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# Summary of Benefits

January 1 – December 31, 2011



*SeniorCare* (Cont.)



**SCOTT & WHITE  
HEALTH PLAN**

*Texas Friendly*

Amendment to the  
SeniorCare (Cost) Plan 2011 Summary of Benefits

This notice serves as an amendment to your SeniorCare Summary of Benefits and replaces the applicable sections noted in the chart below. Please keep this updated information with your current SeniorCare Summary of Benefits materials for future reference.

<b>Location of Error In 2011 Summary of Benefits</b>	<b>Original Benefit/Cost-Sharing Information</b>	<b>Corrected Benefit/Cost-Sharing Information</b>
<b>Page 15, Section #21 Diagnostic Tests, X-Rays, Lab Services and Radiology Services for the Senior Select medical plan only, last paragraph:</b>	<b>(See page 41 for the list of diagnostic tests, X-rays, and lab services subject to the \$30 copay.)</b>	<b>(See page 41 for the list of diagnostic tests, X-rays, and lab services subject to the 20% copay.)</b>
<b>Page 41, under Additional Information, Section regarding Diagnostic Tests, X-Rays, Lab Services and Radiology Services:</b>		<u><b>Senior Select</b></u> <ul style="list-style-type: none"> <li>• <b>20% coinsurance for Angiography, EEGs, MRIs, Myelography, CT Scans, Pet Scans, Stress Tests.</b></li> <li>• <b>20% coinsurance for each service when multiple services are performed in one visit.</b></li> </ul>

“Medicare-Approved HMO”

Thank you for your interest in SeniorCare (Cost). Our plan is offered by SCOTT AND WHITE HEALTH PLAN/Scott and White Health Plan SeniorCare, a Medicare Cost Managed Care organization. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call SeniorCare (Cost) 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 SeniorCare (Cost). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call SeniorCare (Cost) 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 SeniorCare (Cost) 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 SeniorCare (Cost) Available?

The service area for this plan includes the following counties: Anderson, Bastrop, Bell, Bosque, Brazos, Burnetson, Burnet, Cherokee, Coke, Coleman, Concho, Coryell, Crockett, Falls, Fayette\*, Gregg\*, Grimes, Hamilton, Henderson, Hill, Irion, Kimble, Lampasas, Lee, Leon, Limestone, Llano, Madison, Mason, McCulloch, McLennan, Menard, Milam, Mills, Rains, Reagan, Robertson, Runnels, Rusk, San Saba, Schleicher, Smith, Sterling, Suttroff, Tom Green, Travis, Van Zandt, Washington, Williamson,

#### Where Can I Get My Prescriptions If I Join This Plan?

SeniorCare (Cost) 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.swhp.org](http://www.swhp.org). Our customer service number is listed at the end of this introduction.

#### What Is A Prescription Drug Formulary?

SeniorCare (Cost) 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.swhp.org](http://www.swhp.org).

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 Costs Or Get Extra Help With Other Medicare Costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare 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; and see [www.medicare.gov](http://www.medicare.gov)
- \* 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- \* The Social Security Administration at 1-800-772-1213 between 7 a.m. & 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 Cost 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 Cost 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 SeniorCare (Cost), 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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of SeniorCare (Cost), 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

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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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

**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. Contact SeniorCare (Cost) 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 SeniorCare (Cost) for more details.

- Some Antigenes: 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 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.

**WHERE CAN I FIND INFORMATION ON 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 to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

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Please call **Scott and White Health Plan SeniorCare** for more information about SeniorCare (Cost). Visit us at [[www.swhp.org](http://www.swhp.org)] or, call us:

- Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday 8:00 a.m. – 8:00 p.m. Central (TTY/TDD (800)-735-2989)
- Prospective members should call locally (254)-298-3366 for questions related to the Medicare Cost Plan.
- Current members should call toll-free (866)-334-3141 for questions related to the Medicare Cost Plan. (TTY/TDD (800)-735-2989)
- Current and Prospective members should call toll-free (866)-334-3141 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800)-735-2989)
- Prospective members should call toll-free (800)-782-5068 for questions related to the Medicare Cost Plan. (TTY/TDD (800)-735-2989)
- Current members should call locally (254)-298-3141 for questions related to the Medicare Cost Plan. (TTY/TDD (800)-735-2989)
- 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](http://www.medicare.gov) on the web.

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

## SUMMARY OF BENEFITS

Benefit Category	Original Medicare	Senior Select	Notes
<b>IMPORTANT INFORMATION</b>			
<b>1 - Premium and Other Important Information</b>	<p>In 2010 the monthly Part B Premium was \$96.40 and may change for 2011 and the yearly Part B deductible amount was \$155.00 and may change for 2011.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2011, some people will pay a higher premium because of their yearly income. (For 2010, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2011.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p><b>General</b>                      \$35* monthly plan premium                      \$85.10* monthly plan premium with SeniorCare Value Rx (Cost)                      \$75.00* monthly plan premium with SeniorCare Basic Rx (Cost)                      \$133.70* monthly plan premium with SeniorCare Enhanced Rx (Cost) *in addition to your monthly Medicare Part B premium.  <b>In-Network</b>                      \$3,400 out-of-pocket limit.                      All plan services included.</p>	
<b>2 - Doctor and Hospital Choice</b> <small>(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)</small>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b>                      Referral required for network hospitals and specialists (for certain benefits).</p> <p><b>In and Out-of-Network</b>                      You can use any network doctor. If you go to out-of-network doctors the plan may not cover the services, but Medicare will pay its share for Medicare-covered services. When Medicare pays its share, you pay the Medicare Part B deductible and coinsurance.                      (See page 41 for additional information about Doctor and Hospital Choice.)</p>	
<b>INPATIENT CARE</b>			
<b>3 - Inpatient Hospital Care</b> <small>(includes Substance Abuse and Rehabilitation Services)</small>	<p>In 2010 the amounts for each benefit period are:                      Days 1 - 60: \$1,100 deductible                      Days 61 - 90: \$275 per day                      Days 91 - 150: \$550 per lifetime reserve day                      These amounts will change for 2011.</p>	<p><b>In-Network</b>                      \$700 copay for each Medicare-covered hospital stay                      Plan covers 90 days each benefit period.</p>	

