Introduction to the Summary of Benefits Report
for PREFERRED GOLD (HMO-POS), PREFERRED GOLD RX (HMO-POS) and GOLDVALUE RX (HMO-POS)
January 1, 2012 - December 31, 2012
ROCHESTER AREA

Thank you for your interest in Preferred Gold (HMO-POS), Preferred Gold Rx (HMO-POS) or GoldValue Rx (HMO-POS). Our plans are offered by MVP HEALTH PLAN, INC./MVP HEALTH CARE, a Medicare Advantage Health Maintenance Organization (HMO), with a point-of-service option (POS). 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 MVP Health Plan 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 Preferred Gold (HMO-POS), Preferred Gold Rx (HMO-POS) or GoldValue Rx (HMO-POS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call MVP Health Plan 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 Preferred Gold (HMO-POS), Preferred Gold Rx (HMO-POS) and GoldValue Rx (HMO-POS) 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 ARE PREFERRED GOLD (HMO-POS), PREFERRED GOLD RX (HMO-POS) AND GOLDVALUE RX (HMO-POS) AVAILABLE?

The service area for these plans includes: Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, and Yates Counties, NY. You must live in one of these areas to join the plan.

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

WHO IS ELIGIBLE TO JOIN PREFERRED GOLD (HMO-POS), PREFERRED GOLD RX (HMO-POS) AND GOLDVALUE RX (HMO-POS)?

You can join Preferred Gold (HMO-POS), Preferred Gold Rx (HMO-POS) or GoldValue Rx (HMO-POS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in Preferred Gold (HMO-POS), Preferred Gold Rx (HMO-POS) or GoldValue Rx (HMO-POS) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Preferred Gold (HMO-POS), Preferred Gold Rx (HMO-POS) and GoldValue Rx (HMO-POS) have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at www.mvphealthcare.com. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

Generally, you are restricted to a doctor who is part of your network. However, we will cover your care from any provider for emergency or urgently needed care. Also, our point of service benefit allows you to get care from providers not in your network under certain conditions. For more information, please call the customer service number listed at the end of this introduction.

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

Preferred Gold Rx (HMO-POS) and GoldValue Rx (HMO-POS) have 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.mvphealthcare.com. Our customer service number is listed at the end of this introduction.

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

Preferred Gold Rx (HMO-POS) and GoldValue Rx (HMO-POS) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Preferred Gold (HMO-POS) does cover Medicare Part B prescription drugs, but does not cover Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Preferred Gold Rx (HMO-POS) and GoldValue Rx (HMO-POS) use 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

https://www.mvphealthcare.com/medicare/documents/Formulary.pdf.

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

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS 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 '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. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
* Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Preferred Gold (HMO-POS), Preferred Gold Rx (HMO-POS) or GoldValue Rx (HMO-POS), 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 Preferred Gold Rx (HMO-POS) or GoldValue Rx (HMO-POS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on

our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state.
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 MVP Health Plan 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 MVP Health Plan for more details.
-- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
-- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
-- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
-- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
-- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
-- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
-- Some Oral Cancer Drugs: If the same drug is available in injectable form.
-- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
-- Inhalation and Infusion Drugs administered 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 http://www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" 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.

Please call MVP Health Care for information about Preferred Gold (HMO-POS), Preferred Gold Rx (HMO-POS) or GoldValue Rx (HMO-POS).

Visit us at www.joinMVPmedicare.com or, call us:

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

Current members should call toll-free (800)-665-7924 for questions related to the Medicare Advantage Program and Medicare Part D Prescription Drug Coverage. (TTY/TDD (800)-662-1220)

Prospective members should call toll-free (888)-280-6205 for questions related to the Medicare Advantage Program and Medicare Part D Prescription Drug Coverage. (TTY/TDD (800)-662-1220)

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

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be made available in a non-English language. For additional information, call customer service at the phone number listed above.

Summary of Benefits Report

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
IMPORTANT INFORMATION				
1 - Premium and Other Important Information	In 2011 the monthly Part B Premium was $96.40 and may change for 2012 and the annual Part B deductible amount was $162 and may change for 2012. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $0.00 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $3,800 out-of-pocket limit for Medicare-covered services.	**General** $102.50 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $3,800 out-of-pocket limit for Medicare-covered services.	**General** $0.00 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $4,600 out-of-pocket limit for Medicare-covered services.

