

# Senior Preferred (HMO) Summary of Benefits

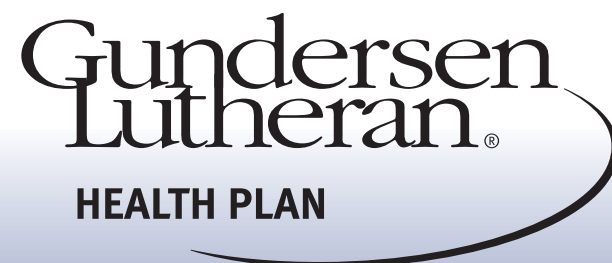
Effective January 1, 2012

ELITE

ELITE - D

VALUE

VALUE - D



La Crosse, Wisconsin (608) 775-8077 or (800) 394-5566  
TTY 711

[seniorpreferred.org](http://seniorpreferred.org)

[seniorpreferred.org](http://seniorpreferred.org)



# Gundersen Lutheran®



## HEALTH PLAN

Other Pharmacies/Physicians/Providers are available in our network.  
Other plans may be available in the service area.

Marketing Comparison  
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CMS Approval Date: 8/29/2011

# Gundersen Lutheran®

## HEALTH PLAN

Thank you for your interest in Senior Preferred (HMO)! Gundersen Lutheran Health Plan, an HMO Plan with a Medicare Contract, offers four Senior Preferred plans. This summary of benefits summarizes some features of these four plans. This summary of benefits does not list every service that we cover, or list every limitation or exclusion. To get a complete list of our benefits, please call Gundersen Lutheran Health Plan to request a copy of 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 Advantage health plan, like Senior Preferred. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Gundersen Lutheran Health Plan at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

### HOW CAN I COMPARE MY OPTIONS?

You can compare all four Senior Preferred Plans, and the Original Medicare Plan, using the following Summary of Benefits starting on page 6 of this brochure. The chart in this brochure lists some important health benefits. For each benefit, you can see what our plans cover 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 SENIOR PREFERRED AVAILABLE?

Your place of residence must be within one of the following counties or zip codes listed below. All Medicare enrollment requirements must be met. The Senior Preferred service area includes:

#### In Wisconsin:

Full Counties: Trempealeau; Monroe; La Crosse; Vernon; Crawford; and Jackson.

Partial Counties by zip code:

Grant County: 53801, 53804, 53817, 53821, 53816, 53827, 53826, and 53805  
Richland County: 53805, 54631, 54655, 54652, 54664, 54639, 54634, 53924, and 53968  
Sauk County: 53924, 53968, and 54634  
Juneau County: 53962, 53968, 54634, 53929, 54638, 54660, 54618, 54641, and 54666  
Buffalo County: 54629, 54612, 54625, 54661, and 54747

#### In Iowa:

Full Counties: Allamakee; Winneshiek; Fayette; Clayton; and Howard.

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

### WHO IS ELIGIBLE TO JOIN SENIOR PREFERRED?

You can join Senior Preferred 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 may not be eligible to enroll in Senior Preferred unless they are members of our organization and have been since their dialysis began.

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### CAN I CHOOSE MY DOCTORS?

Gundersen Lutheran Health Plan has formed a network of providers, specialists, and hospitals. You can only use providers who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list, or visit us at [www.seniorpreferred.org](http://www.seniorpreferred.org). Our Customer Service number is listed at the end of this introduction.

### WHAT HAPPENS IF I GO TO A DOCTOR WHO IS NOT IN YOUR NETWORK?

You must use plan providers except in emergent or urgent care situations or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers, neither Medicare nor Senior Preferred will be responsible for the costs.

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

- Senior Preferred EliteD and ValueD **do** cover both Medicare approved **Part B prescription drugs and Medicare Part D prescription drugs** that are on our formulary.
- Senior Preferred Elite and Value **do** cover Medicare approved Part B prescription drugs. Senior Preferred Elite and Value **do not** cover Part D prescription drugs.

### WHAT IS A PRESCRIPTION DRUG FORMULARY?

Senior Preferred **EliteD** and **ValueD** use a formulary. A formulary is a list of drugs covered by us to meet member 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 members before the change is made. We will send a formulary to you annually, and you can also see our complete formulary on our Web site at [www.seniorpreferred.org](http://www.seniorpreferred.org).

If you are currently taking a drug that is not on our formulary or subject to additional prior authorization requirement or step-therapy 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 doctor's help. You can call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

### WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Gundersen Lutheran Health Plan has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List or visit us at [www.seniorpreferred.org](http://www.seniorpreferred.org). Our Customer Service number is listed at the end of this introduction.

### HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for up to seventy-five (75) percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, your State Medicaid Office, or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you decide to become a member of Senior Preferred **Elite D** or **Value D**, and if you qualify for extra help with your Medicare prescription drug plan costs, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay.

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### WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact Gundersen Lutheran Health Plan 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's supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha 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.

### WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we 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.

### 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 Senior Preferred, 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. In Wisconsin call Metastar at (800) 362-2320. In Iowa call Telligen Health at (800) 752-7014.

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## HEALTH PLAN

As a member of Senior Preferred's **EliteD** or **ValueD** prescription drug plans, 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 prescriptions 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. In Wisconsin call Metastar at (800) 362-2320. In Iowa call Telligen Health at (800) 752-7014.

### 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](http://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 (800)-394-5566 or (608) 775-8077 (TTY 711).

### CONTACT INFORMATION

For full information about this plan, or to schedule an appointment with a representative to enroll, please call Gundersen Lutheran Health Plan at (800) 394-5566 or (608) 775-8077 (TTY 711). Our Customer Service Representatives are available Monday through Sunday, 8 a.m. until 8 p.m. Central Standard Time. Office hours are Monday through Friday 8 a.m. until 5 p.m. You can also visit us at [www.seniorpreferred.org](http://www.seniorpreferred.org). Customer Service has free language interpreter services available for non-English speakers. Medicare beneficiaries may also enroll in Senior Preferred through the Centers for Medicare & Medicaid Services Online Enrollment Center located at [www.medicare.gov](http://www.medicare.gov).

### Current Members:

For questions related to **Medicare Advantage and/or Medicare Part D Prescription Drug Program**, please call: **(800) 394-5566** or **(608) 775-8077 (TTY 711)**.

### Prospective Members:

For questions related to **Medicare Advantage and/or Medicare Part D Prescription Drug Program**, please call: **(800) 370-9718 (TTY 711)**.

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY (877) 486-2048).

You can call 24 hours a day, 7 days a week, or visit their website at [www.medicare.gov](http://www.medicare.gov).