## SUMMARY OF BENEFITS

Benefit Category	Senior Preferred	Senior Preferred Plus	Notes
<b>IMPORTANT INFORMATION</b>			
<b>General</b>			
	<p>\$97* monthly plan premium                      \$147.10* monthly plan premium with SeniorCare Value Rx (Cost)                      \$137.00* monthly plan premium with SeniorCare Basic Rx (Cost)                      \$195.70* monthly plan premium with SeniorCare Enhanced Rx (Cost) *in addition to your monthly Medicare Part B premium.  <b>In-Network</b>                      \$3,400 out-of-pocket limit.                      All plan services included.</p>	<p><b>General</b>                      \$155* monthly plan premium                      \$205.10* monthly plan premium with SeniorCare Value Rx (Cost)                      \$195.00* monthly plan premium with SeniorCare Basic Rx (Cost)                      \$253.70* monthly plan premium with SeniorCare Enhanced Rx (Cost) *in addition to your monthly Medicare Part B premium.  <b>In-Network</b>                      \$3,400 out-of-pocket limit.                      All plan services included.</p>	
	<p><b>In-Network</b>                      Referral required for network hospitals and specialists (for certain benefits).</p> <p><b>In and Out-of-Network</b>                      You can use any network doctor. If you go to out-of-network doctors the plan may not cover the services, but Medicare will pay its share for Medicare-covered services. When Medicare pays its share, you pay the Medicare Part B deductible and coinsurance.                      (See page 41 for additional information about Doctor and Hospital Choice.)</p>	<p><b>In-Network</b>                      Referral required for network hospitals and specialists (for certain benefits).</p> <p><b>In and Out-of-Network</b>                      You can use any network doctor. If you go to out-of-network doctors the plan may not cover the services, but Medicare will pay its share for Medicare-covered services. When Medicare pays its share, you pay the Medicare Part B deductible and coinsurance.                      (See page 41 for additional information about Doctor and Hospital Choice.)</p>	
<b>INPATIENT CARE</b>			
	<p><b>In-Network</b>                      \$450 copay for each Medicare-covered hospital stay                      \$0 copay for additional hospital days</p>	<p><b>In-Network</b>                      \$0 copay</p>	

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Benefit Category	Original Medicare	Senior Select
<b>4 - Inpatient Mental Health Care</b>	<p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>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 without hospital or skilled nursing care. 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.</p>	<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<b>5 - Skilled Nursing Facility (SNF)</b> (in a Medicare-certified skilled nursing facility)	<p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p><b>In-Network</b> \$700 copay for each Medicare-covered hospital stay.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>General</b> Authorization rules may apply.</p> <p><b>In Network</b> For Medicare-covered SNF stays: Days 1 - 20: \$0 copay per day Days 21 - 100: \$100 copay per day</p> <p>Plan covers up to 100 days each benefit period</p>

## SUMMARY OF BENEFITS

Senior Preferred	Senior Preferred Plus	Notes
<p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	
<p><b>In-Network</b> \$450 copay for each Medicare-covered hospital stay.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>General</b> Authorization rules may apply.</p> <p><b>In Network</b> For Medicare-covered SNF stays: Days 1 - 20: \$0 copay per day Days 21 - 100: \$35 copay per day</p> <p>Plan covers up to 100 days each benefit period</p>	<p><b>In-Network</b> \$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>General</b> Authorization rules may apply.</p> <p><b>In Network</b> For Medicare-covered SNF stays: Days 1 - 20: \$0 copay per day Days 21 - 100: \$15 copay per day</p> <p>Plan covers up to 100 days each benefit period</p>	

SUMMARY OF BENEFITS			
Benefit Category	Original Medicare	Senior Select	Notes
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay	In-Network \$0 copay for Medicare-covered home health visits.	
	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	<b>General</b> You must get care from a Medicare-certified hospice. (See page 41 for additional information about Doctor and Hospital Choice.)	
OUTPATIENT CARE			
8 - Doctor Office Visits	20% coinsurance	<b>General</b> See "Physical Exams," for more information. Authorization rules may apply. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. <b>In-Network</b> \$30 copay for each primary care doctor visit for Medicare-covered benefits. \$40 copay for each in-area, network urgent care Medicare-covered visit. \$30 copay for each specialist visit for Medicare-covered benefits.	
9 - Chiropractic Services	Routine care not covered 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.	<b>General</b> Authorization rules may apply. <b>In-Network</b> 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.	

SUMMARY OF BENEFITS			
Benefit Category	Senior Preferred	Senior Preferred Plus	Notes
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay	In-Network \$0 copay for Medicare-covered home health visits.	
	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice. (See page 41 for additional information about Doctor and Hospital Choice.)	<b>General</b> You must get care from a Medicare-certified hospice. (See page 41 for additional information about Doctor and Hospital Choice.)	
OUTPATIENT CARE			
8 - Doctor Office Visits	20% coinsurance	<b>General</b> See "Physical Exams," for more information. Authorization rules may apply. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. <b>In-Network</b> \$30 copay for each primary care doctor visit for Medicare-covered benefits. \$40 copay for each in-area, network urgent care Medicare-covered visit. \$30 copay for each specialist visit for Medicare-covered benefits.	
9 - Chiropractic Services	Routine care not covered 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.	<b>General</b> Authorization rules may apply. <b>In-Network</b> 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.	

## SUMMARY OF BENEFITS

Benefit Category	Original Medicare	Senior Select
<b>10 - Podiatry Services</b>	Routine care not covered. <b>20%</b> coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	<b>General</b> Authorization rules may apply. <b>In-Network</b> <b>20%</b> of the cost for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.
	<b>11 - Outpatient Mental Health Care</b>	<b>In-Network</b> <b>20%</b> of the cost for each Medicare-covered individual or group therapy visit.
<b>12 - Outpatient Substance Abuse Care</b>	<b>20%</b> coinsurance	<b>General</b> Authorization rules may apply. <b>In-Network</b> <b>20%</b> of the cost for Medicare-covered individual or group visits. (See page 41 for additional information about Outpatient Substance Abuse Care.)
	<b>13 - Outpatient Services/Surgery</b>	<b>General</b> Authorization rules may apply. <b>In-Network</b> <b>20%</b> of the cost for each Medicare-covered ambulatory surgical center visit. <b>20%</b> of the cost for each Medicare-covered outpatient hospital facility visit.
<b>14 - Ambulance Services</b> (medically necessary ambulance services)	<b>20%</b> coinsurance	<b>In-Network</b> <b>\$75</b> copay for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay <b>\$0</b> for Medicare-covered ambulance benefits. (See page 41 for additional information about Ambulance Services.)