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2 - Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** No referral required for network doctors, specialists, and hospitals.	**In-Network** No referral required for network doctors, specialists, and hospitals.	**In-Network** No referral required for network doctors, specialists, and hospitals.
INPATIENT CARE				
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2011 the amounts for each benefit period were: Days 1 - 60: $1132 deductible Days 61 - 90: $283 per day Days 91 - 150: $566 per lifetime reserve day These amounts may change for 2012. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital	**In-Network** No limit to the number of days covered by the plan each hospital stay. $300 copay for each Medicare-covered hospital stay. $0 copay for additional hospital days. $900 out-of-pocket limit every year. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $300 copay for each Medicare-covered hospital stay. $0 copay for additional hospital days. $900 out-of-pocket limit every year. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $500 copay for each Medicare-covered hospital stay. $0 copay for additional hospital days. $1,500 out-of-pocket limit every year. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

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3 - Inpatient Hospital Care (continued)	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.			
4 - Inpatient Mental Health Care	In 2011 the amounts for each benefit period were: Days 1 - 60: $1132 deductible Days 61 - 90: $283 per day Days 91 - 150: $566 per lifetime reserve day These amounts may change for 2012. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $300 copay for each Medicare-covered hospital stay. The maximum out-of-pocket limit is covered under "Inpatient Hospital Care". Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $300 copay for each Medicare-covered hospital stay. The maximum out-of-pocket limit is covered under "Inpatient Hospital Care". Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $500 copay for each Medicare-covered hospital stay. The maximum out-of-pocket limit is covered under "Inpatient Hospital Care". Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

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5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: $0 per day Days 21 - 100: $141.50 per day These amounts may change for 2012. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. 3-day prior hospital stay is required. For Medicare-covered SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $135 copay per day	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. 3-day prior hospital stay is required. For Medicare-covered SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $135 copay per day	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. 3-day prior hospital stay is required. For Medicare-covered SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $135 copay per day

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6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered home health visit.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered home health visit.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered home health visit.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE				
8 - Doctor Office Visits	20% coinsurance.	**General** Authorization rules may apply. **In-Network** $15 copay for each primary care doctor visit for Medicare-covered benefits. $25 copay for each in-area, network urgent care Medicare-covered visit. $25 copay for each specialist visit for Medicare-covered benefits.	**General** Authorization rules may apply. **In-Network** $15 copay for each primary care doctor visit for Medicare-covered benefits. $25 copay for each in-area, network urgent care Medicare-covered visit. $25 copay for each specialist visit for Medicare-covered benefits.	**General** Authorization rules may apply. **In-Network** $20 copay for each primary care doctor visit for Medicare-covered benefits. $40 copay for each in-area, network urgent care Medicare-covered visit. $40 copay for each specialist visit for Medicare-covered benefits.

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9 - Chiropractic Services	Supplemental 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.	**General** Authorization rules may apply. **In-Network** $20 copay 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.	**General** Authorization rules may apply. **In-Network** $20 copay 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.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
10 - Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.
11 - Outpatient Mental Health Care	40% coinsurance for most outpatient mental health services. Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered individual therapy visit.	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered individual therapy visit. $25 copay for each Medicare-covered group therapy visit.	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered individual therapy visit. $40 copay for each Medicare-covered group therapy visit.

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11 - Outpatient Mental Health Care (continued)	(CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$25 copay for each Medicare-covered group therapy visit. $25 copay for each Medicare-covered individual therapy visit with a psychiatrist. $25 copay for each Medicare-covered group therapy visit with a psychiatrist. $25 copay for Medicare-covered partial hospitalization program services.	$25 copay for each Medicare-covered individual therapy visit with a psychiatrist. $25 copay for each Medicare-covered group therapy visit with a psychiatrist. $25 copay for Medicare-covered partial hospitalization program services.	$40 copay for each Medicare-covered individual therapy visit with a psychiatrist. $40 copay for each Medicare-covered group therapy visit with a psychiatrist. $40 copay for Medicare-covered partial hospitalization program services.
12 - Outpatient Substance Abuse Care	20% coinsurance.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered individual visits. $25 copay for Medicare-covered group visits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered individual visits. $25 copay for Medicare-covered group visits.	**General** Authorization rules may apply. **In-Network** $40 copay for Medicare-covered individual visits. $40 copay for Medicare-covered group visits.

