			Prior authorization is required for some Part B drugs.

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO	What you should know
Foot Care (podiatry services)	• In-Network: You pay $40 copay per visit • Out-of-Network: You pay $75 copay per visit	• In-Network: You pay $40 copay per visit • Out-Of-Network: You pay 30% coinsurance	For benefit information on therapeutic shoes or inserts, please see below under Diabetes Supplies.
Medical Equipment/Supplies (may require authorization)	**Diabetes supplies (e.g., blood glucose monitors, test strips, lancets, therapeutic shoes and inserts):** • In-Network: You pay 20% coinsurance • Out-of-Network: You pay 40% coinsurance **Durable Medical Equipment (e.g., wheelchairs, oxygen):** • In-Network: You pay 20% coinsurance • Out-of-Network: You pay 40% coinsurance **Prosthetics (e.g., braces, artificial limbs):** • In-Network: You pay 20% coinsurance • Out-of-Network: You pay 40% coinsurance	**Diabetes Supplies (e.g., blood glucose monitors, tests strips, lancets, therapeutic shoes and inserts):** • In-Network: You pay 20% coinsurance • Out-of-Network: You pay 30% coinsurance **Durable Medical Equipment (e.g., wheelchairs, oxygen):** • In-Network: You pay 20% coinsurance • Out-of-Network: You pay 35% coinsurance **Prosthetics (e.g., braces, artificial limbs):** • In-Network: You pay 20% coinsurance • Out-of-Network: You pay 35% coinsurance	Prior authorization is required for coverage on therapeutic shoes and inserts, certain medical equipment and supplies.
Wellness Programs (e.g., fitness)	Not covered	$90 allowance per quarter (every 3 months) for gym membership and exercise programs/classes	Equipment, clothing and personal training fees are not covered. Members are eligible to submit for reimbursement after three months of membership using the Fitness Claim Form.

	Vibra Health Plan Essential Coverage PPO – Prescription Drug Benefits				
Phase 1: Initial Coverage (Initial Coverage Limit is $3,750 in 2018)	**Preferred Retail Rx 31-Day Supply**	**Non-Preferred Retail Rx 31-Day Supply**	**Mail Order Rx 90-Day Supply or Preferred Retail Rx 90-Day Supply**	**Non-Preferred Retail Rx 90-Day Supply**	**What you should know**
Tier 1: Preferred Generic	You pay $0	You pay $15	You pay $0	You pay $30	Preferred retail pharmacies include: Giant/Ahold pharmacies, Rite Aid, Walgreens, Walmart/Sam's Club and independent pharmacies operated by Elevate or AccessHealth. Tier 5 drugs are only offered at a 31-day supply order. In 2018, the coverage gap for prescription drugs is $3,750 to $5,000. During the coverage gap, Tiers 1 & 6 will continue to be available at the copays listed. If you reside in a long-term care facility, you pay the same as at a Standard retail pharmacy. You may purchase drugs from an out-of-network pharmacy, but you may pay more than you pay at an in-network pharmacy.
Tier 2: Generic	You pay $15	You pay $20	You pay $30	You pay $40	
Tier 3: Preferred Brand	You pay $42	You pay $47	You pay $84	You pay $94	
Tier 4: Non-Preferred Brand	You pay $95	You pay $100	You pay $237.50	You pay $250	
Tier 5: Specialty	You pay 33% coinsurance	You pay 33% coinsurance	Not Covered	Not Covered	
Tier 6: Select Care	You pay $0	You pay $5	You pay $0	You pay $10	

	Vibra Health Plan Enhanced Coverage PPO – Prescription Drug Benefits				
Phase 1: Initial Coverage (Initial Coverage Limit is $3,750 in 2018)	**Preferred Retail Rx 31-Day Supply**	**Non-Preferred Retail Rx 31-Day Supply**	**Mail Order Rx 90-Day Supply or Preferred Retail Rx 90-Day Supply**	**Non-Preferred Retail Rx 90-Day Supply**	**What you should know**
Tier 1: Preferred Generic	You pay $0	You pay $10	You pay $0	You pay $20	Preferred retail pharmacies include: Giant/Ahold pharmacies, Rite Aid, Walgreens, Walmart/Sam's Club and independent pharmacies operated by Elevate or AccessHealth. Tier 5 drugs are only offered at a 31-day supply order. In 2018, the coverage gap for prescription drugs is $3,750 to $5,000. During the coverage gap, Tiers 1, 2 & 6 will continue to be available at the copays listed.
Tier 2: Generic	You pay $10	You Pay $15	You pay $20	You pay $30	
Tier 3: Preferred Brand	You pay $35	You pay $40	You pay $70	You pay $80	
Tier 4: Non-Preferred Brand	You pay $90	You pay $95	You pay $225	You pay $237.50	
Tier 5: Specialty	You pay 33% coinsurance	You pay 33% coinsurance	Not Covered	Not Covered	
Tier 6: Select Care	You pay $0	You pay $5	You pay $0	You pay $10	