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Senior Preferred	Senior Preferred Plus	Notes
<b>General</b> Authorization rules may apply. <b>In-Network</b> <b>\$15</b> copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	<b>General</b> Authorization rules may apply. <b>In-Network</b> <b>\$0</b> copay for Medicare-covered podiatry benefits. Medicare-covered podiatry benefits are for medically-necessary foot care.	
<b>In-Network</b> <b>\$15</b> copay for each Medicare-covered individual or group therapy visit.	<b>In-Network</b> <b>\$0</b> copay for Medicare-covered Mental Health visits.	
<b>General</b> Authorization rules may apply. <b>In-Network</b> <b>\$15</b> copay for Medicare-covered individual or group visits. (See page 41 for additional information about Outpatient Substance Abuse Care.)	<b>General</b> Authorization rules may apply. <b>In-Network</b> <b>\$0</b> copay for Medicare-covered visits. (See page 41 for additional information about Outpatient Substance Abuse Care.)	
<b>General</b> Authorization rules may apply. <b>In-Network</b> <b>\$100</b> copay for each Medicare-covered ambulatory surgical center visit. <b>\$15</b> copay for each Medicare-covered outpatient hospital facility visit.	<b>General</b> Authorization rules may apply. <b>In-Network</b> <b>\$0</b> copay for each Medicare-covered ambulatory surgical center visit. <b>\$0</b> copay for each Medicare-covered outpatient hospital facility visit.	
<b>In-Network</b> <b>\$75</b> copay for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay <b>\$0</b> for Medicare-covered ambulance benefits. (See page 41 for additional information about Ambulance Services.)	<b>In-Network</b> <b>\$40</b> copay for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay <b>\$0</b> for Medicare-covered ambulance benefits. (See page 41 for additional information about Ambulance Services.)	

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Benefit Category	Original Medicare	Senior Select
<b>15 - Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit NOT covered outside the U.S. except under limited circumstances.	General \$200 copay for Medicare-covered emergency room visits. Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. If you are admitted to the hospital within 24 hour(s) for the same condition, you pay \$0 for the emergency room visit.
<b>16 - Urgently Needed Care</b> (This is NOT emergency care and, in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	General \$40 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24 hour(s) for the same condition, you pay \$0 for the urgently-needed care visit.
<b>17 - Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/Psychological Services, and more)	20% coinsurance	General Authorization rules may apply. In-Network There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits. 20% of the cost for Medicare-covered Occupational Therapy visits. 20% of the cost for Medicare-covered Physical and/or Speech and Language Therapy visits. 20% of the cost for Medicare-covered Cardiac Rehab services. (See page 41 for additional information about Outpatient Rehabilitation Services.)

OUTPATIENT MEDICAL SERVICES AND SUPPLIES	
<b>18 - Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)	General 20% coinsurance Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.

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Senior Preferred	Senior Preferred Plus	Notes
General \$200 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.	General \$75 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.	
General \$40 copay 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 visit.	General \$40 copay 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 visit.	
General Authorization rules may apply. In-Network There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits. \$15 copay for Medicare-covered Occupational Therapy visits. \$15 copay for Medicare-covered Physical and/or Speech and Language Therapy visits. \$15 copay for Medicare-covered Cardiac Rehab services. (See page 41 for additional information about Outpatient Rehabilitation Services.)	General Authorization rules may apply. In-Network There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits. \$0 copay for Medicare-covered Occupational Therapy visits. \$0 copay for Medicare-covered Physical and/or Speech and Language Therapy visits. \$0 copay for Medicare-covered Cardiac Rehab services. (See page 41 for additional information about Outpatient Rehabilitation Services.)	

OUTPATIENT MEDICAL SERVICES AND SUPPLIES	
General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items.

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Benefit Category	Original Medicare	Senior Select
<b>19 - Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 20% of the cost for Medicare-covered items.</p>
<b>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</b>  (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)	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 counseling to help you manage your diabetes or kidney disease.	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies. Separate Office Visit cost sharing of \$30 may apply.</p>
<b>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b>	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.  \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit.  HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months of up to three times during a pregnancy.	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 0% to 20% of the cost for Medicare-covered lab services. 0-20% of the cost for Medicare-covered diagnostic procedures and tests. 0-20% of the cost for Medicare-covered X-rays. 0-20% of the cost for Medicare-covered diagnostic radiology services (not including x-rays). 0-20% of the cost for Medicare-covered therapeutic radiology services.  Separate Office Visit cost sharing of \$30 may apply for Outpatient Diagnostic Procedures, Tests and Lab services.  Separate Office Visit cost sharing of \$30 may apply for Outpatient Diagnostic and Therapeutic Radiological Services.  (See page 41 for the list of diagnostic tests, X-rays, and lab services subject to the \$30 copay.)</p>

## SUMMARY OF BENEFITS

Senior Preferred	Senior Preferred Plus	Notes
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 20% of the cost for Medicare-covered items.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered items.</p>	
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies. Separate Office Visit cost sharing of \$15 may apply.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.</p>	
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 to \$15 copay for Medicare-covered lab services. \$0 to \$15 copay for Medicare-covered diagnostic procedures and tests. \$0 to \$15 copay for Medicare-covered X-rays. \$0 to \$15 copay for Medicare-covered diagnostic radiology services (not including x-rays). \$0 to \$15 copay for Medicare-covered therapeutic radiology services.  Separate Office Visit cost sharing of \$15 may apply for Outpatient Diagnostic Procedures, Tests and Lab services.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered lab services - diagnostic procedures and tests - X-rays. - diagnostic radiology services (not including X-rays) - therapeutic radiology services</p>	<p>(See page 41 for the list of diagnostic tests, X-rays, and lab services subject to the \$15 copay.)</p>

SUMMARY OF BENEFITS			
Benefit Category	Original Medicare	Senior Select	Notes
<b>PREVENTIVE SERVICES</b>			
<b>22 - Bone Mass Measurement</b> (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement Separate Office Visit cost sharing of \$30 may apply.	
<b>23 - Colorectal Screening Exams</b> (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of \$30 may apply.	
<b>24 - Immunizations</b> (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	
<b>25 - Mammograms (Annual Screening)</b> (for women with Medicare age 40 and older)	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.	<b>In-Network</b> \$0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of \$30 may apply. (See page 41 for additional information about mammograms.)	
<b>26 - Pap Smears and Pelvic Exams</b> (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. 20% coinsurance for Pelvic Exams	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams. Separate Office Visit cost sharing of \$30 may apply.	

SUMMARY OF BENEFITS				
Benefit Category	Original Medicare	Senior Preferred	Senior Preferred Plus	Notes
<b>PREVENTIVE SERVICES</b>				
<b>22 - Bone Mass Measurement</b> (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement Separate Office Visit cost sharing of \$15 may apply.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement	
<b>23 - Colorectal Screening Exams</b> (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of \$15 may apply.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.	
<b>24 - Immunizations</b> (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	
<b>25 - Mammograms (Annual Screening)</b> (for women with Medicare age 40 and older)	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.	<b>In-Network</b> \$0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of \$15 may apply. (See page 41 for additional information about mammograms.)	<b>In-Network</b> \$0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of \$15 may apply. (See page 41 for additional information about mammograms.)	
<b>26 - Pap Smears and Pelvic Exams</b> (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. 20% coinsurance for Pelvic Exams	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams. Separate Office Visit cost sharing of \$15 may apply.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams.	