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13 - Outpatient Services/ Surgery	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services.	**General** Authorization rules may apply. **In-Network** $75 copay for each Medicare-covered ambulatory surgical center visit. $150 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $75 copay for each Medicare-covered ambulatory surgical center visit. $150 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $150 copay for each Medicare-covered ambulatory surgical center visit. $250 copay for each Medicare-covered outpatient hospital facility visit.
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance.	**General** Authorization rules may apply. **In-Network** $75 copay for Medicare-covered ambulance benefits.	**General** Authorization rules may apply. **In-Network** $75 copay for Medicare-covered ambulance benefits.	**General** Authorization rules may apply. **In-Network** $125 copay for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.	**General** $65 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** $65 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** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.

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15 - Emergency Care (continued)	You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.			
16 - Urgently Needed Care (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** $25 copay for Medicare-covered urgently-needed-care visits.	**General** $25 copay for Medicare-covered urgently-needed-care visits.	**General** $40 copay for Medicare-covered urgently-needed-care visits.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance.	**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. $25 copay for Medicare-covered Occupational Therapy visits. $25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.	**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. $25 copay for Medicare-covered Occupational Therapy visits. $25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.	**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. $40 copay for Medicare-covered Occupational Therapy visits. $40 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.
20 - Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training. 20% coinsurance for diabetes supplies. 20% coinsurance for diabetic therapeutic shoes or inserts.	**In-Network** $0 copay for Diabetes self-management training. 20% of the cost for Diabetes monitoring supplies. 20% of the cost for Therapeutic shoes or inserts.	**In-Network** $0 copay for Diabetes self-management training. 20% of the cost for Diabetes monitoring supplies. 20% of the cost for Therapeutic shoes or inserts.	**In-Network** $0 copay for Diabetes self-management training. 20% of the cost for Diabetes monitoring supplies. 20% of the cost for Therapeutic shoes or inserts.
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	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	**General** Authorization rules may apply. **In-Network** $10 copay for Medicare-covered lab services. $0 copay for Medicare-covered diagnostic procedures and tests. $25 copay for Medicare-covered X-rays.	**General** Authorization rules may apply. **In-Network** $10 copay for Medicare-covered lab services. $0 copay for Medicare-covered diagnostic procedures and tests. $25 copay for Medicare-covered X-rays	**General** Authorization rules may apply. **In-Network** $10 copay for Medicare-covered lab services. $0 copay for Medicare-covered diagnostic procedures and tests. $40 copay for Medicare-covered X-rays.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services (continued)	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 supplemental routine screening tests, like checking your cholesterol. 20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.	$40 copay for Medicare-covered diagnostic radiology services (not including X-rays). $0 copay for Medicare-covered therapeutic radiology services.	$40 copay for Medicare-covered diagnostic radiology services (not including X-rays). $0 copay for Medicare-covered therapeutic radiology services.	$60 copay for Medicare-covered diagnostic radiology services (not including X-rays). $0 copay for Medicare-covered therapeutic radiology services.
22 - Cardiac and Pulmonary Rehabilitation Services	20% coinsurance Cardiac Rehabilitation services. 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services. This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**In-Network** $25 copay for Medicare-covered Cardiac Rehabilitation Services. $25 copay for Medicare-covered Intensive Cardiac Rehabilitation Services. $25 copay for Medicare-covered Pulmonary Rehabilitation Services.	**In-Network** $25 copay for Medicare-covered Cardiac Rehabilitation Services. $25 copay for Medicare-covered Intensive Cardiac Rehabilitation Services. $25 copay for Medicare-covered Pulmonary Rehabilitation Services.	**In-Network** $40 copay for Medicare-covered Cardiac Rehabilitation Services. $40 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $40 copay for Medicare-covered Pulmonary Rehabilitation Services.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
PREVENTIVE SERVICES				
23 - Preventive Services and Wellness/ Education Programs	No coinsurance, copayment or deductible for the following: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening - Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine for people with Medicare who are at risk - HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: - Abdominal Aortic Aneurysm screening - Bone Mass Measurement - Cardiovascular Screening - Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine - HIV Screening - Breast Cancer Screening (Mammogram) - Medical Nutrition Therapy Services - Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine - Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) - Smoking Cessation (Counseling to stop smoking)	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: - Abdominal Aortic Aneurysm screening - Bone Mass Measurement - Cardiovascular Screening - Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine - HIV Screening - Breast Cancer Screening (Mammogram) - Medical Nutrition Therapy Services - Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine - Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) - Smoking Cessation (Counseling to stop smoking) - Welcome to Medicare Physical Exam (Initial Preventive	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: - Abdominal Aortic Aneurysm screening - Bone Mass Measurement - Cardiovascular Screening - Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine - HIV Screening - Breast Cancer Screening (Mammogram) - Medical Nutrition Therapy Services - Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine - Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) - Smoking Cessation (Counseling to stop smoking) - Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
23 - Preventive Services and Wellness/ Education Programs (continued)	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. - Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. - Medical Nutrition Therapy Services. 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	- Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) 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. **In-Network** The plan covers the following supplemental education/wellness programs: - Written health education materials, including Newsletters - Nutritional benefit - Additional Smoking Cessation - Health Club Membership/ Fitness Classes - Nursing Hotline	Physical Exam) 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. **In-Network** The plan covers the following supplemental education/ wellness programs: - Written health education materials, including Newsletters - Nutritional benefit - Additional Smoking Cessation - Health Club Membership/ Fitness Classes - Nursing Hotline	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. **In-Network** The plan covers the following supplemental education/ wellness programs: - Written health education materials, including Newsletters - Nutritional benefit - Additional Smoking Cessation - Health Club Membership/ Fitness Classes - Nursing Hotline

