Summary of Benefits

Tennessee

Unison Advantage Plus (HMO)
H5998_003

January 1, 2010 – December 31, 2010

Unison Advantage from AmeriChoice™

A healthier tomorrow begins with you.℠

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Section I - Introduction to Summary of Benefits

Thank you for your interest in Unison Advantage® Plus (HMO). Our plan is offered by UNISON HEALTH PLAN OF TENNESSEE, INC./Unison Advantage®, a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria.

You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Please call Unison Advantage Plus (HMO) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Unison Advantage Plus (HMO) 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 Unison Advantage Plus (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

Please call Unison Advantage Plus (HMO) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How can I Compare my Options?

You can compare Unison Advantage Plus (HMO) 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 Unison Advantage Plus (HMO) Available?

The service area for this plan includes: Carroll, Fayette, Lake, Lauderdale, Obion, Shelby, Tipton Counties, TN. You must live in one of these areas to join the plan.

Who is Eligible to Join Unison Advantage Plus (HMO)?

You can join Unison Advantage Plus (HMO) 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 generally are not eligible to enroll in Unison Advantage Plus (HMO) unless they are members of our organization and have been since their dialysis began.

You must also receive assistance from the state to join this plan.

Please call plan to see if you are eligible to join.

Can I Choose my Doctors?

Unison Advantage Plus (HMO) 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 or for an up-to-date list visit us at www.unisonhealthplan.com.

Our customer service number is listed at the end of this introduction.

What Happens if I Go to a Doctor Who's not in Your Network?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Unison Advantage Plus (HMO) nor the Original Medicare Plan will pay for these services.

Does my Plan Cover Medicare Part B or Part D Drugs?

Unison Advantage Plus (HMO) 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?

Unison Advantage Plus (HMO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.unisonhealthplan.com. Our customer service number is listed at the end of this introduction.

What is a Prescription Drug Formulary?

Unison Advantage Plus (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.unisonhealthplan.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How can I Get Extra Help With my Prescription Drug Plan Costs?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

What are my Protections in This Plan?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Unison Advantage Plus (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qsource, 1-800-528-2655.

As a member of Unison Advantage Plus (HMO), 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. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qsource, 1-800-528-2655.

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 Unison Advantage Plus (HMO) for more details.

What Types of Drugs may be Covered Under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Unison Advantage Plus (HMO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

Plan Ratings

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-888-727-8620 to obtain a copy of the plan ratings for this plan. TTY users call 711.

Please call Unison Advantage® for more information about
Unison Advantage Plus (HMO).

Visit us at **www.unisonhealthplan.com** or, call us:

Customer Service Hours:

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

Current members should call toll-free 1-800-290-4009 for questions related to the Medicare Advantage Program and Medicare Part D Prescription Drug program.

TTY/TDD: 711

Prospective members should call toll-free 1-888-727-8620 for questions related to the Medicare Advantage and Medicare Part D Prescription Drug Program.

TTY/TDD: 711

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.

Section II - Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact Unison Advantage® for details.

Benefit	Original Medicare	Unison Advantage Plus (HMO)
Important Information		
1 **Premium and Other Important Information**	The Medicare cost sharing amount may vary based on your level of Medicaid eligibility. Most Medicare beneficiaries will continue to pay the same $0 or $96.40 Part B premium amount in 2010 and the yearly deductible amount is $0 or $155. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.	**General** $19.40 monthly plan premium in addition to your monthly Medicare Part B premium.* *All cost sharing in this summary of benefits is based on your level of Medicaid eligibility. **In-Network** In 2010 the yearly Part B deductible amount is $0 or $155 .* Contact the plan for services that apply.
2 **Doctor and Hospital Choice** (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.
Inpatient Care		
3 **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	In 2010 the amounts for each benefit period, $0 or: Days 1 - 60: $1,100 deductible* Days 61 - 90: $275 per day* Days 91 - 150: $550 per lifetime reserve day* Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row	**In-Network** In 2010 the amounts for each benefit period, $0 or: Days 1 - 60: $1,100 deductible* Days 61 - 90: $275 per day* Days 91 - 150: $550 per lifetime reserve day* You will not be charged additional cost sharing for professional services. Plan covers 90 days each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Benefit	Original Medicare	Unison Advantage Plus (HMO)
Inpatient Care (continued)		
	without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	
4 **Inpatient Mental Health Care**	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day lifetime limit in a Psychiatric Hospital.	**In-Network** Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care") You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5 **Skilled Nursing Facility (SNF)** (in a Medicare-certified skilled nursing facility)	In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: $0 per day* Days 21 - 100: $0 or $137.50 per day* 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply. **In-Network** In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are: $0 or: Days 1 - 20: $0 per day* Days 21 - 100: $137.50 per day* You will not be charged additional cost sharing for professional services. Plan covers up to 100 days each benefit period 3-day prior hospital stay is required.
6 **Home Health Care** (includes medically necessary intermittent skilled nursing care, home health aide services,	$0 copay.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered home health visit.*