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

**Summary of Benefits for all plans offered by Senior Preferred**

If you have any questions about this plan's benefits or costs, please contact Gundersen Lutheran Health Plan, Inc. at (800)-394-5566 (current members) and (800)-370-9718 (for prospective members).

IMPORTANT INFORMATION		Original Medicare	Senior Preferred Elite
	<b>Premium and Other Important Information</b>	<p>You pay the Medicare Part B premium of \$115.40 each month. (This is the 2011 premium and it may change 1/1/2012).</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2007, some people are required to pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>You pay \$100.00 each month for Senior Preferred Elite benefits.</p> <p>You also continue to pay the Medicare Part B premium of \$115.40 each month. (This is the 2011 premium and it may change 1/1/2012).</p> <p>There is a \$3,400.00 maximum out-of-pocket limit every year for Medicare covered services when received in-network only.</p>
	<b>Doctor and Hospital Choice</b> (For more information, see Emergency and Urgently Needed Care)	You may go to any doctor, specialist or hospital that accepts Medicare.	<p>You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>
<b>INPATIENT CARE</b>	<b>Inpatient Hospital Care</b>	<p>You pay for each benefit period (3):</p> <ul style="list-style-type: none"> <li>• Days 1-60: an initial deductible of \$1,132</li> <li>• Days 61-90: \$283 each day.</li> <li>• Days 91-150: \$566 each lifetime reserve day</li> </ul> <p>(These are the 2011 amounts and they may change 1/1/2012). Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days (4).</p>	<p>If you receive inpatient care at a non-plan hospital and choose not to return to the network after your emergency condition is stabilized, you may be responsible for payment.</p> <p>There is a \$500 copayment per admission for inpatient hospital services received at a network hospital.</p> <p>You are covered for unlimited days each benefit period based on medical necessity.</p>
	<b>Inpatient Mental Health Care</b>	You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.	<p>There is a \$500 copayment per admission for services received at a network hospital based on medical necessity.</p> <p>There is no copayment for additional days received at a network hospital based on medical necessity.</p>

**Summary of Benefits for all plans offered by Senior Preferred**

If you have any questions about this plan's benefits or costs, please contact Gundersen Lutheran Health Plan, Inc. at (800)-394-5566 (current members) and (800)-370-9718 (for prospective members).

IMPORTANT INFORMATION	Senior Preferred EliteD	Senior Preferred Value	Senior Preferred ValueD
	<p>You pay \$139.60 each month for Senior Preferred EliteD benefits and no additional premium for your Medicare Part D prescription benefits.</p> <p>You also continue to pay the Medicare Part B premium of \$115.40 each month. (This is the 2011 premium and it may change 1/1/2012).</p> <p>There is a \$3,400.00 maximum out-of-pocket limit every year for Medicare covered services when received in-network only.</p>	<p>You pay \$0 each month for Senior Preferred Value benefits.</p> <p>You also continue to pay the Medicare Part B premium of \$115.40 each month. (This is the 2011 premium and it may change 1/1/2012).</p> <p>There is a \$3,400.00 maximum out-of-pocket limit every year for Medicare covered services when received in-network only.</p>	<p>You pay \$22.60 each month for Senior Preferred ValueD benefits and no additional premium for your Medicare Part D prescription benefits.</p> <p>You also continue to pay the Medicare Part B premium of \$115.40 each month. (This is the 2011 premium and it may change 1/1/2012).</p> <p>There is a \$3,400.00 maximum out-of-pocket limit every year for Medicare covered services when received in-network only.</p>
	<p>You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>	<p>You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>	<p>You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>
<b>INPATIENT CARE</b>	<p>If you receive inpatient care at a non-plan hospital and choose not to return to the network after your emergency condition is stabilized, you may be responsible for payment.</p> <p>There is a \$500 copayment per admission for inpatient hospital services received at a network hospital.</p> <p>You are covered for unlimited days each benefit period based on medical necessity.</p>	<p>If you receive inpatient care at a non-plan hospital and choose not to return to the network after your emergency condition is stabilized, you may be responsible for payment.</p> <p>There is a copay of \$200 per day for days 1-17 for inpatient hospital services received at a network hospital.</p> <p>You are covered for unlimited days each benefit period based on medical necessity.</p>	<p>If you receive inpatient care at a non-plan hospital and choose not to return to the network after your emergency condition is stabilized, you may be responsible for payment.</p> <p>There is a copay of \$200 per day for days 1-17 for inpatient hospital services received at a network hospital.</p> <p>You are covered for unlimited days each benefit period based on medical necessity.</p>
	<p>There is a \$500 copayment per admission for services received at a network hospital based on medical necessity.</p> <p>There is no copayment for additional days received at a network hospital based on medical necessity.</p>	<p>There is a \$500 copayment per admission for services received at a network hospital.</p> <p>There is no copayment for additional days received at a network hospital based on medical necessity.</p>	<p>There is a \$500 copayment per admission for services received at a network hospital.</p> <p>There is no copayment for additional days received at a network hospital based on medical necessity.</p>

IMPORTANT INFORMATION		Original Medicare	Senior Preferred Elite
	<p><b>Skilled Nursing Facility</b> Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary).</li> <li>• Meals, including special diets.</li> <li>• Regular nursing services.</li> <li>• Physical therapy, occupational therapy, and speech therapy.</li> <li>• Drugs (This includes substances that are naturally present in the body, such as blood clotting factors).</li> <li>• Blood - including storage and administration.</li> <li>• Medical and surgical supplies.</li> <li>• Laboratory tests.</li> <li>• X-rays and other radiology services.</li> <li>• Use of appliances such as wheelchairs.</li> <li>• Physician services.</li> </ul>	<p>You pay for each benefit period (3), following at least a 3-day covered hospital stay:</p> <ul style="list-style-type: none"> <li>• Days 1–20: \$0 for each day.</li> <li>• Days 21–100: \$141.50 for each day.</li> </ul> <p>(This is the 2011 amount and it may change 1/1/2012).</p> <p>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period. (3)</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>• 10% of the cost each day for day(s) 1–20.</li> <li>• 0% of the cost each day(s) 21–100.</li> </ul> <p>No prior hospital stay is required.</p> <p>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs. (3)</p> <p>Prior Authorization is required.</p>
	<p><b>Swing Bed</b> Facility charges and costs associated with an approved swing bed stay when meeting the following criteria:</p> <ul style="list-style-type: none"> <li>• Your physician must certify your stay as medically necessary and daily skilled needs are identified;</li> <li>• You must be confined and receive treatment for which you were hospitalized;</li> <li>• Intensity and frequency of services requires 24-hour nursing intervention;</li> <li>• Frequent or daily physician monitoring is needed;</li> <li>• Services will likely be for a short-term period and may not exceed seven days; and</li> <li>• There is likely no further need for skilled nursing services post discharge.</li> </ul>	<p>You pay for each benefit period (3), following at least a 3-day covered hospital stay:</p> <ul style="list-style-type: none"> <li>• Days 1–20: \$0 for each day.</li> <li>• Days 21–100: \$141.50 for each day.</li> </ul> <p>(This is the 2011 amount and it may change 1/1/2012).</p> <p>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period. (3)</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>• 10% of the cost each day for day(s) 1–20.</li> <li>• 0% of the cost each day(s) 21–100.</li> </ul> <p>No prior hospital stay is required.</p> <p>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs. (3)</p> <p>Prior Authorization is required.</p>