Premiums and Benefits	Vibra Health Plan Essential Coverage PPO	Vibra Health Plan Enhanced Coverage PPO
Coverage Gap (Donut Hole)	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there is a temporary change in what you pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid for drugs purchased through mail order) reaches $3,750 in 2018. After you enter the coverage gap, you pay no more than 35% of the cost of Brand drugs and 44% of the cost of Generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. In addition, you will continue to pay the copays listed on page **13** for drugs in Tiers 1 & 6.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there is a temporary change in what you pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid for drugs purchased through mail order) reaches $3,750 in 2018. After you enter the coverage gap, you pay no more than 35% of the cost of Brand drugs and 44% of the cost of Generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. In addition, you will continue to pay the copays listed on page **14** for drugs in Tiers 1, 2, & 6.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacies and through mail order) reach $5,000 in 2018, you pay the greater of: • 5% of the drug cost, or –$3.35 for Generic/ multi-source Brand drugs – $8.35 for Brand drugs	After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacies and through mail order) reach $5,000 in 2018, you pay the greater of: • 5% of the drug cost, or –$3.35 for Generic/ multi-source Brand drugs – $8.35 for Brand drugs

Summary of Optional Supplemental Benefits
January 1 – December 31, 2018

You may choose to purchase the **Essential Dental** or **Enhanced Dental** optional supplemental benefit in addition to your **Vibra Health Plan PPO** plan. These benefit options provide additional dental coverage to your **Vibra Health Plan PPO** Medicare Advantage medical coverage.

When you enroll in the **Vibra Health Plan PPO** Essential plan, you are eligible to enroll in the supplemental Essential Dental benefit. When you enroll in the **Vibra Health Plan PPO** Enhanced plan, you are eligible to enroll in the supplemental Enhanced Dental benefit. Premiums and additional benefit information can be found in the document below.

There is no deductible, and there is no waiting period before your coverage begins.

Optional Supplemental Dental Benefits			
Premiums and Benefits	**<u>Essential</u> Dental**	**<u>Enhanced</u> Dental**	**What you should know**
Enrollee Monthly premium	You pay $33.30 ***Essential Dental can only be purchased in conjunction with the Essential Coverage plan.**	You pay $28.00 ***Enhanced Dental can only be purchased in conjunction with the Enhanced Coverage plan.**	Enrollee monthly premium for dental coverage is in addition to the premium for medical coverage and your Medicare Part B premium. Essential Coverage PPO ($0) + Essential Dental ($33.30) = $33.30 monthly premium in addition to your Medicare Part B premium. Enhanced Coverage PPO ($55.00) + Enhanced Dental ($28.00) = $83.00 monthly premium in addition to your Medicare Part B premium.
Deductible	$0	$0	
Annual Maximum (per calendar year)	Unlimited for diagnostic and preventive services, $1,000 for all other services	Unlimited for diagnostic and preventive services, $1,000 for all other services	Covered diagnostic and preventive services do not count against the $1,000 annual maximum.

Annual Maximum (per calendar year) continued			**Copays and coinsurances still apply.** Basic Services and Major Services count towards the $1,000 annual maximum **Vibra Health Plan** will pay each plan year.
Preventive Services			
Cleanings	2 per year: You pay $0 per cleaning	Preventive Dental Services are included in the Enhanced Coverage Plan's base benefits. See page **7** under Dental Services for benefit information.	"Per year" refers to calendar years. Preventive services do not count towards the $1,000 annual maximum **Vibra Health Plan** will pay each plan year. Basic Services and Major Services count towards the $1,000 annual maximum **Vibra Health Plan** will pay each plan year.
Exams	2 per year: You pay $20 per exam		
Bitewing X-rays	2 per year: You pay $20 per x-ray		
Full-Mouth X-rays	1 every 3 years: You pay $30 per x-ray		
Panoramic X-rays	1 every 3 years: You pay $30 per x-ray		
Periapical (single tooth) X-rays	As needed: You pay $10 per x-ray		
Basic Services			
Fillings (Basic Restorative Services)	You pay 20% coinsurance	You pay 20% coinsurance	This benefit covers silver (amalgam) fillings. White (composite) fillings will be covered for front teeth.
Other Basic Restorative Services	You pay 20% coinsurance	You pay 20% coinsurance	Example: inlays, onlays, core buildup, pin retention, recementing of crowns, additional crown procedures