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Benefit	Original Medicare	Unison Advantage Plus (HMO)
Inpatient Care (continued)		
and rehabilitation services, etc.)		
⑦ **Hospice**	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.	**General** You must get care from a Medicare-certified hospice.
Outpatient Care		
⑧ **Doctor Office Visits**	0% or 20% coinsurance	**In-Network** 0% or 20% of the cost for each primary care doctor visit for Medicare-covered benefits.* 0% or 20% of the cost for each in-area, network urgent care Medicare-covered visit.* 0% or 20% of the cost for each specialist visit for Medicare-covered benefits.*
⑨ **Chiropractic Services**	Routine care not covered 0% or 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**General** Authorization rules may apply. **In-Network** 0% or 20% of the cost for each Medicare-covered visit.* Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
⑩ **Podiatry Services**	Routine care not covered. 0% or 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** 0% or 20% of the cost for each Medicare-covered visit.* $0 copay for up to 4 routine visit(s) every year Medicare-covered podiatry benefits are for medically-necessary foot care.

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Benefit	Original Medicare	Unison Advantage Plus (HMO)
Outpatient Care (continued)		
(11) **Outpatient Mental Health Care**	0% or 45% coinsurance for most outpatient mental health services.	**General** Authorization rules may apply. **In-Network** 0% or 45% of the cost for each Medicare-covered individual or group therapy visit.*
(12) **Outpatient Substance Abuse Care**	0% or 20% coinsurance	**General** Authorization rules may apply. **In-Network** 0% or 20% of the cost for Medicare-covered individual or group visits.*
(13) **Outpatient Services/Surgery**	0% or 20% coinsurance for the doctor 0% or 20% of outpatient facility charges	**General** Authorization rules may apply. **In-Network** 0% or 20% of the cost for each Medicare-covered ambulatory surgical center visit.* 0% or 20% of the cost for each Medicare-covered outpatient hospital facility visit.*
(14) **Ambulance Services** (medically necessary ambulance services)	0% or 20% coinsurance	**General** Authorization rules may apply. **In-Network** 0% or 20% of the cost for Medicare-covered ambulance benefits.*
(15) **Emergency Care** (You may go to any emergency room if you reasonably believe you need emergency care.)	0% or 20% coinsurance for the doctor 0% or 20% of facility charge You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	**General** $0 or $50 copay for Medicare-covered emergency room visits.* Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit

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Benefit	Original Medicare	Unison Advantage Plus (HMO)
Outpatient Care (continued)		
(16) **Urgently Needed Care** (This is NOT emergency care, and in most cases, is out of the service area.)	0% or 20% coinsurance NOT covered outside the U.S. except under limited circumstances.	**General** 0% or 20% of the cost for Medicare-covered urgently needed care visits.* If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care vist.
(17) **Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	0% or 20% coinsurance	**General** Authorization rules may apply. **In-Network** 0% or 20% of the cost for Medicare-covered Occupational Therapy visits.* 0% or 20% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.*
Outpatient Medical Services and Supplies		
(18) **Durable Medical Equipment** (includes wheelchairs, oxygen, etc.)	0% or 20% coinsurance	**General** Authorization rules may apply. **In-Network** 0% or 20% of the cost for Medicare-covered items.*
(19) **Prosthetic Devices** (includes braces, artificial limbs and eyes, etc.)	0% or 20% coinsurance	**General** Authorization rules may apply. **In-Network** 0% or 20% of the cost for Medicare-covered items.*
(20) **Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies** (includes coverage for glucose monitors,	0% or 20% coinsurance Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and	**General** Authorization rules may apply. **In-Network** 0% or 20% of the cost for Diabetes self-monitoring training.* 0% or 20% of the cost for Nutrition Therapy for Diabetes.*

