



# Summary of Benefits

MoreCare Home (HMO SNP)  
MoreCare At Home (HMO SNP)

**Coverage Period**  
January 1, 2021 to  
December 31, 2021

**MoreCare**<sup>®</sup>  
A Medical Home Network Affiliate

## Summary of Benefits – MoreCare Home and MoreCare At Home (HMO SNP)

January 1, 2021 – December 31, 2021

This booklet provides a summary of what we cover and what you pay. This summary does not list every service that we cover or list every limitation or exclusion. To get a complete list of the services that we cover, call us to ask for the “Evidence of Coverage”. You can also find a copy on our website at [mymorecare.com](http://mymorecare.com).

### You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare Advantage health plan, such as MoreCare (HMO SNP).
- In a Medicare Advantage HMO plan, you pick one primary care provider (PCP). Most of your health care services will be referred by the PCP you select. Visits to health care professionals outside of your network typically aren't covered by the plan.

### Tips for comparing your Medicare choices

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, you can visit the Medicare Plan Finder on <http://www.medicare.gov>.
- 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.

### Sections in this booklet

- Things to Know About *MoreCare Home* and *MoreCare At Home* (HMO SNP)
- Monthly Premiums, Deductibles, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This information is not a complete description of benefits. For more information contact the plan at **844-480-8528 (TTY: 711)**. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

## About MoreCare

Community-based and provider led, MoreCare brings a unique, coordinated approach to health care – making it easier for Medicare-eligible folks like yourself to get the **quality, whole-person care** you deserve. MoreCare’s Medicare Advantage plans are designed to give you the coverage and options you need to stay healthy. We strive to keep **quality high and costs low** by working with local providers and hospitals to deliver **personalized, coordinated care you can trust**.

## How do I contact MoreCare?

Our hours of operation are 8 a.m. to 8 p.m. CST, 7 days a week from October 1 – March 31. (Monday through Friday from April 1 – September 30).

- If you’re a member of this plan, call us toll-free at **844-480-8528** (TTY: 711).
- If you’re **not** a member of this plan, call us toll-free at **877-770-2636** (TTY: 711)
- Or, visit us at our website: [mymorecare.com](http://mymorecare.com).

## Who can Join?

- You must be entitled to Medicare Part A, be enrolled in Part B, and live in the plan’s service area. Our service area is **Cook County, Illinois**.
- To join **MoreCare Home**, you must:
  - Live in a nursing home or other long-term care facility that is part of our network
- To join **MoreCare At Home**, you must:
  - Live in a nursing home or other long-term care facility that is part of our network
  - *Or* – You live at home and the *State of Illinois* has certified that you need the type of care that is usually provided in a nursing home

## What Providers can I use?

- **MoreCare (HMO SNP)** has a network of doctors, hospitals, pharmacies, and other providers. Except in emergency situations, if you use providers that are not in our network, the plan may not pay for the services.
- When you enroll in our plan, you will select a primary care provider (PCP). Most of your health care services will be referred by your PCP. You may need a referral before you can see other providers. Certain services will require a prior authorization.
- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can see our plan’s Provider Directory and Pharmacy Directory at our website at [mymorecare.com](http://mymorecare.com). Or, call us and we will send you a copy of the Provider and Pharmacy Directories.

## What does Original Medicare cover?

To know more about the coverage and cost of Original Medicare, look in the current “Medicare and You” handbook at [www.medicare.gov](http://www.medicare.gov). Or obtain a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY: 1-877-486-2048).

## What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more.

- **For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.
- We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.
- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, [mymorecare.com](http://mymorecare.com)
- Or, call us and we will send you a copy of the formulary.

## Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

How much is the monthly premium?	<b>\$0 per month.</b> In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan(s) does <b>not</b> have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.
What is my maximum out-of-pocket responsibility?	Your yearly limit(s) in this plan: <b>\$3,450</b> for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

## Covered Medical and Hospital Benefits

\*Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart below by an asterisk.

Most of your health care services will be referred by the doctor you select.