## SUMMARY OF BENEFITS

Benefit Category	Original Medicare	Senior Select
<b>27 - Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)	<p><b>20%</b> coinsurance for the digital rectal exam.</p> <p><b>\$0</b> for the PSA test; <b>20%</b> coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> <b>\$0</b> copay for Medicare-covered prostate cancer screening.</p> <p>Separate Office Visit cost sharing of <b>\$30</b> may apply.</p>
<b>28 - End-Stage Renal Disease</b>	<p><b>20%</b> coinsurance for renal dialysis</p> <p><b>20%</b> coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>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.</p>	<p><b>General</b> Cost plan members pay Fee-for-Service cost sharing for out-of-area dialysis.</p> <p>Authorization rules may apply.</p> <p><b>In-Network</b> <b>20%</b> of the cost for renal dialysis</p> <p><b>\$0</b> copay for Nutrition Therapy for End-Stage Renal Disease.</p>
<b>29 - Prescription Drugs</b>	<p>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.</p>	<p><b>Drugs Covered under Medicare Part B</b></p> <p><b>General</b> <b>20%</b> of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p>

## SUMMARY OF BENEFITS

Senior Preferred	Senior Preferred Plus	Notes
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> <b>\$0</b> copay for Medicare-covered prostate cancer screening.</p> <p>Separate Office Visit cost sharing of <b>\$15</b> may apply.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> <b>\$0</b> copay for Medicare-covered prostate cancer screening.</p>	
<p><b>General</b> Cost plan members pay Fee-for-Service cost sharing for out-of-area dialysis.</p> <p>Authorization rules may apply.</p> <p><b>In-Network</b> <b>\$15</b> copay for renal dialysis</p> <p><b>\$0</b> copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p><b>General</b> Cost plan members pay Fee-for-Service cost sharing for out-of-area dialysis.</p> <p>Authorization rules may apply.</p> <p><b>In-Network</b> <b>\$0</b> copay for renal dialysis</p> <p><b>\$0</b> copay for Nutrition Therapy for End-Stage Renal Disease.</p>	
<p><b>Drugs Covered under Medicare Part B</b></p> <p><b>General</b> <b>\$0</b> copay for Part B-covered drugs.</p>	<p><b>Drugs Covered under Medicare Part B</b></p> <p><b>General</b> <b>\$0</b> copay for Part B-covered drugs.</p>	

## SUMMARY OF BENEFITS

Benefit Category	Value Rx
Original Medicare	<p><b>Drugs Covered under Medicare Part D</b></p> <p><b>General</b>                      This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.swhp.org">www.swhp.org</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>- have limited incomes,</li> <li>- live in long term care facilities, or</li> <li>- have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details.</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from SeniorCare (Cost) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p>

## SUMMARY OF BENEFITS

Basic Rx	Enhanced Rx	Notes
<p><b>Drugs Covered under Medicare Part D</b></p> <p><b>General</b>                      This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.swhp.org">www.swhp.org</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>- have limited incomes,</li> <li>- live in long term care facilities, or</li> <li>- have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details.</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from SeniorCare (Cost) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p>	<p><b>Drugs Covered under Medicare Part D</b></p> <p><b>General</b>                      This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.swhp.org">www.swhp.org</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>- have limited incomes,</li> <li>- live in long term care facilities, or</li> <li>- have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details.</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from SeniorCare (Cost) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p>	

## SUMMARY OF BENEFITS

Benefit Category	Original Medicare	Value Rx
		<p>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.</p> <p><b>In-Network</b>  <b>\$310 yearly deductible.</b></p> <p><b>Initial Coverage</b>                      After you pay your yearly deductible, you pay 25% until total yearly drug costs reach <b>\$2,840</b>.</p> <p><b>Retail Pharmacy</b>                      You can get drugs the following way(s):</p> <ul style="list-style-type: none"> <li>- one-month (30-day) supply</li> <li>- three-month (90-day) supply</li> <li>- 60-day supply</li> </ul> <p>Not all drugs are available at this extended day supply. Please contact the plan for more information.</p>

## SUMMARY OF BENEFITS

Basic Rx	Enhanced Rx	Notes
<p>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.</p> <p>If you request a formulary exception for a drug and Scott and White Health Plan SeniorCare (Cost) approves the exception, you will pay Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs cost sharing for that drug.</p> <p><b>In-Network</b>  <b>\$0 deductible.</b></p> <p><b>Initial Coverage</b>                      You pay the following until total yearly drug costs reach <b>\$2,840</b>.</p> <p><b>Retail Pharmacy</b>                      Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> <li>- \$7 copay for a one-month (30-day) supply of drugs in this tier</li> <li>- \$14 copay for a 60-day supply of drugs in this tier</li> <li>- \$21 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> <li>- \$35 copay for a one-month (30-day) supply of drugs in this tier</li> <li>- \$70 copay for a 60-day supply of drugs in this tier</li> <li>- \$105 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> <li>- \$64 copay for a one-month (30-day) supply of drugs in this tier</li> </ul>	<p>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.</p> <p>If you request a formulary exception for a drug and Scott and White Health Plan SeniorCare (Cost) approves the exception, you will pay Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs cost sharing for that drug.</p> <p><b>In-Network</b>  <b>\$0 deductible.</b></p> <p><b>Initial Coverage</b>                      You pay the following until total yearly drug costs reach <b>\$2,840</b>.</p> <p><b>Retail Pharmacy</b>                      Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> <li>- \$0 copay for a one-month (30-day) supply of drugs in this tier</li> <li>- \$0 copay for a 60-day supply of drugs in this tier</li> <li>- \$0 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> <li>- \$35 copay for a one-month (30-day) supply of drugs in this tier</li> <li>- \$70 copay for a 60-day supply of drugs in this tier</li> <li>- \$105 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> <li>- \$65 copay for a one-month (30-day) supply of drugs in this tier</li> </ul>	

**SUMMARY OF BENEFITS**

Benefit Category	Original Medicare	Value Rx
		<p><b>Long Term Care Pharmacy</b>                      You can get drugs the following way(s):</p> <ul style="list-style-type: none"> <li>- one-month (34-day) supply</li> </ul>