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Benefit	Original Medicare	Unison Advantage Plus (HMO)
Outpatient Medical Services and Supplies (continued)		
test strips, lancets, screening tests, and self-management training)	counseling to help you manage your diabetes or kidney disease.	0% or 20% of the cost for Diabetes supplies.*
(21) **Diagnostic Tests, X-Rays, Lab Services, and Radiology Services**	0% or 20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** 0% of the cost for Medicare-covered lab services.* 0% or 20% of the cost for Medicare-covered diagnostic procedures and tests.* 0% or 20% of the cost for Medicare-covered X-rays.* 0% or 20% of the cost for Medicare-covered diagnostic radiology services.* 0% or 20% of the cost for Medicare-covered therapeutic radiology services.*
Preventive Services		
(22) **Bone Mass Measurement** (for people with Medicare who are at risk)	0% or 20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	**In-Network** 0% or 20% of the cost for Medicare-covered bone mass measurement.*
(23) **Colorectal Screening Exams** (for people with Medicare age 50 and older)	0% or 20% coinsurance Covered when you are high risk or when you are age 50 and older.	**In-Network** 0% or 20% of the cost for Medicare-covered colorectal screenings.*
(24) **Immunizations** (Flu vaccine, Hepatitis B vaccine - for people with	$0 copay for Flu and Pneumonia vaccines 0% or 20% coinsurance for Hepatitis B vaccine	**In-Network** $0 copay for Flu and Pneumonia vaccines. No referral needed for Flu and pneumonia vaccines.

*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Benefit	Original Medicare	Unison Advantage Plus (HMO)
Preventive Services (continued)		
Medicare who are at risk, Pneumonia vaccine)	You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	20% of the cost for Hepatitis B vaccine.* No referral needed for other immunizations.
25 **Mammograms (Annual Screening)** (for women with Medicare age 40 and older)	0% or 20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	**In-Network** 0% or 20% of the cost for Medicare-covered screening mammograms.*
26 **Pap Smears and Pelvic Exams** (for women with Medicare)	$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 0% or 20% coinsurance for Pelvic Exams	**In-Network** 0% or 0% of the cost for Medicare-covered pap smears.* 0% or 20% of the cost for Medicare-covered pelvic exams.*
27 **Prostate Cancer Screening Exams** (for men with Medicare age 50 and older)	0% or 20% coinsurance for the digital rectal exam. $0 for the PSA test; 0% or 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	**In-Network** 0% or 20% of the cost for Medicare-covered prostate cancer screening.*
28 **End-Stage Renal Disease**	0% or 20% coinsurance for renal dialysis 0% or 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**In-Network** 0% or 20% of the cost for renal dialysis* 0% or 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.*

*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Benefit	Original Medicare	Unison Advantage Plus (HMO)
Preventive Services (continued)		
(29) **Prescription Drugs**	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B General** $0 yearly deductible for Part B-covered drugs.* 0% or 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.* **Drugs covered under Medicare Part D General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.unisonhealthplan.com on the web. Different out-of-pocket costs may apply for people who ▪ have limited incomes, ▪ live in long term care facilities, or ▪ have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Unison Advantage Plus (HMO) for certain drugs. The plan will pay for certain over-the-counter drugs as part of its