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
23 - Preventive Services and Wellness/ Education Programs (continued)	dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. - Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. - Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. - Welcome to Medicare Physical Exam (initial preventive physical exam). When you join			

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
23 - Preventive Services and Wellness/ Education Programs (continued)	Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.			
24 - Kidney Disease and Conditions	20% coinsurance for renal dialysis. 20% coinsurance for kidney disease education services	**In-Network** $0 copay for renal dialysis. $0 copay for kidney disease education services.	**In-Network** $0 copay for renal dialysis. $0 copay for kidney disease education services.	**In-Network** $0 copay for renal dialysis. $0 copay for kidney disease education services.
25 - Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. **Drugs Covered under Medicare Part D** **General** This plan does not offer prescription drug coverage	**Drugs covered under Medicare Part B** **General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.mvphealthcare.com/medicare/documents/Formulary.pdf on the web.	**Drugs covered under Medicare Part B** **General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.mvphealthcare.com/medicare/documents/Formulary.pdf on the web.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)			Different out-of-pocket costs may apply for people who -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Preferred Gold Rx (HMO-POS) for certain drugs.	Different out-of-pocket costs may apply for people who -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in - network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from GoldValue Rx (HMO-POS) for certain drugs.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)		.	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. 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. If you request a formulary exception for a drug and Preferred Gold Rx (HMO-POS) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930:	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. 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. If you request a formulary exception for a drug and GoldValue Rx (HMO-POS) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930:

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)			**Retail Pharmacy** Tier 1: Preferred Generic Drugs - $8 copay for a one-month (30-day) supply of drugs in this tier. - $24 copay for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Preferred Brand Drugs - $35 copay for a one-month (30-day) supply of drugs in this tier. - $105 copay for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Non-Preferred Brand Drugs - $90 copay for a one-month (30-day) supply of drugs in this tier. - $270 copay for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	**Retail Pharmacy** Tier 1: Preferred Generic Drugs - $8 copay for a one-month (30-day) supply of drugs in this tier. - $24 copay for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Preferred Brand Drugs - $35 copay for a one-month (30-day) supply of drugs in this tier. - $105 copay for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Non-Preferred Brand Drugs - $90 copay for a one-month (30-day) supply of drugs in this tier. - $270 copay for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)			Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30-day) supply of drugs in this tier. Tier 5: No Cost 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. **Long Term Care Pharmacy** Tier 1: Preferred Generic Drugs - $8 copay for a one-month (31-day) supply of drugs in this tier. Tier 2: Preferred Brand Drugs - $35 copay for a one-month (31-day) supply of drugs in this tier. Tier 3: Non-Preferred Brand Drugs - $90 copay for a one-month (31-day) supply of drugs in this tier. Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (31-day) supply of drugs in this tier. Tier 5: No Cost Generic Drugs - $0 copay for a one-month (31-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. Tier 5: No Cost 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. **Long Term Care Pharmacy** Tier 1: Preferred Generic Drugs - $8 copay for a one-month (31-day) supply of drugs in this tier. Tier 2: Preferred Brand Drugs - $35 copay for a one-month (31-day) supply of drugs in this tier. Tier 3: Non-Preferred Brand Drugs - $90 copay for a one-month (31-day) supply of drugs in this tier. Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (31-day) supply of drugs in this tier. Tier 5: No Cost Generic Drugs - $0 copay for a one-month (31-day) supply of drugs in this tier.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)			**Mail Order** Tier 1: Preferred Generic Drugs - $8 copay for a one-month (30-day) supply of drugs in this tier. - $16 copay for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. 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. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Non-Preferred Brand Drugs - $90 copay for a one-month (30-day) supply of drugs in this tier. - $180 copay for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	**Mail Order** Tier 1: Preferred Generic Drugs - $8 copay for a one-month (30-day) supply of drugs in this tier. - $16 copay for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. 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. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Non-Preferred Brand Drugs - $90 copay for a one-month (30-day) supply of drugs in this tier. - $180 copay for a three-month (90-day) supply of drugs in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)			Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30-day) supply of drugs in this tier. Tier 5: No Cost 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. **Additional Coverage Gap** You pay the following: **Retail Pharmacy** Tier 5: No Cost Generic Drugs - $0 copay for a one-month (30-day) supply of all drugs covered in this tier. - $0 copay for a three-month (90-day) supply of all drugs covered in this tier. **Long Term Care Pharmacy** Tier 5: No Cost Generic Drugs - $0 copay for a one-month (31-day) supply of all drugs covered in this tier. **Mail Order** Tier 5: No Cost Generic Drugs - $0 copay for a one-month (30-day) supply of all drugs covered in this tier.	Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30-day) supply of drugs in this tier. Tier 5: No Cost 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. **Additional Coverage Gap** You pay the following: **Retail Pharmacy** Tier 5: No Cost Generic Drugs - $0 copay for a one-month (30-day) supply of all drugs covered in this tier. - $0 copay for a three-month (90-day) supply of all drugs covered in this tier. **Long Term Care Pharmacy** Tier 5: No Cost Generic Drugs - $0 copay for a one-month (31-day) supply of all drugs covered in this tier. **Mail Order** Tier 5: No Cost Generic Drugs - $0 copay for a one-month (30-day) supply of all drugs covered in this tier.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)			- $0 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 supply. Please contact the plan for more information. After your total yearly drug costs reach $2,930, 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 86% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,700. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: - 5% coinsurance, or - $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network	- $0 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 supply. Please contact the plan for more information. After your total yearly drug costs reach $2,930, 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 86% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,700. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: - 5% coinsurance, or - $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)			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 Preferred Gold Rx (HMO-POS). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: Tier 1: Preferred Generic Drugs - $8 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 Brand Drugs - $90 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.	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 GoldValue Rx (HMO-POS). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: Tier 1: Preferred Generic Drugs - $8 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 Brand Drugs - $90 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.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)			Tier 5: No Cost Generic Drugs - $0 copay for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Preferred Generic Drugs - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. - 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 $4,700. Tier 2: Preferred Brand Drugs - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700.	Tier 5: No Cost Generic Drugs - $0 copay for a one-month (30-day) supply of drugs in this tier. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Preferred Generic Drugs - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. - 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 $4,700. Tier 2: Preferred Brand Drugs - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)			- 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 $4,700. Tier 3: Non-Preferred Brand Drugs - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. - 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 $4,700. Tier 4: Specialty Tier Drugs - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. - 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 $4,700.	- 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 $4,700. Tier 3: Non-Preferred Brand Drugs - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. - 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 $4,700. Tier 4: Specialty Tier Drugs - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. - 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 $4,700.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
25 - Outpatient Prescription Drugs (continued)			Tier 5: No Cost Generic Drugs - $0 copay for a one-month (30-day) supply of all drugs covered in this tier. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	Tier 5: No Cost Generic Drugs - $0 copay for a one-month (30-day) supply of all drugs covered in this tier. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
26 - Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $25 copay for Medicare-covered dental benefits.	**In-Network** $0 copay for the following preventive dental benefits: - up to 2 oral exam(s) every year. - up to 2 cleaning(s) every year. - up to 2 dental x-ray(s) every year. $25 copay for Medicare-covered dental benefits. $300 plan coverage limit for preventive dental benefits every year.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $40 copay for Medicare-covered dental benefits.
27 - Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** Hearing aids not covered. - $25 copay for Medicare-covered diagnostic hearing exams. - $25 copay for supplemental routine hearing exams.	**In-Network** Hearing aids not covered. - $25 copay for Medicare-covered diagnostic hearing exams. - $25 copay for supplemental routine hearing exams.	**In-Network** Hearing aids not covered. - $40 copay for Medicare-covered diagnostic hearing exams. - $40 copay for supplemental routine hearing exams.
28 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.	**In-Network** - 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery. - $25 copay for exams to diagnose and treat diseases and conditions of the eye. - $25 copay for up to 1 supplemental routine eye exam(s) every year.	**In-Network** - 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery. - $25 copay for exams to diagnose and treat diseases and conditions of the eye. - $25 copay for up to 1 supplemental routine eye exam (s) every year.	**In-Network** - 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery. - $40 copay for exams to diagnose and treat diseases and conditions of the eye. - $40 copay for up to 1 supplemental routine eye exam(s) every year.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
28 - Vision Services (continued)	Annual glaucoma screenings covered for people at risk.	- 0% of the cost for up to 1 pair(s) of glasses every year - 0% of the cost for up to 1 pair(s) of contacts every year $100 plan coverage limit for eye wear every year.	- 0% of the cost for up to 1 pair(s) of glasses every year. - 0% of the cost for up to 1 pair(s) of contacts every year $100 plan coverage limit for eye wear every year.	
Over-the-Counter Items	Not covered.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	**In-Network** This plan does not cover supplemental routine transportation.	**In-Network** This plan does not cover supplemental routine transportation.	**In-Network** This plan does not cover supplemental routine transportation.
Acupuncture	Not covered.	**In-Network** 50% of the cost per visit up to 10 visit(s) every year	**In-Network** 50% of the cost per visit up to 10 visit(s) every year.	**In-Network** 50% of the cost per visit up to 10 visit(s) every year.

