Health Choice Generations (HCG) CY2017 Supplemental Benefits

For Medicare Non-Standard Benefits

PLAN		**HCG H5587**	
COUNTY		Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, Pinal	
PBP		002	
		Monetary Amount + Length	**Service Description**
Dental Related	**Dental (Preventive)**	$1,600 per calendar year (for all dental services combined)	Preventive dental services have no coinsurance, no deductible, $0 copay. No authorization or referral required. Cost of all preventive services **will** be deducted from total coverage amount for dental benefit. Coverage is for: - Two Oral Exams per year, one every 6 months. - Two Prophylaxis (Cleanings) per year, one every 6 months. - One Dental X-Ray per year. Exam and cleaning must be performed in the same office visit. X-Rays must be taken during office visit.
	Dental (Comprehensive)		Comprehensive dental services have no coinsurance (for dental services not covered by original Medicare), no deductible, $0 copay. No authorization or referral required (as long as the service is not covered by original Medicare). Coverage is for: - non-routine Diagnostic Services - non-routine Restorative Services - non-routine Endodontics/Periodontics/Extractions **NOT COVERED**: Prosthodontics, meaning dental and facial restoration including cosmetics, dental implants, **bridges, dentures,** and temporomandibular restorative procedures.
Vision Related	**Eye Wear (Glasses / Contacts)**	$175 per calendar year	Eye Wear services have no coinsurance (for eyewear services not covered by original Medicare), no deductible, $0 copay. No authorization or referral required (as long as the service is not covered by original Medicare, i.e. post cataract, intraocular lens implantation surgery). Coverage is for: - One pair of glasses (lenses plus frames) every year. **NOT COVERED**: Contacts.
	Eye Exams	Coverage Amt.: No max per year	Eye exam service has no coinsurance (for eye exam services not covered by original Medicare), no deductible, $0 copay. No authorization or referral required (as long as the service is not covered by original Medicare). Cost of annual routine eye exam will **not** be deducted from total coverage amount for vision related benefits. Coverage is for: - One routine eye exam per year.
Hearing Related	**Hearing Aid**	$500 per year	Hearing Aid service has no coinsurance, no deductible, $0 copay. No authorization or referral required. Coverage is for: - One hearing aid for one ear + fitting, every year.
	Hearing Exam	Coverage Amt.: No max per year	Hearing Exam service has no coinsurance (for hearing exam services not covered by Original Medicare), no deductible, $0 copay. No authorization or referral required. Cost of exams will **not** be deducted from total coverage amount for hearing related benefits. Coverage is for: - One routine hearing exam per year.
	Over the Counter (OTC)	$60 every three months	No authorization or referral required. Shipping is free for first order in each quarter; additional orders in a quarter will incur a flat shipping charge per order. Unused quarterly amount does not roll over into following quarter. Coverage is for: - Items consistent with CMS guidance, as found in the OTC catalog provided to members. OTC purchases and procedures are done through catalogue only unless specified otherwise in the catalogue.