Services that are covered for you	What you must pay when you get these services	
<b>Inpatient Hospital Care*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<p>Inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services.</p> <p>Your benefit period is the same as Original Medicare. It begins the day you are admitted to the hospital or SNF and ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days. There is no limit to the number of benefit periods.</p> <p><i>*Prior authorization required for elective admissions.</i></p>	<p><b>\$295</b> copay each day for days 1-6.</p> <p>No copay, coinsurance, or deductible for days 7-90.</p>	<p><b>\$295</b> copay each day for days 1-6.</p> <p>No copay, coinsurance, or deductible for days 7-90.</p>
<b>Outpatient Hospital Care/Ambulatory Surgical Center*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, outpatient surgery</li> <li>• Laboratory and diagnostic tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies such as splints and casts</li> <li>• Certain drugs and biologicals that you can't give yourself</li> </ul>	<p><b>20%</b> coinsurance</p>	<p><b>20%</b> coinsurance</p>
<b>Doctor's Office Visits</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<ul style="list-style-type: none"> <li>• Medical care or surgery services in a physician's office, ambulatory surgical center, hospital outpatient department, or other location</li> <li>• Consultation, diagnosis, and treatment by a specialist*</li> </ul>	<p><b>\$0</b> copay for Primary Care Provider (PCP) visits.</p> <p><b>20%</b> coinsurance for Physician Specialist services.</p>	<p><b>\$0</b> copay for Primary Care Provider (PCP) visits.</p> <p><b>20%</b> coinsurance for Physician Specialist services.</p>

Services that are covered for you	What you must pay when you get these services	
<b>Preventive Care</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<p>We cover many preventive services, including:</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screenings</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)</li> <li>• Depression screening</li> <li>• Diabetes screenings</li> <li>• HIV screening</li> <li>• Medical nutrition therapy services</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Sexually transmitted infections screening and counseling</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>• “Welcome to Medicare” preventive visit (one-time)</li> <li>• Yearly “Wellness” visit</li> </ul>	No coinsurance, copay, or deductible for Medicare-covered preventive services.	No coinsurance, copay, or deductible for Medicare-covered preventive services.
<b>Emergency Care / Post-Stabilization Care</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Emergency medical care covered in the U.S. only.	<p><b>\$120</b> copay per visit</p> <p>Copay is waived if admitted within three (3) days.</p>	<p><b>\$120</b> copay per visit</p> <p>Copay is waived if admitted within three (3) days.</p>
<b>Urgently Needed Services</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care	<b>\$25</b> copay per visit	<b>\$25</b> copay per visit

Services that are covered for you	What you must pay when you get these services	
<b>Outpatient Diagnostic Tests, Lab and Radiology Services, and X-rays*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<p><i>(Costs for these services may vary based on place of services)</i></p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy including technician materials and supplies</li>   <li>• Laboratory tests</li> <li>• Other outpatient diagnostic tests <ul style="list-style-type: none"> <li>○ Genetic testing*</li> </ul> </li> </ul> <p><i>*Prior authorization required for genetic testing. Prior authorization and a referral are required for MRI, CT, PET, and Nuclear services.</i></p>	<p><b>\$0</b> copay for X-rays</p> <p><b>20%</b> coinsurance diagnostic radiation services and therapeutic radiation services.</p> <p><b>\$0</b> copay for laboratory tests or other diagnostic procedures/tests.</p>	<p><b>20%</b> coinsurance for X-rays</p> <p><b>20%</b> coinsurance for diagnostic radiation services and therapeutic radiation services.</p> <p><b>\$0</b> copay for laboratory tests or other diagnostic procedures/tests.</p>
<b>Hearing Services</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<ul style="list-style-type: none"> <li>• Diagnostic hearing and balance evaluations performed by your PCP or specialty provider</li> <li>• Routine hearing exams covered once (1) every year</li> <li>• \$2,000 hearing aid allowance per year, both ears combined</li> <li>• <i>No authorization or referral required</i></li> </ul>	<p><b>\$0</b> copay for one (1) in-network routine hearing exam per year.</p> <p><b>\$2,000</b> hearing aid allowance each year.</p>	<p><b>\$0</b> copay for one (1) in-network routine hearing exam per year.</p> <p><b>\$2,000</b> hearing aid allowance each year.</p>
<b>Dental Services</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Preventive services, cleaning, X-rays, filling, extractions, crowns, dentures, and periodontics.	<b>\$0</b> copay	<b>\$0</b> copay
<b>Dental Preventive Services:</b> <b>Preventive/Diagnostic Services Exams</b> One (1) initial or periodic routine oral exam every year, including diagnosis and charting  <b>Cleanings (prophylaxis)</b> One (1) cleaning every six (6) months, including minor scaling and polishing  <b>Fluoride Treatment</b> One (1) treatment every six (6) months	<p><b>\$0</b> copay</p> <p><b>\$0</b> copay</p> <p><b>\$0</b> copay</p> <p><b>\$0</b> copay</p>	<p><b>\$0</b> copay</p> <p><b>\$0</b> copay</p> <p><b>\$0</b> copay</p> <p><b>\$0</b> copay</p>