**SUMMARY OF BENEFITS**

Basic Rx	Enhanced Rx	Notes
<ul style="list-style-type: none"> <li>- <b>\$128</b> copay for a 60-day supply of drugs in this tier</li> <li>- <b>\$192</b> copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> <li>- <b>33%</b> coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>- <b>33%</b> coinsurance for a 60-day supply of drugs in this tier</li> <li>- <b>33%</b> coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Long Term Care Pharmacy</b></p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> <li>- <b>\$7</b> copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> <li>- <b>\$35</b> copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> <li>- <b>\$64</b> copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> <li>- <b>33%</b> coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul>	<ul style="list-style-type: none"> <li>- <b>\$130</b> copay for a 60-day supply of drugs in this tier</li> <li>- <b>\$195</b> copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> <li>- <b>33%</b> coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>- <b>33%</b> coinsurance for a 60-day supply of drugs in this tier</li> <li>- <b>33%</b> coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Long Term Care Pharmacy</b></p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> <li>- <b>\$0</b> copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> <li>- <b>\$35</b> copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> <li>- <b>\$65</b> copay for a one-month (34-day) supply of drugs in this tier</li> </ul> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> <li>- <b>33%</b> coinsurance for a one-month (34-day) supply of drugs in this tier</li> </ul>	

## SUMMARY OF BENEFITS

Benefit Category	Original Medicare	Value Rx
		<p><b>Mail Order</b>                      You can get drugs the following way(s):</p> <ul style="list-style-type: none"> <li>- one-month (30-day) supply</li> <li>- three-month (90-day) supply</li> </ul> <p>Not all drugs are available at this extended day supply. Please contact the plan for more information.</p>

## SUMMARY OF BENEFITS

Basic Rx	Enhanced Rx	Notes
<p><b>Mail Order</b>                      Tier 1: Preferred Generic Drugs                      - \$7 copay for a one-month (30-day) supply of drugs in this tier                      - \$14 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs                      - \$35 copay for a one-month (30-day) supply of drugs in this tier                      - \$70 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs                      - \$64 copay for a one-month (30-day) supply of drugs in this tier                      - \$128 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs                      - 33% coinsurance for a one-month (30-day) supply of drugs in this tier                      - 33% coinsurance for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>	<p><b>Mail Order</b>                      Tier 1: Preferred Generic Drugs                      - \$0 copay for a one-month (30-day) supply of drugs in this tier                      - \$0 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs                      - \$35 copay for a one-month (30-day) supply of drugs in this tier                      - \$70 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs                      - \$65 copay for a one-month (30-day) supply of drugs in this tier                      - \$130 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs                      - 33% coinsurance for a one-month (30-day) supply of drugs in this tier                      - 33% coinsurance for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>	

## SUMMARY OF BENEFITS

Benefit Category	Original Medicare	Value Rx
		<p><b>Coverage Gap</b> After your total yearly drug costs reach <b>\$2,840</b>, you receive a discount on brand name drugs and pay 93% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach <b>\$4,550</b>.</p> <p><b>Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach <b>\$4,550</b>, you pay the greater of: - A <b>\$ 2.50</b> copay for generic (including brand drugs treated as generic) and a <b>\$ 6.30</b> copay for all other drugs, or - <b>5%</b> coinsurance.</p>

## SUMMARY OF BENEFITS

Basic Rx	Enhanced Rx	Notes
<p><b>Coverage Gap</b> After your total yearly drug costs reach <b>\$2,840</b>, you receive a discount on brand name drugs and pay 93% of the plan's costs for all generic drugs, until your yearly out-of-pocket drug costs reach <b>\$4,550</b>.</p> <p><b>Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach <b>\$4,550</b>, you pay the greater of: - A <b>\$ 2.50</b> copay for generic (including brand drugs treated as generic) and a <b>\$ 6.30</b> copay for all other drugs, or - <b>5%</b> coinsurance.</p>	<p><b>Additional Coverage Gap</b> You pay the following: <b>Retail Pharmacy</b> Tier 1: Preferred Generic Drugs - <b>\$4</b> copay for a one-month (30-day) supply of all drugs covered in this tier - <b>\$8</b> copay for a 60-day supply of all drugs covered in this tier - <b>\$12</b> copay for a three-month (90-day) supply of all drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <b>Long Term Care Pharmacy</b> Tier 1: Preferred Generic Drugs - <b>\$4</b> copay for a one-month (34-day) supply of all drugs covered in this tier <b>Mail Order</b> Tier 1: Preferred Generic Drugs - <b>\$4</b> copay for a one-month (30-day) supply of all drugs covered in this tier - <b>\$8</b> copay for a three-month (90-day) supply of all drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. After your total yearly drug costs reach <b>\$2,840</b>, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 93% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach <b>\$4,550</b>. <b>Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach <b>\$4,550</b>, you pay the greater of: - A <b>\$ 2.50</b> copay for generic (including brand drugs treated as generic) and a <b>\$ 6.30</b> copay for all other drugs, or - <b>5%</b> coinsurance.</p>	

## SUMMARY OF BENEFITS

Benefit Category	Original Medicare	Value Rx
		<p><b>Out-of-Network</b> 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 SeniorCare (Cost).</p> <p>You can get drugs the following way: - one-month (30-day) supply</p> <p><b>Out-of-Network Initial Coverage</b> After you pay your yearly deductible, you will be reimbursed up to 75% of the actual cost for drugs purchased out-of-network until total yearly drug costs reach <b>\$2,840</b>.</p>

## SUMMARY OF BENEFITS

Basic Rx	Enhanced Rx	Notes
<p><b>Out-of-Network</b> 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 SeniorCare (Cost).</p> <p><b>Out-of-Network Initial Coverage</b> You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach <b>\$2,840</b>:</p> <p><b>Out-of-Network Pharmacy</b> Tier 1: Preferred Generic Drugs - \$7 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - \$35 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs - \$64 copay for a one-month (30-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30 day) supply of drugs in this tier</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<p><b>Out-of-Network</b> 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 SeniorCare (Cost).</p> <p><b>Out-of-Network Initial Coverage</b> You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach <b>\$2,840</b>:</p> <p><b>Out-of-Network Pharmacy</b> Tier 1: Preferred Generic Drugs - \$0 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - \$35 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs - \$65 copay for a one-month (30-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30 day) supply of drugs in this tier</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	

## SUMMARY OF BENEFITS

Benefit Category	Original Medicare	Value Rx
		<p><b>Out-of-Network Coverage Gap</b> You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach <b>\$4,550</b>.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Out-of-Network Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach <b>\$4,550</b>, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of: - A <b>\$ 2.50</b> copay for generic (including brand drugs treated as generic) and a <b>\$ 6.30</b> copay for all other drugs, or - <b>5%</b> coinsurance.</p>