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Benefit	Original Medicare	Unison Advantage Plus (HMO)
Preventive Services (continued)		
		utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
In-Network		You pay a $0 yearly deductible.
Initial Coverage		Depending on your income and institutional status, you pay the following: For generic drugs (including brand drugs treated as generic), either: ▪ A $0 copay or ▪ A $1.10 copay or ▪ A $2.50 copay For all other drugs, either: ▪ A $0 copay or ▪ A $3.30 copay or ▪ A $6.30 copay.
Retail Pharmacy		You can get drugs the following way(s): ▪ one-month (31-day) supply ▪ three-month (90-day) supply
Long Term Care Pharmacy		You can get drugs the following way(s): ▪ one-month (31-day) supply

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Benefit	Original Medicare	Unison Advantage Plus (HMO)
Preventive Services (continued)		
Mail Order		You can get drugs the following way(s): ▪ three-month (90-day) supply
Catastrophic Coverage		After your yearly out-of-pocket drug costs reach $4,550, you pay a $0 copay.
Out-of-Network		Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Unison Advantage Plus (HMO). You can get drugs the following way: ▪ one-month (31-day) supply
Out-of-Network Initial Coverage		Depending on your income and institutional status, you will be reimbursed by Unison Advantage Plus (HMO) up to the full cost of the drug minus the following: For generic drugs purchased out-of-network (including brand drugs treated as generic), either: ▪ A $0 copay or ▪ A $1.10 copay or ▪ A $2.50 copay For all other drugs purchased out-of-network, either: ▪ A $0 copay or ▪ A $3.30 copay or ▪ A $6.30 copay.
Out-of-Network Catastrophic Coverage		After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed in full for drugs purchased out-of-network.

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Benefit	Original Medicare	Unison Advantage Plus (HMO)
Preventive Services (continued)		
30 **Dental Services**	Preventive dental services (such as cleaning) not covered.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered dental benefits.* ▪ $0 copay for up to 1 oral exam(s) every six months ▪ $0 copay for up to 1 cleaning(s) every six months ▪ $0 copay for up to 1 dental x-ray visit(s) Plan offers additional comprehensive dental benefits.
31 **Hearing Services**	Routine hearing exams and hearing aids not covered. 0% or 20% coinsurance for diagnostic hearing exams.	**In-Network** ▪ $0 copay for Medicare-covered diagnostic hearing exams* ▪ $0 copay for up to 1 routine hearing test(s) every year ▪ $0 copay for up to 1 hearing aid(s) every two years $750 limit for hearing aids every two years.
32 **Vision Services**	0% or 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** ▪ $0 copay for one pair of eyeglasses or contact lenses after cataract surgery* ▪ $0 copay for exams to diagnose and treat diseases and conditions of the eye.* ▪ $0 copay for up to 1 routine eye exam(s) every year ▪ $0 copay for up to 1 pair(s) of contacts every two years ▪ $0 copay for up to 1 pair(s) of lenses every two years ▪ $0 copay for up to 1 frame(s) every two years $150 limit for eye wear every two years.
33 **Physical Exams**	0% or 20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage	**In-Network** When you get Medicare Part B, you can get a one-time physical within the first 12 months of your new Part B coverage. The coverage does not include lab tests.

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Benefit	Original Medicare	Unison Advantage Plus (HMO)
Preventive Services (continued)		
	When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	Routine exams not covered. 0% to 20% of the cost for Medicare-covered benefits*
Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	**In-Network** The plan covers the following health/ wellness education benefits: ▪ Written health education materials, including Newsletters ▪ Nursing Hotline ▪ Other Wellness Benefits $0 copay for each Medicare-covered smoking cessation counseling session.*
Transportation (Routine)	Not covered.	**In-Network** $0 copay for up to 24 one-way trip(s) to plan approved location every year.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.

*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Section III - Additional Benefit Information

More Benefits to Help Keep You Healthy	
Health Care Products	You are given an allowance of up to $80 every quarter for non-prescription, health related items purchased from a plan approved vendor catalog. The catalog may include such items as vitamins, Ben-Gay, deodorants, skin lotion, digital scale, chair cushions, bath aids, shower aids, and other items.
Transportation	Need a ride to your doctor's or a ride to pick up your prescription? Your membership in Unison Advantage Plus (HMO) gives you up to 24 one-way trips a year. All you have to do is call your Personal Care Specialist and they will make the arrangements for you. Your 24 one-way trips to plan approved locations will cost you $0.
Comprehensive Dental	Unison Advantage Plus (HMO) will be offering additional comprehensive dental benefits. $0 for the cost for comprehensive benefits which includes diagnostic examinations, routine restorations and non-precious metal permanent crowns (1 crown per tooth every 5 years). Please contact Customer services with any questions you may have regarding this benefit.