IMPORTANT INFORMATION	Senior Preferred EliteD	Senior Preferred Value	Senior Preferred ValueD
	<p>You pay:</p> <ul style="list-style-type: none"> <li>• 10% of the cost each day for day(s) 1–20.</li> <li>• 0% of the cost each day(s) 21–100.</li> </ul> <p>No prior hospital stay is required.</p> <p>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.</p> <p>Prior Authorization is required.</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>• 10% of the cost each day for day(s) 1–20.</li> <li>• 0% of the cost each day(s) 21–100.</li> </ul> <p>No prior hospital stay is required.</p> <p>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.</p> <p>Prior Authorization is required.</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>• 10% of the cost each day for day(s) 1–20.</li> <li>• 0% of the cost each day(s) 21–100.</li> </ul> <p>No prior hospital stay is required.</p> <p>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.</p> <p>Prior Authorization is required.</p>
	<p>You pay:</p> <ul style="list-style-type: none"> <li>• 10% of the cost each day for day(s) 1–20.</li> <li>• 0% of the cost each day(s) 21–100.</li> </ul> <p>No prior hospital stay is required.</p> <p>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.</p> <p>Prior Authorization is required.</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>• 10% of the cost each day for day(s) 1–20.</li> <li>• 0% of the cost each day(s) 21–100.</li> </ul> <p>No prior hospital stay is required.</p> <p>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.</p> <p>Prior Authorization is required.</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>• 10% of the cost each day for day(s) 1–20.</li> <li>• 0% of the cost each day(s) 21–100.</li> </ul> <p>No prior hospital stay is required.</p> <p>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.</p> <p>Prior Authorization is required.</p>

IMPORTANT INFORMATION		Original Medicare	Senior Preferred Elite
	<b>Home Health Care</b> (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no copayment for all covered home health visits.	There is no copayment for covered home health visits.
	<b>Hospice Care</b>	You pay part of the cost for outpatient drugs and inpatient respite care.  You must receive care from a Medicare-certified hospice.	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by Medicare, not our Plan.  You pay \$20 for the consultation service.
<b>DOCTOR SERVICES/ OUTPATIENT CARE</b>	<b>Doctor Office Visits</b>	You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$20 for each primary care physician office visit for covered services.  You pay \$20 for each specialist visit for covered services.
	<b>Chiropractic Services</b>	You pay 20% of Medicare-approved amounts. (1)(2)  You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.  You pay 100% for routine care.	You pay \$15 for each covered visit.  There is no copayment for lab and x-ray.  Coverage does not include maintenance therapy.
	<b>Podiatry Services</b>	You pay 20% of Medicare-approved amounts. (1)(2)  You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.  You pay 100% for routine care.	You pay \$20 for each covered visit (medically necessary foot care).
	<b>Outpatient Mental Health Care</b> (Including partial hospitalization services).	You pay 45% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2) (This is the 2011 coinsurance and it may change 1/1/2012.)	For covered Mental Health services, you pay \$20 for each individual/group therapy visit.  There is no copayment for covered partial hospitalization services.  Coverage does not include maintenance or activity therapy.
	<b>Outpatient Substance Abuse Services</b>	You pay 45% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2) (This is the 2011 coinsurance and it may change 1/1/2012.)	For covered services you pay \$20 for each individual/group visit.

IMPORTANT INFORMATION	Senior Preferred EliteD	Senior Preferred Value	Senior Preferred ValueD
	There is no copayment for covered home health visits.	There is no copayment for covered home health visits.	There is no copayment for covered home health visits.
	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by Medicare, not our Plan.  You pay \$20 for the consultation service.	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by Medicare, not our Plan.  You pay \$35 for the consultation service.	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by Medicare, not our Plan.  You pay \$35 for the consultation service.
<b>DOCTOR SERVICES/ OUTPATIENT CARE</b>	You pay \$20 for each primary care physician office visit for covered services.  You pay \$20 for each specialist visit for covered services.	You pay \$35 for each primary care physician office visit for covered services.  You pay \$35 for each specialist visit for covered services.	You pay \$35 for each primary care physician office visit for covered services.  You pay \$35 for each specialist visit for covered services.
	You pay \$15 for each covered visit.  There is no copayment for lab and x-ray.  Coverage does not include maintenance therapy.	You pay \$15 for each covered visit.  You pay 10% of the cost for each lab or x-ray service.  Coverage does not include maintenance therapy.	You pay \$15 for each covered visit.  You pay 10% of the cost for each lab or x-ray service.  Coverage does not include maintenance therapy.
	You pay \$20 for each covered visit (medically necessary foot care).	You pay \$35 for each covered visit (medically necessary foot care).	You pay \$35 for each covered visit (medically necessary foot care).
	For covered Mental Health services, you pay \$20 for each individual/group therapy visit.  There is no copayment for covered partial hospitalization services.  Coverage does not include maintenance or activity therapy.	For covered Mental Health services, you pay \$35 for each individual/group therapy visit.  There is no copayment for covered partial hospitalization services.  Coverage does not include maintenance or activity therapy.	For covered Mental Health services, you pay \$35 for each individual/group therapy visit.  There is no copayment for covered partial hospitalization services.  Coverage does not include maintenance or activity therapy.
	For covered services you pay \$20 for each individual/group visit.	For covered services you pay \$35 for each individual/group visit.	For covered services you pay \$35 for each individual/group visit.

IMPORTANT INFORMATION		Original Medicare	Senior Preferred Elite
	<b>Outpatient Services/Surgery</b>	You pay 20% of Medicare-approved amounts for the doctor. (1)(2) You pay 20% of outpatient facility charges. (1)(2)	There is no copayment for each covered visit to an ambulatory surgical center. There is no copayment for each covered visit to an outpatient hospital facility. Prior authorization may be required.
	<b>Ambulance Services</b> (Medically necessary ambulance Services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)	There is no copayment for covered ambulance services.
	<b>Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2) You pay 20% of doctor charges. (1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay \$50 for each covered emergency room visit; You do not pay this amount if you are admitted to the hospital within the next three days for the same condition. * Worldwide Coverage
	<b>Urgently Needed Care</b> (This is NOT emergency care, and in most cases, is out of the service area.)	You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay \$20 for each covered urgently needed care visit. * Worldwide Coverage
	<b>Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Cardiac or Pulmonary Rehabilitation Therapy)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$20 for each covered Occupational, Physical and/or Speech/Language Therapy visit. You pay \$10 for each covered Cardiac or Pulmonary Rehabilitation Therapy visit.
	<b>Durable Medical Equipment</b> (Includes Wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts (1)(2)	You pay 10% of the cost for each covered item. Prior Authorization is required for purchases and repairs over \$1,000, and all rentals.
	<b>Prosthetic Devices</b> (Include braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 10% of the cost for each covered item. Prior Authorization is required for purchases and repairs over \$1,000, and all rentals.