## SUMMARY OF BENEFITS

Basic Rx	Enhanced Rx	Notes
<p><b>Out-of-Network Coverage Gap</b> You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach <b>\$4,550</b>.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p><b>Out-of-Network Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach <b>\$4,550</b>, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of: - A <b>\$ 2.50</b> copay for generic (including brand drugs treated as generic) and a <b>\$ 6.30</b> copay for all other drugs, or - <b>5%</b> coinsurance.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<p><b>Additional Out-of-Network Coverage Gap</b> You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:  Tier 1: Preferred Generic Drugs - <b>\$4</b> copay for a one-month (30-day) supply of all drugs covered in this tier  You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach <b>\$4,550</b>.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p><b>Out-of-Network Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach <b>\$4,550</b>, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of: - A <b>\$ 2.50</b> copay for generic (including brand drugs treated as generic) and a <b>\$ 6.30</b> copay for all other drugs, or - <b>5%</b> coinsurance.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	

## SUMMARY OF BENEFITS

Benefit Category	Original Medicare	Senior Select
<b>30 - Dental Services</b>	Preventive dental services (such as cleaning) not covered.	<p><b>In-Network</b> \$0 copay for Medicare-covered dental benefits</p> <p>In general, preventive dental benefits (such as cleaning) not covered.</p>
<b>31 - Hearing Services</b>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> In general, routine hearing exams and hearing aids not covered. - \$30 copay for Medicare-covered diagnostic hearing exams</p>
<b>32 - Vision Services</b>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><b>In-Network</b> Non-Medicare-covered eye exams and glasses not covered. - \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$0-30 copay for exams to diagnose and treat diseases and conditions of the eye.</p>

## SUMMARY OF BENEFITS

Benefit Category	Senior Preferred	Senior Preferred Plus	Notes
<b>30 - Dental Services</b>	<p><b>In-Network</b> \$0 copay for Medicare-covered dental benefits</p> <p>In general, preventive dental benefits (such as cleaning) not covered.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered dental benefits</p> <p>\$0 copay for the following preventive dental benefits: - up to 1 oral exam(s) every six months - up to 1 cleaning(s) every six months - up to 1 dental x-ray(s) every year</p> <p>(See page 39 for additional information about Dental Services.)</p>	
<b>31 - Hearing Services</b>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> Hearing aids not covered. - \$15 copay for Medicare-covered diagnostic hearing exams - \$15 copay for up to 1 routine hearing test(s) every year</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered diagnostic hearing exams - up to 1 routine hearing test(s) every year - 50% of the cost per hearing aid</p> <p>\$1,000 plan coverage limit for hearing aids every two years.</p>	
<b>32 - Vision Services</b>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> - \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$0-15 copay for exams to diagnose and treat diseases and conditions of the eye. - \$15 copay for up to 1 routine eye exam(s) every year - \$15 copay for up to 1 pair(s) of glasses every two years</p> <p>(See page 40 for additional information about Vision Services.)</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> - \$0 copay for diagnosis and treatment for diseases and conditions of the eye and up to 1 routine eye exam(s) every year - \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$15 copay for up to 1 pair(s) of glasses every two years</p> <p>(See page 40 for additional information about Vision Services.)</p>	

## SUMMARY OF BENEFITS

Benefit Category	Original Medicare	Senior Select
<b>33 - Physical Exams</b>	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage</p> <p>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.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$30 copay for routine exams.</p> <p>No plan coverage limit on the number of covered exams.</p> <p>\$0 copay for Medicare-covered benefits.</p> <p>Separate Office Visit cost sharing of \$30 may apply.</p>
<b>Health/Wellness Education</b>	<p>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.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletters</li> <li>- Nutritional Training</li> <li>- Additional Smoking Cessation</li> <li>- Nursing Hotline</li> <li>- Other Wellness Benefits</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>(See page 41 for additional information about Health/Wellness Education.)</p>
<b>Transportation (Routine)</b>	Not covered.	<b>In-Network</b> This plan does not cover routine transportation.
<b>Acupuncture</b>	Not covered.	<b>In-Network</b> This plan does not cover Acupuncture.

## SUMMARY OF BENEFITS

Senior Preferred	Senior Preferred Plus	Notes
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$15 copay for routine exams.</p> <p>No plan coverage limit on the number of covered exams.</p> <p>\$0 copay for Medicare-covered benefits.</p> <p>Separate Office Visit cost sharing of \$15 may apply.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for routine exams.</p> <p>No plan coverage limit on the number of covered exams.</p>	
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletters</li> <li>- Nutritional Training</li> <li>- Additional Smoking Cessation</li> <li>- Nursing Hotline</li> <li>- Other Wellness Benefits</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>(See page 41 for additional information about Health/Wellness Education.)</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletters</li> <li>- Nutritional Training</li> <li>- Additional Smoking Cessation</li> <li>- Nursing Hotline</li> <li>- Other Wellness Benefits</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>(See page 41 for additional information about Health/Wellness Education.)</p>	
<b>In-Network</b> This plan does not cover routine transportation.	<b>In-Network</b> This plan does not cover routine transportation.	
<b>In-Network</b> This plan does not cover Acupuncture.	<b>In-Network</b> This plan does not cover Acupuncture.	

**Dental Services for Senior Preferred Plus Only:**

Dental Procedure	Limit	Covered Percentage
Periodic Oral Evaluations	Two per year	In Network: 100% of PDP Fee* Out of Network: 100% of R&C Fee**
Radiographs (X-rays)		
• Bitewings	• One per year	In Network: 100% of PDP Fee*
• Intraoral - Complete Series, including Bitewings or Panoramic Film	• Once every 36 months	Out of Network: 100% of R&C Fee**
Dental Prophylaxis (Cleaning)	Once every 6 months	In Network: 100% of PDP Fee* Out of Network: 100% of R&C Fee**

Dental coverage is underwritten by MetLife (Metropolitan Life Insurance Company, New York, NY 10166).

**Customer Service: 1-800-275-4638 (Monday – Friday, 7 a.m. – 10 p.m., Central Time)**  
**TTY/TDD#888-638-4863 To find a dentist go to: [metlife.com/dental](http://metlife.com/dental)**

**\*In-Network Benefits** means benefits provided under this plan for covered dental services that are provided by a participating PDP(Preferred Dentist Program) provider. **PDP Fee** refers to the PDP Table of Maximum Allowed Charges (PDP Schedule). Participating PDP dentists have agreed to accept the PDP fee schedule as payment in full for services rendered.

