



**Introduction to the Summary of Benefits for  
Preferred Care GoldAnywhere  
January 1, 2007 - December 31, 2007  
Greater Rochester Area**

Thank you for your interest in Preferred Care GoldAnywhere. Our plan is offered by ROCHESTER AREA HEALTH MAINTENANCE ORG., a Medicare Advantage Preferred Provider Organization (PPO). 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 Preferred Care GoldAnywhere 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 Care GoldAnywhere. 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 Preferred Care GoldAnywhere at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

**HOW CAN I COMPARE MY OPTIONS?**

You can compare Preferred Care GoldAnywhere 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 Preferred Care GoldAnywhere AVAILABLE?**

The service area for this plan includes: Livingston, Monroe, Ontario, Genesee, Orleans, Seneca, Wayne, Wyoming, Yates counties, and the following ZIP codes in Steuben County: 14418, 14437, 14512, 14529, 14572, 14807, 14808, 14809, 14810, 14823, 14826, 14840, 14843, 14873, and 14874, NY. You must live in one of these places to join the plan.

**WHO IS ELIGIBLE TO JOIN Preferred Care GoldAnywhere?**

You can join Preferred Care GoldAnywhere 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 not eligible to enroll in Preferred Care GoldAnywhere.

## **CAN I CHOOSE MY DOCTORS?**

Preferred Care GoldAnywhere has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. 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 up-to-date list or visit us at [www.preferredcare.org](http://www.preferredcare.org). 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?**

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

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

Yes Preferred Care does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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

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

## **WHAT IS A PRESCRIPTION DRUG FORMULARY?**

Preferred Care GoldAnywhere uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected 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.preferredcare.org](http://www.preferredcare.org).

If you are currently taking a drug that is not on our formulary or subject to additional requirement 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 PRESCRIPTION DRUG PLAN COSTS?**

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Preferred Care GoldAnywhere, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-Medicare (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

## **WHAT ARE MY PROTECTIONS IN THIS PLAN?**

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Preferred Care GoldAnywhere, 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.

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

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Preferred Care GoldAnywhere for more details.

Please call Preferred Care GoldAnywhere for more information about this plan.

Visit us at [www.preferredcare.org](http://www.preferredcare.org) or, call us:

Customer Service Hours:

Sunday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern

Monday, Tuesday, Wednesday, Thursday, Friday, 7:00 a.m. - 8:00 p.m. Eastern

Current members should call **(585) 327-2480** or **(800) 665-7924** for questions related to the Medicare Advantage program and the Medicare Part D prescription drug program. TTY users may call **(585) 325-2629** or **(800) 252-2452**.

Prospective members should call **(585) 327-5760** or **(888) 280-6205** for questions related to the Medicare Advantage program and the Medicare Part D prescription drug program. TTY users may call **(585) 325-2629** or **(800) 252-2452**.

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.

**SUMMARY OF BENEFITS - IMPORTANT INFORMATION**

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
1 - Premium and Other Important Information	<p>You pay the Medicare Part B premium of \$93.50 each month.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2007 some people will have to pay a higher premium because of their yearly income (over \$80,000 for singles, \$160,000 for married couples). For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>You pay \$66.40 each month <b>without</b> Medicare Part D.</p> <p>You pay \$107.00 each month <b>with</b> Medicare Part D.</p> <p>You also continue to pay the Medicare Part B premium of 93.50 each month.</p>	<p>If there is no note that a service is covered out-of-network, it is generally covered in-network only.</p>

**You pay one initial deductible of \$500 for the following plan services when received out-of-network only:**

- Inpatient Hospital Care & Inpatient Mental Health Care
- Skilled Nursing Facility
- Home Health Care
- Doctor Office Visits, Chiropractic Services & Podiatry Services
- Outpatient Mental Health Care & Substance Abuse Care
- Outpatient Services/Surgery & Outpatient Blood
- Outpatient Rehabilitation Services & Cardiac Rehabilitation Services
- Durable Medical Equipment & Prosthetic Devices
- Diabetes Self-Monitoring, Training and Supplies
- Diagnostic Tests, X-Rays, and Clinical/Diagnostic Lab Services
- Bone Mass Measurement, & Colorectal Screening Exam
- Immunizations
- Mammograms (Annual Screenings), Pap Smears and Pelvic Exams
- Prostate Cancer Screening Exams
- Outpatient Prescription Drugs
- Hearing Services, Vision Services
- Routine Physical Exams
- Health/Wellness Education
- Partial Hospitalization
- Other Health Care Professional Services
- Radiation Therapy Services