IMPORTANT INFORMATION	Senior Preferred EliteD	Senior Preferred Value	Senior Preferred ValueD
	There is no copayment for each covered visit to an ambulatory surgical center. There is no copayment for each covered visit to an outpatient hospital facility. Prior authorization may be required.	There is a \$75 copayment for each covered visit to an ambulatory surgical center. There is a \$75 copayment for each covered visit to an outpatient hospital facility. Prior authorization may be required.	There is a \$75 copayment for each covered visit to an ambulatory surgical center. There is a \$75 copayment for each covered visit to an outpatient hospital facility. Prior authorization may be required.
	There is no copayment for covered ambulance services.	There is no copayment for covered ambulance services.	There is no copayment for covered ambulance services.
	You pay \$50 for each covered emergency room visit; You do not pay this amount if you are admitted to the hospital within the next three days for the same condition. * Worldwide Coverage	You pay \$50 for each covered emergency room visit; You do not pay this amount if you are admitted to the hospital within the next three days for the same condition. * Worldwide Coverage	You pay \$50 for each covered emergency room visit; You do not pay this amount if you are admitted to the hospital within the next three days for the same condition. * Worldwide Coverage
	You pay \$20 for each covered urgently needed care visit. * Worldwide Coverage	You pay \$35 for each covered urgently needed care visit. * Worldwide Coverage	You pay \$35 for each covered urgently needed care visit. * Worldwide Coverage
	You pay \$20 daily for each covered Occupational, Physical and/or Speech/Language Therapy visit. You pay \$10 for each covered Cardiac or Pulmonary Rehabilitation Therapy visit.	You pay \$35 daily for each covered Occupational, Physical and/or Speech/Language Therapy visit. You pay \$15 for each covered Cardiac or Pulmonary Rehabilitation Therapy visit.	You pay \$35 daily for each covered Occupational, Physical and/or Speech/Language Therapy visit. You pay \$15 for each covered Cardiac or Pulmonary Rehabilitation Therapy visit.
	You pay 10% of the cost for each covered item. Prior Authorization is required for purchases and repairs over \$1,000, and all rentals.	You pay 20% of the cost for each covered item. Prior Authorization is required for purchases and repairs over \$1,000, and all rentals.	You pay 20% of the cost for each covered item. Prior Authorization is required for purchases and repairs over \$1,000, and all rentals.
	You pay 10% of the cost for each covered item. Prior Authorization is required for purchases and repairs over \$1,000, and all rentals.	You pay 20% of the cost for each covered item. Prior Authorization is required for purchases and repairs over \$1,000, and all rentals.	You pay 20% of the cost for each covered item. Prior Authorization is required for purchases and repairs over \$1,000, and all rentals.

IMPORTANT INFORMATION		Original Medicare	Senior Preferred Elite
	<b>Diabetes Self-Monitoring, Training and Supplies</b> (Includes coverage for glucose monitors, test strips, lancets, screening tests and self-management training.)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copay for covered Diabetes self-monitoring training.  You pay 5% of the cost for each preferred covered Diabetic testing supply item. Non-Preferred blood glucose monitors and blood glucose test strips require a Prior Authorization. If approved, you will pay 25% of the cost for each covered Diabetic supply item.  There is no copayment for covered diabetic screening tests.
	<b>Medical Nutrition Therapy</b>	There is no copay for each covered Medical Nutrition Therapy visit.	There is no copay for each covered Medical Nutrition Therapy visit.
	<b>Diagnostic Tests, X-Rays and Lab Services</b>	You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2)  There is no copayment for Medicare-approved lab services.	There is no copayment for covered Services.
	<b>Kidney Dialysis Services, Supplies and Education</b>	You pay 20% of Medicare-approved amounts.	You pay 20% of Medicare-approved amounts.
<b>PREVENTIVE CARE AND SCREENING TESTS</b>	<b>Abdominal Aorta Ultrasound Screening</b>	There is no copayment for 1 screening Abdominal Aorta Ultrasound per lifetime.	There is no copayment for 1 screening Abdominal Aorta Ultrasound per lifetime.
	<b>Bone-Mass Measurements</b> (For People with Medicare who are at risk.)	There is no copayment for each covered Bone Mass Measurement.	There is no copayment for each covered Bone Mass Measurement.
	<b>HIV Screening</b>	You pay nothing for the test, but you generally have to pay the doctor 20% of the Medicare-approved amount for the doctor's visit. (1) (2)	There is no copayment for each covered HIV Screening.
	<b>EKG Screening</b>	You pay nothing for this one-time screening EKG if ordered by your doctor as part of your one-time "Welcome to Medicare" physical exam. You pay 20% of the Medicare-approved amount for the doctor visit. (1) (2)	There is no copayment for each covered EKG Screening.
	<b>Colorectal Screening</b>	You pay nothing for the test, however you generally have to pay 20% of the Medicare-approved amount for the doctor visit. (1) (2)	There is no copayment for covered colorectal screening exams.