Services that are covered for you	What you must pay when you get these services	
Dental Services (continue)	MoreCare Home (Plan 003)	MoreCare At Home (Plan 004)
<b>Dental X-rays</b> <ul style="list-style-type: none"> <li>• One (1) set of bite-wing x-rays per every two (2) years</li> <li>• One (1) set of intraoral x-rays per year</li> <li>• Full mouth set of x-rays or panoramic x-rays every five (5) years</li> </ul>	\$0 copay	\$0 copay
<b>Comprehensive Dental Services:</b> <b>Fillings</b> – Amalgam fillings (resin) or composite fillings (white fillings), on all teeth. Fillings are covered up to the annual dental benefit maximum. <b>Simple Extractions and Oral Surgery*</b> – Tooth extraction including surgical extraction up to the annual dental benefit maximum. Dental extractions and oral surgery require prior authorization. <b>Crowns</b> – Covered up to the annual dental benefit maximum. <b>Dentures and Denture Repair</b> – Dentures and denture repair, including services to adjust or realign dentures, covered up to the annual dental benefit maximum.	 \$0 copay  \$0 copay  \$0 copay  \$0 copay	 \$0 copay  \$0 copay  \$0 copay  \$0 copay
<b>Annual Dental Benefit Maximum</b> Maximum per calendar year for covered dental services.	\$1,800	\$1,800
Vision Services	MoreCare Home (Plan 003)	MoreCare At Home (Plan 004)
Outpatient physician services for diagnosis and treatment of diseases and injuries of the eye.  One (1) pair of eyeglasses or contact lenses after each cataract surgery  One (1) pair of eyeglasses (frame and lenses) or elective contact lenses with fitting every calendar year up to \$300.	\$0 copay for one (1) routine eye exam every year.  \$0 copay for one (1) pair of eyeglasses or contact lenses after cataract surgery.  \$300 plan coverage for one (1) pair of eyeglasses (frame and lenses) or elective contact lenses every calendar year.	\$0 copay for one (1) routine eye exam every year.  \$0 copay for one (1) pair of eyeglasses or contact lenses after cataract surgery.  \$300 plan coverage for one (1) pair of eyeglasses (frame and lenses) or elective contact lenses every calendar year.

Services that are covered for you	What you must pay when you get these services	
<b>Inpatient Mental Health Care*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<p>Your benefit period is the same as Original Medicare. It begins the day you are admitted to the hospital or SNF and ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days. There is no limit to the number of benefit periods.</p> <p><i>*Prior authorization required for elective admissions.</i></p>	<p><b>\$295</b> copay each day for days 1-5.</p> <p>No copay, coinsurance, or deductible for days 6-90.</p> <p>You are covered for unlimited additional days each benefit period.</p> <p>No copay, coinsurance, or deductible for additional days.</p>	<p><b>\$295</b> copay each day for days 1-5.</p> <p>No copay, coinsurance, or deductible for days 6-90.</p> <p>You are covered for unlimited additional days each benefit period.</p> <p>No copay, coinsurance, or deductible for additional days.</p>
<b>Outpatient Mental Health Care</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Individual or group sessions	20% coinsurance	20% coinsurance
<b>Outpatient Substance Abuse</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Individual and group substance abuse services	20% coinsurance	20% coinsurance
<b>Skilled Nursing Facility (SNF) care*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<p>Your benefit period is the same as Original Medicare. It begins the day you are admitted to the hospital or SNF and ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days. There is no limit to the number of benefit periods.</p>	<p><b>\$0</b> copay each day for days 1-20.</p> <p><b>\$184</b> copay each day for days 21-100.</p> <p>You are covered for up to 100 days each benefit period for inpatient services in a SNF.</p>	<p><b>\$0</b> copay each day for days 1-20.</p> <p><b>\$184</b> copay each day for days 21-100.</p> <p>You are covered for up to 100 days each benefit period for inpatient services in a SNF.</p>
<b>Outpatient Rehabilitation Services*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<p>Physical, occupational, and speech language therapy</p> <p><i>*Prior authorization required beyond initial evaluation and four (4) visits.</i></p>	\$0 copay	20% coinsurance