**There is a \$2,500 maximum out-of-pocket limit every year for the following plan services when received out-of-network only:**

- Inpatient Hospital Care & Inpatient Mental Health Care
- Skilled Nursing Facility
- Home Health Care
- Doctor Office Visits, Chiropractic Services & Podiatry Services
- Outpatient Mental Health Care & Substance Abuse Care
- Outpatient Services/Surgery & Outpatient Blood
- Outpatient Rehabilitation Services & Cardiac Rehabilitation Services
- Durable Medical Equipment & Prosthetic Devices
- Diabetes Self-Monitoring, Training and Supplies
- Diagnostic Tests, X-Rays, and Clinical/Diagnostic Lab Services
- Bone Mass Measurement, & Colorectal Screening Exam
- Immunizations,
- Mammograms (Annual Screenings), Pap Smears and Pelvic Exams
- Prostate Cancer Screening Exams
- Outpatient Prescription Drugs
- Hearing Services, Vision Services, Routine Physical Exams, Dental Services
- Health/Wellness Education
- Partial Hospitalization
- Other Health Care Professional Services
- Radiation Therapy Services

If there is no note describing an out of network service, then the note describes the in-network service. Contact plan for details on the covered out of network service.

## INPATIENT CARE

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
<p>2 – Doctor and Hospital Choice</p> <p>(For more information, see Emergency - #15 and Urgently Needed Care #16)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare</p>	<p>You can go to the doctors, specialists, and hospitals in or out of the network.</p> <p>You need a referral to go to network hospitals and certain doctors, including specialists for certain services.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>	<p>You can go to the doctors, specialists, and hospitals in or out of the network.</p> <p>Higher costs apply for out-of-network services.</p>
<p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>You pay for each benefit period (3):</p> <p>Days 1 - 60: an initial deductible of \$992</p> <p>Days 61 - 90: \$248 each day</p> <p>Days 91 - 150: \$496 each lifetime reserve day (4)</p> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)</p>	<p>There is no copayment for Inpatient Hospital services received at a network hospital.</p> <p>You are covered for 90-days each benefit period. There is no limit to the number of benefit periods you can have.</p> <p>Except in an emergency, your provider must obtain authorization from Preferred Care.</p>	<p>You pay 20% of the cost for each stay at an out of network hospital.</p> <p>You are covered for 90-days days each benefit period. There is no limit to the number of benefit periods you can have.</p> <p>Except in an emergency, your provider must obtain authorization from Preferred Care.</p>

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
4 – Inpatient Mental Health Care	You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.	There is no copayment for services received at a network hospital.  Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.  Except in an emergency, your provider must obtain authorization from Preferred Care.	You pay 20% of the cost for each stay at an out of network hospital.  Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.  Except in an emergency, your provider must obtain authorization from Preferred Care.

- (1) Each year, you pay a total of one \$131 deductible.
- (2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
- (3) A benefit period begins on the first day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
- (4) Lifetime reserve days can only be used once.

## SKILLED NURSING FACILITY CARE

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
5 - Skilled Nursing Facility  (in a Medicare-certified skilled nursing facility)	<p>You pay for each benefit period (3), following at least a 3-day covered hospital stay:</p> <p>Days 1 - 20: \$0 for each day</p> <p>Days 21 - 100: \$124 for each day</p> <p>There is a limit of 100 days for each benefit period. (3)</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>– \$0 each day for day(s) 1–15</li> <li>– \$65 each day for day(s) 16 – 100</li> <li>– for a Medicare-covered stay at a Skilled Nursing Facility.</li> </ul> <p>3-day prior hospital stay is required.</p> <p>You are covered for 100 days each benefit period.</p> <p>Authorization rules may apply for services. Contact your plan for details.</p>	<p>You pay 20% of the cost for Medicare-covered services at an out of network Skilled Nursing Facility.</p> <p>3-day prior hospital stay is required.</p> <p>You are covered for 100 days each benefit period.</p> <p>Authorization rules may apply for services. Contact your plan for details.</p>

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- (2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
- (3) A benefit period begins on the first day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into a 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.