IMPORTANT INFORMATION	Senior Preferred EliteD	Senior Preferred Value	Senior Preferred ValueD
	There is no copay for covered Diabetes self-monitoring training.  You pay 5% of the cost for each preferred covered Diabetic testing supply item. Non-Preferred blood glucose monitors and blood glucose test strips require a Prior Authorization. If approved, you will pay 25% of the cost for each covered Diabetic supply item.  There is no copayment for covered diabetic screening tests.	There is no copay for covered Diabetes self-monitoring training.  You pay 15% of the cost for each preferred covered Diabetic testing supply item. Non-Preferred blood glucose monitors and blood glucose test strips require a Prior Authorization. If approved, you will pay 35% of the cost for each covered Diabetes supply item.  There is no copayment for covered diabetic screening tests.	There is no copay for covered Diabetes self-monitoring training.  You pay 15% of the cost for each preferred covered Diabetic testing supply item. Non-Preferred blood glucose monitors and blood glucose test strips require a Prior Authorization. If approved, you will pay 35% of the cost for each covered Diabetes supply item.  There is no copayment for covered diabetic screening tests.
	There is no copay for each covered Medical Nutrition Therapy visit.	There is no copay for each covered Medical Nutrition Therapy visit.	There is no copay for each covered Medical Nutrition Therapy visit.
	There is no copayment for covered Services.	You pay: <ul style="list-style-type: none"> <li>• 10% of the cost for each covered clinical/diagnostic lab service.</li> <li>• 10% of the cost for each covered radiation therapy service.</li> <li>• 10% of the costs for each covered x-ray visit.</li> </ul>	You pay: <ul style="list-style-type: none"> <li>• 10% of the cost for each covered clinical/diagnostic lab service.</li> <li>• 10% of the cost for each covered radiation therapy service.</li> <li>• 10% of the cost for each covered x-ray visits.</li> </ul>
	You pay 20% of Medicare-approved amounts.	You pay 20% of Medicare-approved amounts.	You pay 20% of Medicare-approved amounts.
<b>PREVENTIVE CARE AND SCREENING TESTS</b>	There is no copayment for 1 screening Abdominal Aorta Ultrasound per lifetime.	There is no copayment for 1 screening Abdominal Aorta Ultrasound per lifetime.	There is no copayment for 1 screening Abdominal Aorta Ultrasound per lifetime.
	There is no copayment for each covered Bone Mass Measurement.	There is no copayment for each covered Bone Mass Measurement.	There is no copayment for each covered Bone Mass Measurement.
	There is no copayment for each covered HIV Screening.	There is no copayment for each covered HIV Screening.	There is no copayment for each covered HIV Screening.
	There is no copayment for each covered EKG Screening.	There is no copayment for each covered EKG Screening.	There is no copayment for each covered EKG Screening.
	There is no copayment for covered colorectal screening exams.	There is no copayment for covered colorectal screening exams.	There is no copayment for covered colorectal screening exams.

IMPORTANT INFORMATION	Original Medicare	Senior Preferred Elite
<b>Immunizations</b> (Flu Vaccine, Hepatitis B Vaccine – for people with Medicare who are at risk, Pneumonia Vaccine).	There is no copayment for the Pneumonia and Flu vaccines.  You pay nothing for the Hepatitis B shot, if the doctor accepts assignment.  You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no copayment for the Pneumonia and Flu vaccines.  Flu and Pneumonia vaccines by any qualified practitioner are covered.  There is no copayment for the Hepatitis B vaccine.
<b>Mammography Screening</b> (Annual Screening)	There is no copayment for 1 screening mammogram every calendar year.  No referral necessary for Medicare-covered screenings.	There is no copayment for 1 screening mammogram every calendar year.
<b>Pap Smears, Pelvic Exams and Clinical Breast Exams</b> (For women with Medicare)	There is no copayment for a pap smear, pelvic exam and clinical breast exam once every 2 years, or annually for beneficiaries at high risk.	There is no copayment for 1 screening pap smear, pelvic exam and clinical breast exam every calendar year.
<b>Prostate Cancer Screening Exams</b> (For men with Medicare age 50 and older).	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (1)(2)	There is no copayment for 1 screening Prostate Cancer exam every calendar year.
<b>Cardiovascular Screening Blood Tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).</b>	There is no copayment for the test once every 5 years. You pay 20% of the Medicare-approved amount for the doctor's visit. (1) (2)	There is no copayment for covered tests.
<b>Physical Exams</b>	There is no copayment for a one time "Welcome to Medicare" exam within the first 12 months of having Part B.  There is no copayment for a yearly "Wellness" exam.  This will not include lab tests.	There is no copayment for routine physical exams. If the exam is for the treatment of a suspected or existing condition, \$20 office copay may apply.
<b>Tobacco/Smoking Cessation</b>	You pay 20% of Medicare-approved amounts. (1)(2)  If you haven't been diagnosed with an illness caused or complicated by tobacco use, you pay nothing for the counseling sessions.	You pay a \$20 copayment for each tobacco counseling session.  Reimbursement of approved smoking cessation program upon receipt of your program completion certificate and proof of payment.

IMPORTANT INFORMATION	Senior Preferred EliteD	Senior Preferred Value	Senior Preferred ValueD
	There is no copayment for the Pneumonia and Flu vaccines.  Flu and Pneumonia vaccines by any qualified practitioner are covered.  There is no copayment for the Hepatitis B vaccine.	There is no copayment for the Pneumonia and Flu vaccines.  Flu and Pneumonia vaccines by any qualified practitioner are covered.  There is no copayment for the Hepatitis B vaccine.	There is no copayment for the Pneumonia and Flu vaccines.  Flu and Pneumonia vaccines qualified practitioner are covered.  There is no copayment for the Hepatitis B vaccine.
	There is no copayment for 1 screening mammogram every calendar year.	There is no copayment for 1 screening mammogram every calendar year.	There is no copayment for 1 screening mammogram every calendar year.
	There is no copayment for 1 screening pap smear, pelvic exam and clinical breast exam every calendar year.	There is no copayment for 1 screening pap smear, pelvic exam and clinical breast exam every calendar year.	There is no copayment for 1 screening pap smear, pelvic exam and clinical breast exam every calendar year.
	There is no copayment for 1 screening Prostate Cancer exam every calendar year.	There is no copayment for 1 screening Prostate Cancer exam every calendar year.	There is no copayment for 1 screening Prostate Cancer exam every calendar year.
	There is no copayment for covered tests.	There is no copayment for covered tests.	There is no copayment for covered tests.
	There is no copayment for routine physical exams. If the exam is for the treatment of a suspected or existing condition, \$20 office copay may apply.	There is no copayment for routine physical exams. If the exam is for the treatment of a suspected or existing condition, \$35 office copay may apply.	There is no copayment for routine physical exams. If the exam is for the treatment of a suspected or existing condition, \$35 office copay may apply.
	You pay a \$20 copayment for each tobacco counseling session.  Reimbursement of approved smoking cessation program upon receipt of your program completion certificate and proof of payment.  <ul style="list-style-type: none"> <li>• Medications for tobacco/smoking cessation that require a prescription, limited to 180 days per calendar year.</li> <li>• Nicotine inhalation system or nasal spray that requires a prescription is covered for 90 days, per calendar year. An additional 90 days may be covered, upon submission of your smoking cessation program completion certificate.</li> </ul>	You pay a \$35 copayment for each tobacco counseling session.  Reimbursement of approved smoking cessation program upon receipt of your program completion certificate and proof of payment.	You pay a \$35 copayment for each tobacco counseling session.  Reimbursement of approved smoking cessation program upon receipt of your program completion certificate and proof of payment.  <ul style="list-style-type: none"> <li>• Medications for tobacco/smoking cessation that require a prescription, limited to 180 days per calendar year.</li> <li>• Nicotine inhalation system or nasal spray that requires a prescription is covered for 90 days, per calendar year. An additional 90 days may be covered, upon submission of your smoking cessation program completion certificate.</li> </ul>