Major Services			
Major Restorative	You pay 50% coinsurance	You pay 50% coinsurance	Example: crowns *Implants are **not** covered.
Endodontics	You pay 50% coinsurance	You pay 50% coinsurance	Example: root canals
Simple Extractions	You pay 50% coinsurance	You pay 50% coinsurance	Example: tooth removal
Complex Oral Surgery	You pay 50% coinsurance	You pay 50% coinsurance	Example: jawbone shaping
Non-Surgical Periodontics	You pay 50% coinsurance	You pay 50% coinsurance	Example: cleaning teeth below gum lines
Surgical Periodontics	You pay 50% coinsurance	You pay 50% coinsurance	Example: gum surgery
Prosthodontics	You pay 50% coinsurance	You pay 50% coinsurance	Example: bridges, dentures *Implants are **not** covered.
Orthodontia	Not Covered		Example: braces

It is recommended that dentists submit a pre-treatment estimate request prior to performing any basic or major service.

Vibra Health Plan PPO has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, you will have a larger share of the cost for the services.

Out-of-network/non-contracted providers are under no obligation to treat **Vibra Health Plan PPO** members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Vibra Health Plan PPO covers Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see our plan's provider and pharmacy directory, as well as the plan formulary (list of Part D prescription drugs) and any restrictions, at our website at www.vibrahealthplan.com. The formulary, pharmacy network and /or provider network may change at any time. You will receive notice when necessary.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio. Please contact us if you would like to receive this in an alternative format.

Important Terms

Ambulatory Surgical Center – An entity that operates exclusively for furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $5,000.00 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member must pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (2) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of the 6 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug

Deductible – The amount you are responsible for paying out of pocket for your healthcare services before your plan begins helping you pay.

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for medical reasons. Examples are walkers, wheelchairs, or hospital beds.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $3750.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (nonpreferred) providers.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "network providers" when they have an agreement with **Vibra Health Plan** to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits to get them.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-Network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

Pre-Treatment Estimate (Delta Dental) - an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Member.

Premium – The monthly payment you make to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Physician (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. In a PPO, some medical services are covered only if your doctor or other provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Vibra Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Vibra Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Vibra Health Plan provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓Qualified sign language interpreters
- ✓Written information in other formats (large print, audio, accessible electronic format, other formats)
- ✓Qualified interpreters, and information written in other languages

If you need these services, call 1-844-388-8268 (TTY: 711).

If you believe that Vibra Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person; or you can file a grievance by mail, phone, fax, or email at:

Vibra Health Plan
P.O. Box 60250 Harrisburg, PA 17106-0250
1-717-510-6203 (TTY: 711), fax, 1-844-744-5585
CRC@vibrahealthplan.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Room 509F, HHH Building, Washington, D.C. 20201, Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language assistance

To talk to an interpreter in your language at no cost, call 1-844-388-8268 (TTY: 711).
Para hablar con un intérprete de forma gratuita, llame al 1-844-388-8268 (TTY: 711).
欲免费用本国语言洽询传译员，请拨电话1-844-388-8268 (TTY: 711).
Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 1-844-388-8268 (TTY: 711).
Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 1-844-388-8268 (TTY: 711).
Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 1-844-388-8268 uff (TTY: 711).
무료 전화 통역 서비스1-844-388-8268 (TTY: 711).
Per parlare con un interpete nella vostra lingua gratis, chiami 1-844-388-8268 (TTY: 711).
للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 1-844-388-8268(الهاتف النصي: 711)
Pour parler à un interpréter dans votre langue sans charges, téléphoner à 1-844-388-8268 (TTY: 711).
Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-388-8268 an (TTY: 711).
ક્ષભાષીયા જોડે વાત કરવા, 1-844-388-8268 (TTY: 711) પર ફોન કરો.
Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 1-844-388-8268 (TTY: 711).
Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 1-844-388-8268 (TTY: 711).
ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 1-844-388-8268 (TTY: 711).
Para falar com um intérprete em seu idioma de graça, ligue para 1-844-388-8268 (TTY: 711).

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