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
Point of Service	You may go to any doctor, specialist or hospital that accepts Medicare.	**General** Authorization rules may apply. **Out-of-Network** Point of Service coverage is available for the following benefits: - Inpatient Hospital Acute - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services	**General** Authorization rules may apply. **Out-of-Network** Point of Service coverage is available for the following benefits: - Inpatient Hospital Acute - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services	**General** Authorization rules may apply. **Out-of-Network** Point of Service coverage is available for the following benefits: - Inpatient Hospital Acute - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
		- Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies $5,000 plan coverage limit every year for the following POS Benefits: - Inpatient Hospital Acute - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Physical Therapy and Speech-Language Pathology Services	- Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies $5,000 plan coverage limit every year for the following POS Benefits: - Inpatient Hospital Acute - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services	- Ambulatory Surgical Center (ASC) Services - Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies $5,000 plan coverage limit every year for the following POS Benefits: - Inpatient Hospital Acute - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
		- Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies 30% of the cost per hospital stay. 30% of the cost for - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Primary Care Physician Services - Chiropractic Services - Occupational Therapy	- Ambulatory Surgical Center (ASC) Services - Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies 30% of the cost per hospital stay. 30% of the cost for - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services	- Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies 30% of the cost per hospital stay. 30% of the cost for - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Physical Therapy and Speech-Language Pathology Services

Benefit Category	Original Medicare	Contract H3305, Plan 007 Preferred Gold (HMO-POS)	Contract H3305, Plan 011 Preferred Gold Rx (HMO-POS)	Contract H3305, Plan 015 GoldValue Rx (HMO-POS)
		Services - Physician Specialist Services - Podiatry Services - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies	- Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies	- Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies

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