Services that are covered for you	What you must pay when you get these services	
<b>Cardiac Rehabilitation Services*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Comprehensive programs	20% coinsurance	20% coinsurance
<b>Pulmonary Rehabilitation Services*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Comprehensive programs	20% coinsurance	20% coinsurance
<b>Ambulance Services*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Air (fixed and rotary wing) and ground ambulance to the nearest appropriate facility <i>*Prior authorization required for non-emergency services.</i>	20% coinsurance	20% coinsurance
<b>Transportation</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Routine services to and from your PCP or specialist's office or dentist within our service area.	\$0 copay for up to <b>18 one-way trips</b> to plan approved locations every year.	\$0 copay for up to <b>18 one-way trips</b> to plan approved locations every year.
<b>Medicare Part B Drugs*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Includes drugs that usually are not self-administered	20% coinsurance for each Medicare Part B drug.	20% coinsurance for each Medicare Part B drug

## Prescription Drug Benefits

You may get your drugs at network retail pharmacies and mail-order pharmacies.

If you reside in a long-term care facility, you pay the same for a 31-day supply at a retail pharmacy.

<b>Stage 1: Annual Prescription Drug Deductible</b>	For Part D Prescription Drugs in Tier 2 – Tier 5* <b>\$365</b> per year for MoreCare Home (Plan 003) <b>\$445</b> per year for MoreCare At Home (Plan 004) <b>*There is no deductible for Tier 1 Drugs.</b>		
<b>Cost Sharing for Covered Drugs</b>		<b>Retail / Mail Order</b>	<b>Retail / Mail Order</b>
<b>Stage 2: Initial Coverage Stage</b> (After you pay the deductible, if applicable)		<b>30-day supply</b>	<b>Up to 90-day supply*</b>
	<b>Tier 1*</b> <i>Preferred Generic</i>	\$3 copay	\$9 copay
	<b>Tier 2</b> <i>Non-Preferred Generic</i>	\$18 copay	\$54 copay
	<b>Tier 3</b> <i>Preferred Brand</i>	\$45 copay	\$135 copay
	<b>Tier 4</b> <i>Non-Preferred Brand</i>	40% coinsurance	40% coinsurance
	<b>Tier 5</b> <i>Specialty Drugs</i>	25% coinsurance	A long-term supply is not available for drugs in Tier 5
<b>Stage 3: Coverage Gap Stage</b>	After your total drug costs reach <b>\$4,130</b> , you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug that is in the Coverage Gap.		
<b>Stage 4: Catastrophic Coverage</b>	After your yearly out-of-pocket costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of: <ul style="list-style-type: none"> <li>○ 5% coinsurance, or</li> <li>○ <b>\$3.70</b> for a generic drug or a drug that is treated like a generic and <b>\$9.20</b> for all other drugs.</li> </ul>		

## Other Care and Services

Services that are covered for you	What you must pay when you get these services	
<b>Caregiver support services</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<p>Web-based and telephonic resources to reduce stress of caregiving related burdens and improve effectiveness of caring for loved ones. Members and their caregivers can access this benefit two (2) ways:</p> <ol style="list-style-type: none"> <li><b>MyCareDesk:</b> a digital platform that includes a comprehensive suite of web-based tools and resources. <ul style="list-style-type: none"> <li>To access, please visit <i>morecare.mycaredesk.com</i> and register using your MoreCare Member ID.</li> </ul> </li> <li><b>Care Advocate Support Line:</b> A telephonic consultation option for personalized, expert caregiver guidance. <ul style="list-style-type: none"> <li>To speak to a Care Advocate, please call (833) 676-0660. They are available Monday – Friday, 7 a.m. to 6 p.m. CST.</li> <li>You can also connect with a Care Advocate through the Chat feature on the MyCareDesk platform.</li> </ul> </li> </ol>	\$0 copay for caregiver support services.	\$0 copay for caregiver support services.
<b>Health and Wellness Education Programs</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Gym membership at participating fitness facilities.	Not covered.	\$0 copay for monthly gym membership
<b>Healthy Food*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<p>With your PCP's approval, you can receive one (1) box of healthy food per month, delivered to your residence.</p> <p><i>*Prior authorization required. This benefit is administered via primary care order.</i></p>	Not covered.	\$0 copay
<b>Over-the-Counter Items</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
<p>Drugs and other health-related pharmacy products at participating retailers or mail-order catalogue.</p> <p>Unused funds do not roll over.</p>	We cover <b>\$95</b> for approved over-the-counter items <b>every three (3) months.</b>	We cover <b>\$95</b> for approved over-the-counter items <b>every three (3) months.</b>