**\*\*Out-of-Network Benefits** means benefits provided under this plan for covered dental services that are provided by a non participating PDP provider. **R&C (Reasonable & Customary) charges** are based on the lowest of: **1)** the dentist’s actual charge; **2)** the dentist’s usual charge for the same or similar services; or **3)** the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife. If the actual charge is greater than the R&C fee, the member’s out-of-pocket expense is the amount remaining after the covered percentage of the R&C fee is reimbursed plus the difference between the R&C fee and the actual charge.

**Coordination of Benefits:** MetLife plans contain a coordination of benefits clause that reduces benefits paid under our plan based on benefits received from other group, employer or government sponsored plans excluding Medicaid. The benefits under a MetLife group dental plan and any other plan providing benefits for covered dental services cannot exceed **100%** of the allowable charge.

**Cancellation/Termination:** Coverage is subject to the terms and provisions in the Group Policy (Form GPNP99-DSC-SW) issued to Scott & White Health Plan and certificates of insurance (Form G.23000-SWSC) issued to each insured subscriber. Coverage under this policy terminates when:

- you cease to be covered under the Scott & White Senior Preferred Plus (Cost) plan,
- required premiums are not paid by the policyholder, Scott & White Health Plan, or
- the policy issued to Scott & White Health Plan ends.

**Note:** Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife group representative for costs and complete details.

**Senior Preferred Plus and Senior Preferred Only Vision Services**

You are entitled to prescription eyewear as stated when such eyewear is prescribed by a Group Physician or a contracting optometrist and is obtained at a Health Plan contracting optical dispensary. Members are entitled to one of the following every two Contract Years: one pair of single vision plastic lenses and frames or one pair of bifocal/trifocal plastic lenses, type 28, and frames. See Evidence of Coverage for more details. Frames are limited to those in stock. You pay a **\$5** copayment for single vision glasses or a **\$15** copayment for bifocal/trifocal glasses.

**Prescription Benefits**

**For New Prescriptions:**

- Take your prescription to a Scott & White Health Plan Pharmacy or a participating network pharmacy of your choice.

**Transfer Prescriptions:**

- Call the pharmacy and give the prescription label information to the staff or take your label to a Scott & White Health Plan Pharmacy or participating network pharmacy of your choice. They will complete the transfer for you. Please allow 24 hours for transfer prescriptions.

**Refills:**

Refills may be picked up at your local participating network pharmacy.

- Call the Scott & White Health Plan Network Pharmacy where you would like to pick up your prescription.
- Give the prescription number and name of the pharmacy where you placed the original order.

**Mail Order:**

- To establish mail order service, please see the Pharmacy Provider Directory or contact Customer Service.

**After Hours/Weekends:**

- For prescriptions received during evening or weekend hours that must be started immediately, please call the appropriate Network pharmacy for emergency number instructions.

**Out-of-Network Pharmacy Benefits:**

Prescription drugs are available at out-of-network pharmacies in special circumstances including: 1) illness while traveling outside of the plan’s service area where there is no network pharmacy; 2) traveling outside plan’s service area and running out or losing drug with no access to network pharmacy; 3) no access to network pharmacy; 4) drug not stocked at network or mail order pharmacy; or 5) vaccine administered in physician’s office; or 6) drug dispensed in out-of-network pharmacy while in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.

You pay **100%** of the Out-of-Network Pharmacy usual and customary charge. You then submit the claim to Scott and White Health Plan for reimbursement. In addition to paying the copayments/co-insurance, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.

## Additional Information

**Allergy Injections (Senior Select Only):** For allergy injections, you pay **\$25** per vial of serum.

**Ambulance Services:** Copay for Ambulance Services is waived if you are transported.

### **Diagnostic Tests, X-Rays, Lab Services and Radiology Services:**

#### **Senior Preferred**

- \$15 copay for Angiography, EEGs, MRIs, Myelography, CT Scans, Pet Scans, Stress Tests.
- \$15 copay for each service when multiple services are performed in one visit

**Doctor and Hospital Choice:** No referral is needed to network ophthalmologists, optometrists, or gynecologists. You need a referral to go to any non-network doctor, specialist, or hospital.

**Hospice:** You pay part of the cost for outpatient drugs and inpatient respite care. Please contact Plan for details. Hospice care is provided by Original Medicare.

**Mammograms:** Although a referral is not required, your appointment to receive a mammogram can be arranged by a physician.

**Health/Wellness Education:** Nutritional Training, smoking cessation, managing chronic diseases, managing weight and controlling stress are services we offer through a web-based program, Vital Care, on our website.

**Outpatient Rehabilitation Services:** Occupational, Physical, Speech, and Language Therapies are provided by an independent therapist on an outpatient basis in a therapist's office, or at the Subscriber's home; the maximum allowable benefit is the same as Medicare.

**Outpatient Substance Abuse Care:** Treatment for chemical abuse includes medical services for acute detoxification and outpatient rehabilitation according to Medicare guidelines.

### **EXCEPTIONS, GRIEVANCES AND APPEALS NOTICE**

The Scott & White Health Plan encourages you to let us know right away, if after becoming a member you have questions, concerns, or problems related to your covered services or the care you receive. For assistance, you will call our Customer Service Department at 1-866-334-3141, Monday – Sunday, 8AM–8PM.

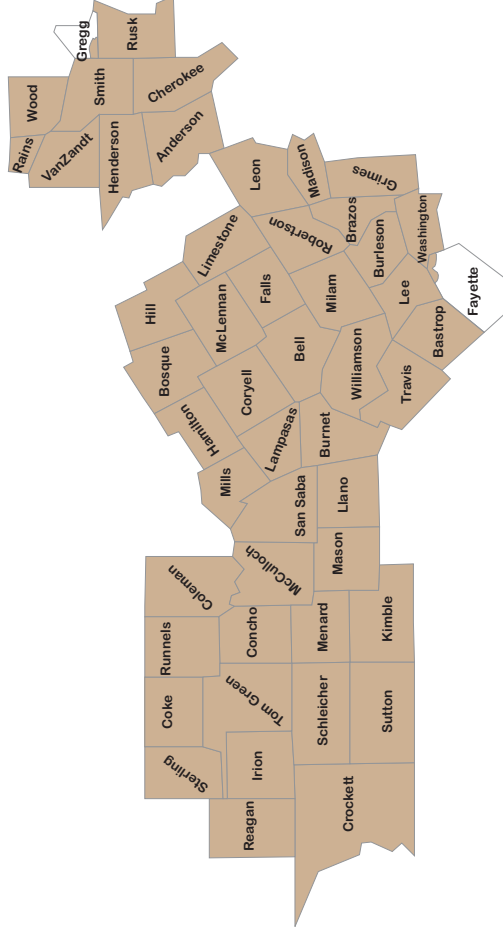
**Exception** – A type of coverage determination that, if approved, allows you to obtain a drug that is not on our formulary (a formulary exception), or receive a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if we require you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

**Grievance** – A type of complaint you make about us or one of our providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes.