IMPORTANT INFORMATION		Original Medicare	Senior Preferred Elite
	<b>Dental Services</b>	In general, you pay 100% for preventive dental services.	In general, you pay 100% for preventive dental services.  You pay \$20 for each covered dental exam.
	<b>Hearing Services</b> (You pay 100% for Hearing Aids).	You pay 100% for routine hearing exams and hearing aids.  You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)	There is no copayment for the following services: <ul style="list-style-type: none"> <li>• Covered hearing tests (diagnostic hearing tests).</li> <li>• Routine hearing tests up to 1 test every calendar year.</li> </ul>
	<b>Vision Care</b>	You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)  For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)  You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)  You pay 100% for routine eye exams and glasses.	There is no copayment for the following items:  Covered eyewear includes: <ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses after each cataract surgery.</li> <li>• \$300.00 limit for routine eyewear every year (for frames, lenses, and eyewear upgrades at participating network providers).</li> <li>• First Routine Eye Exam each calendar year.</li> </ul> You pay: <ul style="list-style-type: none"> <li>• Any amount over the allowable amount for frames.</li> <li>• \$20 for each covered eye exam (diagnosis and treatment for diseases and conditions of the eye).</li> <li>• There is no co-pay for each annual glaucoma exam.</li> </ul>
	<b>Health and Wellness Education</b>  The following is available to you at no cost: <ul style="list-style-type: none"> <li>• Health Education Classes</li> <li>• Newsletter</li> <li>• Nurse Advisor Line</li> <li>• Disease Management</li> <li>• Case Management</li> </ul>	You pay 100%.	There is no copayment for these services.

IMPORTANT INFORMATION	Senior Preferred EliteD	Senior Preferred Value	Senior Preferred ValueD
	In general, you pay 100% for preventive dental services.  You pay \$20 for each covered dental exam.	In general, you pay 100% for preventive dental services.  You pay \$35 for each covered dental exam.	In general, you pay 100% for preventive dental services.  You pay \$35 for each covered dental exam.
	There is no copayment for the following services: <ul style="list-style-type: none"> <li>• Covered hearing tests (diagnostic hearing tests).</li> <li>• Routine hearing tests up to 1 test every calendar year.</li> </ul>	There is no copayment for the following services: <ul style="list-style-type: none"> <li>• Covered hearing tests (diagnostic hearing tests).</li> <li>• Routine hearing tests up to 1 test every calendar year.</li> </ul>	There is no copayment for the following services: <ul style="list-style-type: none"> <li>• Covered hearing tests (diagnostic hearing tests).</li> <li>• Routine hearing tests up to 1 test every calendar year.</li> </ul>
	There is no copayment for the following items:  Covered eyewear includes: <ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses after each cataract surgery.</li> <li>• \$300.00 limit for routine eyewear every year (for frames, lenses, and eyewear upgrades at participating network providers).</li> <li>• First Routine Eye Exam each calendar year.</li> </ul> You pay: <ul style="list-style-type: none"> <li>• Any amount over the allowable amount for frames.</li> <li>• \$20 for each covered eye exam (diagnosis and treatment for diseases and conditions of the eye).</li> <li>• There is no co-pay for each annual glaucoma exam.</li> </ul>	There is no copayment for the following items:  Covered eyewear includes: <ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses after each cataract surgery.</li> <li>• \$100.00 limit for routine eyewear every year (for frames, lenses, and eyewear upgrades at participating network providers).</li> <li>• First Routine Eye Exam each calendar year.</li> </ul> You pay: <ul style="list-style-type: none"> <li>• Any amount over the allowable amount for frames.</li> <li>• \$35 for each covered eye exam (diagnosis and treatment for diseases and conditions of the eye).</li> <li>• There is no co-pay for each annual glaucoma exam.</li> </ul>	There is no copayment for the following items:  Covered eyewear includes: <ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses after each cataract surgery.</li> <li>• \$100.00 limit for routine eyewear every year (for frames, lenses, and eyewear upgrades at participating network providers).</li> <li>• First Routine Eye Exam each calendar year.</li> </ul> You pay: <ul style="list-style-type: none"> <li>• Any amount over the Medicare allowable amount for frames.</li> <li>• \$35 for each covered eye exam (diagnosis and treatment for diseases and conditions of the eye).</li> <li>• There is no co-pay for each annual glaucoma exam.</li> </ul>
	There is no copayment for these services.	There is no copayment for these services.	There is no copayment for these services.

IMPORTANT INFORMATION		Original Medicare	Senior Preferred Elite
<b>PART D DRUG BENEFIT</b>	<b>Prescription Drugs</b>	<p>You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.</p> <p>Most people will pay the standard monthly Part D premium.</p> <p>However, starting January 1, 2011, some people are required to pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>You pay 100% for most prescription drugs. This Plan does not cover Medicare Part D prescription drugs or vaccines.</p> <p>There is no benefit limit on drugs covered under Original Medicare. Some quantity limits may apply.</p>

IMPORTANT INFORMATION	Senior Preferred EliteD	Senior Preferred Value	Senior Preferred ValueD
<b>PART D DRUG BENEFIT</b>	<p>This plan uses a formulary. A formulary is a list of drugs covered by us to meet our member's needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <a href="http://www.seniorpreferred.org">www.seniorpreferred.org</a></p> <p>People who have limited incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact Gundersen Lutheran Health Plan at (800) 394-5566 or (608) 775-8077 (TTY 711) for details</p> <p>There is a \$0 deductible.</p> <p>Before the total yearly drug costs (paid by both you and Senior Preferred EliteD) reach \$2,930, you pay the following for prescription drugs:</p> <ul style="list-style-type: none"> <li>• \$9 for a one-month (30 day) supply of Generic (Tier 1).</li> <li>• \$33 for a one-month (30 day) supply of Non-Preferred Generic Drugs (Tier 2).</li> <li>• \$44 for a one-month (30 day) supply of Formulary Preferred Brand Drugs (Tier 3).</li> <li>• \$95 for a one-month (30 day) supply of Formulary Non-Preferred Brand Drugs (Tier 4).</li> <li>• 33% coinsurance for a one-month (30 day) supply of Specialty High Cost Drugs (Tier 5).</li> <li>• \$27 for a three-month (90 day) supply of Generic Drugs.</li> </ul>	<p>You pay 100% for most prescription drugs. This Plan does not cover Medicare Part D prescription drugs or vaccines.</p> <p>There is no benefit limit on drugs covered under Original Medicare. Some quantity limits may apply.</p>	<p>This plan uses a formulary. A formulary is a list of drugs covered by us to meet our member's needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <a href="http://www.seniorpreferred.org">www.seniorpreferred.org</a></p> <p>People who have limited incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact Gundersen Lutheran Health Plan at (800) 394-5566 or (608) 775-8077 (TTY 711) for details</p> <p>There is an \$80 deductible on brand name drugs only.</p> <p>Before the total yearly drug costs (paid by both you and Senior Preferred ValueD) reach \$2,930, you pay the following for prescription drugs:</p> <ul style="list-style-type: none"> <li>• \$9 for a one-month (30 day) supply of Generic (Tier 1).</li> <li>• \$33 for a one-month (30 day) supply of Non-Preferred Generic Drugs (Tier 2).</li> <li>• \$44 for a one-month (30 day) supply of Formulary Preferred Brand Drugs (Tier 3).</li> <li>• \$95 for a one-month (30 day) supply of Formulary Non-Preferred Brand Drugs (Tier 4).</li> <li>• 31% coinsurance for a one-month (30 day) supply of Specialty High Cost Drugs (Tier 5).</li> <li>• \$27 for a three-month (90 day) supply of Generic Drugs.</li> </ul>