Member Appeals and Grievances Process

Members of our Medicare Advantage health plans have the right to request an organization determination including the right to file an appeal and the right to file a grievance. Medicare Advantage health plan organizations must identify, track, resolve and report all activity related to an appeal or grievance.

Medicare Advantage Member Appeals

What is an Appeal?
An appeal is a type of request you make when you want us to reconsider a decision concerning coverage of a service or the amount your health plan pays or will pay for a service. The initial decision concerning medical care or services is called an "organization determination."

When can an Appeal be filed?
You may file an appeal within 60 calendar days of the date of the initial organization determination. The 60-day limit may be extended for good cause. Include in your written request the reason why you could not file within the 60-day timeframe.

Who can file an Appeal?
You may file an appeal or someone else may file an appeal on your behalf. You must appoint the individual to act as your representative to file the appeal for you. To learn how to name a representative, contact Customer Service.

How can an Appeal be filed?
An appeal must be filed in writing directly to us. You may call Customer Service for additional information. Refer to Section I of the Summary of Benefits for the Customer Service address and phone number.

Fast Reviews
You have the right to request and receive fast decisions affecting your medical treatment in "time-sensitive" situations. A situation is time-sensitive if waiting for a decision to be made within the standard timeframe could seriously harm your health or your ability to function. If your doctor provides a written or oral statement supporting your need of a fast review we will automatically give you a fast review. A decision will be issued as quickly as possible but no later than 72 hours after receiving the request.

Medicare Advantage Member Grievances

What is a Grievance?
A grievance is a complaint that doesn't involve coverage for an item or service by your health plan or a contracting medical provider. If your grievance involves quality of care, you have the right to file a grievance with the Quality Improvement Organization (QIO) of your state. Refer to Section I of the Summary of Benefits for the name and phone number of the QIO in your state.

When can a Grievance be filed?
You may file a grievance within 60 calendar days of the date of the event causing the grievance. The 60-day limit may be extended for good cause. Include in your written request the reason why you could not file within the 60-day timeframe. There is no time limit for complaints concerning quality of care.

Who can file a Grievance?
You may file a grievance or someone else may file a grievance on your behalf. You must appoint the individual to act as your representative to file the grievance for you. To learn how to name a representative, contact Customer Service.

How can a Grievance be filed?
A grievance may be filed in writing or verbally by contacting Customer Service. Refer to Section I of the Summary of Benefits for the Customer Service address and phone number.

Fast Grievances
You have the right to file a fast grievance. We will respond to fast grievances within 24 hours of receipt. You may file a fast grievance if you disagree with our decision to deny your request for a fast review. You may also file a fast grievance if we notify you that we are extending our timeframe to make an organization determination or reconsideration decision.

For Members with Medicare Part D Drug Coverage through our Plan

Coverage Determinations
We will make an initial decision as to whether or not we will provide the Part D drug you are requesting or pay for the Part D drug you already received. This initial decision is called a "coverage determination."

Exceptions
You or your doctor may ask us to make an exception to our Part D coverage determination. You may request an exception if you believe you need a drug that is not on our list of covered drugs. Generally, we will only approve your request for an exception if the alternative Part D drug is included in your plan's formulary would not be as effective in treating your condition and/or would cause you to have adverse medical effects. **Your doctor or other prescriber must submit a statement supporting your exception request.** In order to help us make a decision more quickly, the supporting medical information from your doctor or other prescriber should be sent to us with the exception request. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy.

Part D Drug Appeals
If you are getting Medicare prescription Part D drug coverage through our plan you have the right to file an appeal. This includes the right to appeal our decision regarding your exception request. Follow the process outlined above to file an appeal. An appeal concerning coverage determinations must be filed in writing directly to us.