Services that are covered for you	What you must pay when you get these services	
<p><b>Foot Care (Podiatry Services)*</b></p> <ul style="list-style-type: none"> <li>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with certain medical conditions affecting the lower limbs</li> <li>• Routine foot care services not normally covered by Original Medicare. Includes trimming of toenails and removal of calluses. You are covered for two (2) visits per year.</li> </ul> <p><i>*Prior authorization required for services beyond initial evaluation and four (4) visits</i></p>	<p><b>MoreCare Home (Plan 003)</b></p> <p><b>20%</b> coinsurance for Medicare-covered podiatry services.</p> <p><b>\$0</b> copay for two (2) routine foot care visits per year.</p>	<p><b>MoreCare At Home (Plan 004)</b></p> <p><b>20%</b> coinsurance for Medicare-covered podiatry services.</p> <p><b>\$0</b> copay for two (2) routine foot care visits per year.</p>
<p><b>Diabetes self-management training, diabetic services and supplies</b></p> <ul style="list-style-type: none"> <li>• Supplies to monitor your blood glucose</li> <li>• Medicare-covered therapeutic shoes</li> <li>• Diabetes self-management training</li> </ul>	<p><b>MoreCare Home (Plan 003)</b></p> <p><b>\$0</b> copay for Abbott Freestyle covered blood glucose monitors and blood glucose test strips.</p> <p><b>35%</b> coinsurance for non-preferred brand diabetic self-monitoring supplies</p> <p><b>\$0</b> copay for each pair of Medicare-covered therapeutic shoes.</p> <p><b>\$0</b> copay for Medicare-covered classes.</p>	<p><b>MoreCare At Home (Plan 004)</b></p> <p><b>\$0</b> copay for Abbott Freestyle covered blood glucose monitors and blood glucose test strips.</p> <p><b>35%</b> coinsurance for non-preferred brand diabetic self-monitoring supplies</p> <p><b>\$0</b> copay for each pair of Medicare-covered therapeutic shoes.</p> <p><b>\$0</b> copay for Medicare-covered classes.</p>
<p><b>Chiropractic Care*</b></p>	<p><b>MoreCare Home (Plan 003)</b></p>	<p><b>MoreCare At Home (Plan 004)</b></p>
<p>Manual manipulation of the spine to correct subluxation</p> <p><i>*Prior authorization required beyond initial evaluation and four (4) visits.</i></p>	<p><b>20%</b> coinsurance</p>	<p><b>20%</b> coinsurance</p>
<p><b>Durable Medical Equipment (DME) and Related Supplies*</b></p>	<p><b>MoreCare Home (Plan 003)</b></p>	<p><b>MoreCare At Home (Plan 004)</b></p>
<p>Generally limited to preferred vendors. Contact us for this list.</p> <p><i>*Prior authorization is required for all DME items with a purchase price greater than \$500 or \$38.50 per month, if rented</i></p>	<p><b>20%</b> coinsurance for each Medicare-covered DME and related supplies.</p>	<p><b>20%</b> coinsurance for each Medicare-covered DME and related supplies.</p>

Services that are covered for you	What you must pay when you get these services	
<b>Home Health Agency Care*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Medicare-covered visits.	No copay, coinsurance or deductible for visits.	No copay, coinsurance or deductible for visits.
<b>Prosthetic Devices and Related Supplies*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Devices and certain supplies, and repair and/or replacement.	20% coinsurance for each device and related supplies.	20% coinsurance for each device and related supplies.
<b>Renal Dialysis*</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
Dialysis treatment and services. <i>*Authorization and referral required for non-emergent care</i>	20% coinsurance	20% coinsurance
<b>Hospice</b>	<b>MoreCare Home (Plan 003)</b>	<b>MoreCare At Home (Plan 004)</b>
You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care. You must get care from a Medicare certified hospice.	Hospice is covered outside of our plan and not by MoreCare. Contact us for more information.	Hospice is covered outside of our plan and not by MoreCare. Contact us for more information.

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