IMPORTANT INFORMATION		Original Medicare	Senior Preferred Elite

IMPORTANT INFORMATION	Senior Preferred EliteD	Senior Preferred Value	Senior Preferred ValueD
	<ul style="list-style-type: none"> <li>• \$99 for a three-month (90 day) supply of Non-Preferred Generic Drugs.</li> <li>• \$132 for a three-month (90 day) supply of Formulary Preferred Brand Drugs.</li> <li>• \$285 for a three-month (90 day) supply of Formulary Non-Preferred Brand Drugs.</li> </ul> <p>After the total yearly drug costs (paid by both you and Senior Preferred EliteD) reach \$2,930, you receive a 50% discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p> <p>After your yearly out-of-pocket drug costs reach \$4,700 you pay the greater of:</p> <ul style="list-style-type: none"> <li>• \$2.60 for generic (including brand drugs treated as generic) and</li> <li>• \$6.50 for all other drugs, or</li> <li>• 5% Coinsurance.</li> </ul> <p>In some cases, Senior Preferred EliteD requires you to first try one drug to treat your medical condition before we will cover another drug for that condition.</p> <p>Certain prescription drugs will have maximum quantity limits. Your provider must get prior authorization from Senior Preferred EliteD for certain prescription drugs. Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of our service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy. Please contact Gundersen Lutheran Health Plan for details.</p>		<ul style="list-style-type: none"> <li>• \$99 for a three-month (90 day) supply of Non-Preferred Generic Drugs.</li> <li>• \$132 for a three-month (90 day) supply of Formulary Preferred Brand Drugs.</li> <li>• \$285 for a three-month (90 day) supply of Formulary Non-Preferred Brand Drugs.</li> </ul> <p>After the total yearly drug costs (paid by both you and Senior Preferred ValueD) reach \$2,930, you receive a 50% discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p> <p>After your yearly out-of-pocket drug costs reach \$4,700 you pay the greater of:</p> <ul style="list-style-type: none"> <li>• \$2.60 for generic (including brand drugs treated as generic) and</li> <li>• \$6.50 for all other drugs, or</li> <li>• 5% Coinsurance.</li> </ul> <p>In some cases, Senior Preferred ValueD requires you to first try one drug to treat your medical condition before we will cover another drug for that condition.</p> <p>Certain prescription drugs will have maximum quantity limits. Your provider must get prior authorization from Senior Preferred ValueD for certain prescription drugs. Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of our service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy. Please contact Gundersen Lutheran Health Plan for details.</p>

1. Each year, you pay a total of one \$162 deductible. (This is the 2011 amount and it may change 1/1/2012).
2. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
3. A benefit period begins the day you go to a hospital, swing bed, or skilled nursing facility. The benefit period ends when you have not received hospital, swing bed, or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
4. Lifetime reserve days can only be used once.



## What to Do When Your Membership Begins

On the effective date of your membership, put your Medicare card away. If you leave our program for any reason, you will need it again so put it in a safe place and start using your Senior Preferred card and our network of contracted physicians and pharmacies.

### Your Financial Responsibilities Are Simple

Remember, because Senior Preferred is partly funded through Medicare, you must continue to pay your Medicare Part B premium. This premium is usually deducted from your Social Security check. If it is not, you may visit your local Social Security office and arrange for a payment method.

Your Senior Preferred Premiums are billed monthly and must be paid monthly. You may pay by one of these methods: deduction from your Social Security check, automatic checking account withdrawal or mailing a check with your payment coupon. There is a one-month grace period. If you decided to switch to premium withhold from Social Security or move from premium withhold from Social Security to direct bill, it could take up to three months for it to take effect and you will remain responsible for the premiums during the switch.

### Items Not Covered in Your Senior Preferred Membership

The easiest way to tell what will be covered by Senior Preferred is to check the listing of benefits in the Evidence of Coverage. Or, you can call Gundersen Lutheran Health Plan at (608) 775-8077 or (800) 394-5566, TTY 711.

- Acupuncture.
- Christian Science practitioners' services.
- Cosmetic surgery.
- Custodial care.
- Dental care, except for covered oral surgery procedures.
- Drugs and supplies which can be purchased without a prescription.
- Routine foot care, unless associated with disease affecting the lower limbs which requires the care of a podiatrist or physician.
- Experimental procedures and items.
- Eye surgery (radial keratotomy) to correct refractive errors.
- Homemaker services.
- Immunizations required for travel.
- Meals delivered to the home.
- Nursing care on a full-time basis in your home.
- Orthopedic shoes, unless part of a leg brace and included in the orthopedist's charges.
- Personal convenience items, such as telephone or television in hospital or skilled nursing facility.
- Private duty nurses.
- Private hospital room, unless medically necessary.
- Services performed by immediate relatives or household members.
- Durable medical equipment, prosthetic devices, supplies or footwear not covered by Medicare.
- Benefits and services not covered by Medicare unless specifically described as a covered service in the Member Handbook.
- Services which are not reasonable and necessary under Medicare program standards.
- Services from nonplan providers except for emergency or urgently needed care or by a written referral that has been approved by Gundersen Lutheran Health Plan's Medical Director.