Part D Drug Grievance
If you are getting Medicare prescription Part D drug coverage through our plan you have the right to file a grievance. Follow the process outlined above to file a Part D prescription drug grievance.

Section IV - Additional Information for People with Medicare and Medicaid

People who qualify for Medicare and Medicaid are known as **dual eligibles**. As a dual eligible, you are eligible for benefits under both the federal Medicare program and the state-operated Medicaid program. The Original Medicare and supplemental benefits you receive as a member of this plan are listed in Section II and Section III.

The kind of Medicaid benefits you receive are determined by your state and may vary based upon your income and resources. With the assistance of Medicaid, some dual eligibles do not have to pay for certain Medicare costs. The Medicaid benefit categories and type of assistance are listed below:

- **Full Benefit Dual Eligible (FBDE):** Payment of your Medicare Part A premiums, in some cases Medicare Part B premiums and full Medicaid benefits.
- **Qualified Disabled and Working Individual (QDWI):** Payment of your Medicare Part A premiums.
- **Qualifying Individual (QI):** Payment of your Medicare Part B premiums.
- **Specified Low Income Medicare Beneficiary (SLMB):** Payment of your Medicare Part B premiums.
- **SLMB-Plus:** Payment of your Medicare Part B premiums and full Medicaid benefits.
- **Qualified Medicare Beneficiary (QMB Only):** Payment of your Medicare Part A and Part B premiums, deductibles and cost-sharing (excluding Part D copayments).
- **QMB-Plus:** Payment of your Medicare Part A and Part B premiums, deductibles, cost-sharing (excluding Part D copayments) and full Medicaid benefits.

If you are a QMB or QMB-Plus, you pay $0 for Medicare-covered services as shown in Section II and III, except any copayments for Part D prescription drugs.

The following chart describes Medicaid benefits that may be available to you under your state Medicaid program if you qualify for full Medicaid benefits. The chart also explains if a similar benefit is available under our plan. In most cases, the benefits listed below are not covered by traditional Medicare.

It is important to understand that Medicaid benefits can vary based on your income level and other standards. Also, your Medicaid benefits can change throughout the year. Depending on your current status, you may not be qualified for all Medicaid benefits. However, while a member of our plan, you can access plan benefits regardless of your Medicaid status.

Please contact your state Medicaid program at 1-866-311-4287 for the most current and accurate information regarding your eligibility and benefits.

Benefit Category (excludes Medicare-covered services)	Tennessee Medicaid-Covered Services	Plan Benefits*
Dental Services	Adults 21 and older do not have access to routine dental services. Children under the age of 21 are provided comprehensive dental services. $0 copay for all preventative care.	**In-Network** $0 copay
Medical/Surgical Services of Dentist	$0 copay for children under the age of 21. Adults 21 and older do not have access to dental services.	Not available
Optometrist Services	Adults 21 and older do not have access to routine vision services. Medical eye care is covered. Children under the age of 21 are provided vision services. $0 copay for all preventative care.	**In-Network** $0 copay
Podiatrist Services	Must be medically necessary and be provided by a participating provider. Copayments are only required of TennCare Standard children for these services.	**In-Network** $0 copay
Eyeglasses	Adults 21 and older do not have access to routine vision services. The first pair of glasses or lenses after cataract surgery is covered Children under the age of 21 are provided glasses as needed. $0 copay.	**In-Network** $0 copay
Non-Emergency Transportation	Transportation must be provided by approved and contracted transportation providers. $0 copay.	**In-Network** $0 copay
Private Duty Nursing	Adults 21 and older are only covered when medically necessary and:	Not available

Benefit Category (excludes Medicare-covered services)	Tennessee Medicaid-Covered Services	Plan Benefits*
	▪ are ventilator dependent for at least 12 hours per day ▪ OR have a a functioning tracheotomy AND need Certain other kinds of nursing care too. Children under the age of 21 are covered when medically necessary. $0 copay.	
Inpatient SNF / ICF	$0 copay.	Not available
Inpatient Psychiatric Services (under 21)	$0 copay	Not available
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)	$0 copay	Not available

* *For more information on plan benefits, please see Summary of Benefits Section II and III.*

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