**Appeal** – A 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 complete details of our exceptions, appeals and grievances procedures, please call Scott & White Health Plan and ask for the "Evidence of Coverage".**

## SeniorCare (Cost) Service Area



Scott and White Health Plan SeniorCare (Cost) Service Area

Subscribers who move out of the service area, or are away from the service area for more than 90 days in a row, will no longer have SeniorCare (Cost) coverage; and might have a special temporary right to buy a Medigap policy.

Fayette - the cities of Carmine and Ledbetter and all of the zip codes 78932 and 78946;

Gregg - the city of Kilgore and all of the zip codes 75662 and 75663.

All of the following counties in central Texas:

Anderson, Bastrop, Bell, Bosque, Brazos, Burleson, Burnet, Cherokee, Coke, Coleman, Concho, Coryell, Crockett, Falls, Grimes, Hamilton, Henderson, Hill, Irion, Kimble, Lampasas, Lee, Leon, Limestone, Llano, Madison, Mason, McCulloch, McLennan, Menard, Milam, Mills, Rains, Reagan, Robertson, Runnels, Rusk, San Saba, Schleichler, Smith, Sterling, Sutton, Tom Green, Travis, Van Zandt, Washington, Williamson, and Wood; and the portion of each of the following counties in central Texas:

## Exclusions and Limitations

The purpose of this section is to tell you about medical care and services, items and/or drugs that are not covered (“are excluded”) or are limited by SeniorCare (Cost). The list below tells about these exclusions and limitations. The list describes services, items and/or drugs that are not covered under any conditions, and some services that are covered only under specific conditions. We will not pay for the exclusions that are listed in this section, and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items, and/or drugs that we should have paid or covered.

### What services are not covered or are limited by SeniorCare (Cost)?

In addition to any exclusions or limitations described anywhere else in this booklet, the following items and services are not covered under the Original Medicare Plan or by SeniorCare (Cost):

1. Services that are not covered under the Original Medicare Plan, unless such services are specifically listed as covered.
2. Services that you get from non-plan providers, except for emergency care, urgently needed care while you are temporarily outside the plan’s service area, and care from the non-plan providers that is arranged or approved by a plan provider. (Care provided by non-plan providers, without plan authorization, is covered under the Original Medicare Plan and enrollees will be obligated to pay the Original Medicare Plan cost sharing amounts.)
3. Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service. Services provided without a referral or prior authorization may be covered under the Original Medicare Plan if they are medically necessary, and you will be obligated to pay the Original Medicare Plan cost sharing amounts.
4. Services that you get without prior authorization, when prior authorization is required for getting that service. Services provided without a referral or prior authorization may be covered under the Original Medicare Plan if they are medically necessary, and you will be obligated to pay the Original Medicare Plan cost sharing amounts.
5. Services that are not reasonable and necessary according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
6. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.
7. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through the Original Medicare Plan for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
8. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare Plan.
9. Private room in a hospital, unless medically necessary.
10. Private duty nurses.
11. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
12. Nursing care on a full-time basis in your home.
13. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. “Custodial care” includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
14. Homemaking services.
15. Charges imposed by immediate relatives or members of your household.
16. Meals delivered to your home.
17. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance unless medically necessary.
18. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

## Exclusions and Limitations

19. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered.
20. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine), and is limited according to Medicare guidelines.
21. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
22. Orthopedic shoes, unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
23. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
24. Hearing aids and routine hearing examinations.
25. Eyeglasses (except after cataract surgery), routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
26. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hypogasmia.
27. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
28. Acupuncture.
29. Naturopath services.
30. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
31. Coverage for drugs is limited to those pharmaceuticals prescribed or ordered by a Provider and utilized by the Subscriber while in the hospital. Take home drugs are not covered, except to the extent covered by Medicare, such as anti-nausea drugs following chemotherapy.
32. Physical exams and reports for any purpose other than necessary medical care, such as employment, licenses, insurance, school or travel.
33. Services for which reimbursement would be available to a Subscriber for the care of an occupational injury or disease under circumstances covered by any employer’s liability law.
34. Non-medically necessary psychological or other testing for educational or developmental purposes.
35. Except as otherwise required by law, Scott and White Health Plan shall not pay any provider or reimburse Subscriber for any Covered Service for which Subscriber would have no obligation to pay in the absence of coverage under this agreement.
36. Treatment for injuries or sickness as a result of war.
37. Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.
38. Artificial aids, corrective applicance and medical supplies, such as batteries, condoms, dressings, syringes, dentures, hearing aids, eyeglasses and corrective lenses, are excluded, unless specifically outlined in the Summary of Benefits or the Evidence of Coverage.
39. Costs/charges associated with completion and/or copying of medical or other related forms.

### Additional Exclusions for Senior Select Only

- The first three (3) pints of blood annually are excluded and shall be Subscriber’s responsibility.
- No benefits are provided under this agreement when Subscriber is outside of the United States, except to the extent benefits would be provided under Medicare.

# Exclusions and Limitations

## Excluded Drugs

The following is about drugs that are “excluded,” meaning they aren’t normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself. We won’t pay for the exclusions that are listed in this section (or in the EOC), and neither will the Original Medicare Plan, *unless* they are found upon appeal to be drugs that we should have paid or covered.

- A Medicare Prescription Drug Plan cannot cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan cannot cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug’s label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include:

Non-prescription drugs (or over-the counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines
Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction	

If you receive extra help, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

## Sales and Service Locations

### Bryan/College Station

3000 Briarcrest, Suite 422  
Bryan, Texas 77802  
(979) 268-7947 • (800) 782-5068

### Georgetown

204 S. IH-35, Suite 100  
Georgetown, Texas 78628  
(512) 930-6040 • (800) 782-5068

### San Angelo

1131B Knickerbocker Road  
San Angelo, Texas 76903  
(800) 782-5068

### Temple

2401 S. 31st Street  
Temple, Texas 76508  
(254) 298-3000 • (800) 782-5068

### Tyler

Collins Law Firm Building  
522 Broadway  
Tyler, Texas 75711  
(800) 782-5068

### Waco

200 W. State Highway 6, Suite 300  
Waco, Texas 76712  
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