## Summary of Utilization Management Process

Gundersen Lutheran Health Plan is committed to providing members a comprehensive managed care network, which delivers the highest quality, most cost effective care possible. The Health Plan assesses the appropriateness and timeliness of inpatient and ambulatory care (including: pre-service, concurrent, or post-service authorization) using utilization review criteria. The Gundersen Lutheran Health Plan utilizes and adopts nationally developed medical policies, commercially recognized criteria sets, regionally developed medical coverage policies and locally produced specialty medical coverage policies. Additionally, the Health Plan involves appropriate practitioners in development, adoption, and review of criteria and medical coverage policies. The Health Plan implements the use of approved emerging medical technologies or new uses of existing technologies after thorough review of the literature and recommendations from our specialists. The Gundersen Lutheran Health Plan measures and analyzes practitioner and member satisfaction with UM services and takes action on identified opportunities for improvement.

## Summary of Chronic Complex Case Management

Gundersen Lutheran Health Plan Complex Case Management (CCM) consists of the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources. Complex Case Management assists members in navigating the system in order to facilitate appropriate delivery of care and services. Gundersen Lutheran Health Plan will evaluate the satisfaction level of members involved in CCM through an annual survey. The Health Plan also reports the effectiveness of Complex Case Management using identified measures, including but not limited to: use of diuretics, receiving a flu shot, improved quality of life, decreased hospitalizations, and emergency room usage.

# RIGHTS FOR SENIOR PREFERRED MEMBERS

## WHAT TO DO IF YOU HAVE A COMPLAINT

We encourage you to let us know if you have any questions, concerns, or problems related to the services or the care you receive. You may contact us to speak with one of our Customer Service Representatives. The Customer Service Representative acts as an intermediary to resolve any questions, concerns, or problems you may have with Gundersen Lutheran Health Plan or one of our plan providers. A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint.

## Part C – Medical Care

### COVERAGE DETERMINATION

A decision about whether we will pay for or approve medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days), or it can be a “fast decision” that is made more quickly (typically within 72 hours). A fast decision is also called an “expedited organization determination.” You may ask for a fast decision only if you or any physician believe that waiting for a standard decision could seriously harm your health or your ability to function.

### WHAT IS AN APPEAL?

An “appeal” is the type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. For a decision about payment for care you already received, we have 60 days to make a decision. For a standard decision about medical care, we have 30 days to make a decision, but will decide sooner if your health condition requires. For a fast decision about medical care, we have 72 hours to make a decision, but will decide sooner if your health requires.

#### *EXAMPLES OF THIS:*

- Not getting the care you want, and you believe the care is covered by the Plan.
- Denial of medical treatment your provider wants to give you, and you believe the treatment is covered by the Plan.
- If you are being told a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by the Plan, but we have refused to pay for this care because we say it is not medically necessary or is not a plan benefit.

### WHAT IS A GRIEVANCE?

A grievance is any complaint or dispute, (other than one that involves an organization determination), expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. We will respond to your grievance within 24 hours if the complaint involves a decision to invoke an extension relating to an organization determination or reconsideration, or the complaint involves our refusal to grant your request for an expedited organization determination or appeal reconsideration.

#### *EXAMPLES OF THIS:*

- Problems getting an appointment, or having to wait a long time for an appointment
- The quality of care received, including care during a hospital stay
- Disrespectful or rude behavior by doctors, nurses or other plan clinic or hospital staff
- The plan’s benefit design;
- The plan’s failure to issue a decision in a timely manner
- The plan’s denial of a member’s request for an expedited coverage determination or expedited reconsideration.

## Part D – Drug Coverage

### COVERAGE DETERMINATION

A decision about whether we will give you, or pay for, the Part D drug you are requesting can be a “standard” decision that is made. We must give you a decision no later than 72 hours after we receive your physician’s “supporting statement” explaining why the drug you are asking for is medically necessary. The other option available is a “fast” decision we will give you our decision within 24 hours after you or your doctor ask for a fast review. A fast decision is also called an “expedited” decision.

### WHAT IS AN EXCEPTION?

An exception is a type of initial determination (also called a “coverage determination”) involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

#### *EXAMPLES OF THIS:*

- You ask for a Part D drug that is not on Gundersen Lutheran Senior Preferred list of covered drugs (called a “formulary”). This is a request for a “formulary exception.”
- You ask for an exception to our utilization management tools – (such as prior authorization, dosage limits, quantity limits, or step therapy requirements). Requesting an exception to a utilization management tool is a type of “formulary exception.”
- You ask for a non-preferred Part D drug at the preferred cost sharing level. This is a request for a “Tiering exception.”

### WHAT IS AN APPEAL?

An “appeal” is the type of complaint you make when you want us to reconsider and change a decision we have made about what drugs are covered for you or what we will pay for drug coverage.

#### *EXAMPLES OF THIS:*

- A decision not to pay for or provide a medication because the drug is not on the formulary.
- When the drug is considered not medically necessary.
- When the drug is furnished by an out-of-network pharmacy.
- If a coverage determination is not provided in a timely manner, when the delay could adversely affect your health.
- A request for a drug exception is rejected.

### WHAT IS A GRIEVANCE?

A grievance is any complaint or dispute, (other than one that involves an organization determination), expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. We will respond to your grievance within 24 hours if the complaint involves or decision to invoke an extension relating to an organization determination or reconsideration or the complaint involves our refusal to grant your request for an expedited organization determination or appeal reconsideration.

#### *EXAMPLES OF THIS:*

- Problems with pharmacies, such as long wait times, rude behavior, lack of explanations about medications, access to and cleanliness;
- Disrespectful or rude behavior by pharmacists, or pharmacy staff;
- The plan’s benefit design;
- The plan’s failure to issue a decision in a timely manner;
- The plan’s denial of a member’s request for an expedited coverage determination or expedited redetermination.

## Protecting Your Privacy

Protecting Your Privacy Gundersen Lutheran Health Plan, Inc. is committed to protecting the privacy and confidentiality of your protected personal and health information. We comply with all state and federal privacy laws, including the Gramm-Leach-Bliley Act (GLBA), the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). These laws require that we provide our members with a Privacy Notice that explains our privacy practices. We must also provide you with access to your records, allow you to request corrections to your information as well as allow you to request that access to your information be limited.

In order to provide you with insurance products and services, we must collect healthcare and personal information about you. Access to your information is restricted to only those persons who need to know about that information to provide service or administer Gundersen Lutheran Health Plan insurance products and services. We maintain physical, electronic, and procedural safeguards that comply with state and federal laws to protect your information. Gundersen Lutheran Health Plan does not use, disclose, sell, or make available any protected personal or health information about you to affiliates or non-affiliated third parties, unless required or permitted by law. Furthermore, if any of this information is disclosed without your authorization, we will notify you as required by law.

For a complete copy of our Notice of Privacy Practices, please visit our Web site at [www.seniorpreferred.org](http://www.seniorpreferred.org) or call our customer service department to request a copy.

### *NOTES:*

Gundersen  
Lutheran®

HEALTH PLAN