## HOME CARE

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
6 - Home Health Care (Includes medically necessary intermittent Skilled Nursing care, home health aide service and rehabilitation services, etc.)	There is no copayment for all covered home health visits.	You pay \$0 to \$15 for Medicare- covered home health visits.  See page 27 - Home Health Care for additional information.  Authorization rules may apply for services. Contact your plans for details.	You pay 20% for out of network home health visits.  See page 27 - Home Health Care for additional information.  Authorization rules may apply for services. Contact your plans for details.
7 – Hospice	You pay part of the cost for outpatient drugs and inpatient respite care.  You must receive care from any Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.

## OUTPATIENT CARE

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	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
8 - Doctor Office Visits	You pay 20% of Medicare-approved amounts. (1)(2)	<p>You pay \$10 for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay \$15 for each specialist visit for Medicare covered services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay \$25 for each out of network primary care doctor office visit.</p> <p>You pay \$25 for each out of network specialist visit.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>

- (1) Each year, you pay a total of one \$131 deductible.
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## OUTPATIENT CARE

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	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
9 - Chiropractic Services	<p>You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.</p> <p>You pay 100% for routine care.</p> <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>	<p>You pay \$15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay \$25 for out-of-network chiropractic services. (manual manipulation of the spine to correct subluxation).</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
10 - Podiatry Services	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p> <p>You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>You pay 100% for routine care.</p>	<p>You pay \$15 for each Medicare-covered visit. (Medically necessary foot care).</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay \$25 for out of network podiatry services. (Medically necessary foot care).</p> <p>Authorization rules may apply for services. Contact plan for details.</p>

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## OUTPATIENT CARE

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	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
11- Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1) (2)	For Medicare-covered Mental Health services, you pay:  \$15 for each individual/group therapy visit(s) 1  50% of the cost for each individual/ group therapy visit(s) 2 and beyond.  Authorization rules may apply for services. Contact your plan for details.	For Medicare-covered Mental Health services, you pay:  50% of the cost for out of network Mental Health services.  You pay 50% of the cost for out of network Mental Health services with a psychiatrist.  Authorization rules may apply for services. Contact your plan for details.
12 - Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts. (1)(2)	For Medicare-covered services, you pay \$15 for each individual/ group visit.  Except in an emergency, your provider must obtain authorization from Preferred Care.	You pay 50% of the cost for out of network outpatient substance abuse services.  Except in an emergency, your provider must obtain authorization from Preferred Care.

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## OUTPATIENT CARE

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	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
13 - Outpatient Services / Surgery	<p>You pay 20% of Medicare-approved amounts for the doctor. (1)(2)</p> <p>You pay 20% of outpatient facility charges. (1)(2)</p>	<p>There is no copayment for each Medicare-covered visit to an ambulatory surgical center.</p> <p>There is no copayment for each Medicare-covered visit to an outpatient hospital facility.</p> <p>Authorization rules may apply for services. Contact your plan for details.</p>	<p>You pay 20% of the cost for services at an out of network outpatient hospital facility.</p> <p>Authorization rules may apply for services. Contact your plan for details.</p>
14 - Ambulance Services (medically necessary ambulance services)	<p>You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)</p>	<p>You pay \$35 for Medicare-covered ambulance services.</p>	<p>You pay \$35 for out-of-network ambulance service.</p>

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## OUTPATIENT CARE

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	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
<p>15 - Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2)</p> <p>NOT covered outside the U.S. except under limited circumstances.</p> <p>You pay 20% of doctor charges. (1)(2)</p>	<p>You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition.</p> <p>Worldwide coverage.</p>	<p>You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition.</p> <p>Worldwide coverage.</p>
<p>16 - Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>You pay 20% of Medicare-approved amounts or applicable copayment. (1)(2)</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>You pay \$20 for each Medicare-covered urgently needed care visit.</p> <p>Worldwide coverage.</p>	<p>You pay \$20 for each Medicare-covered urgently needed care visit.</p> <p>Worldwide coverage.</p>

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## OUTPATIENT CARE

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	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
17 - Outpatient Rehabilitation Services  (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$15 for each Medicare-covered Occupational Therapy visit.  You pay \$15 for each Medicare-covered Physical Therapy and/or Speech / Language Therapy visit.  Authorization rules may apply for services. Contact your plan for details.	You pay 20% of the cost for out of network Occupational Therapy services.  You pay 20% of the cost for out of network Physical Therapy and/or Speech / Language therapy services.  Authorization rules may apply for services. Contact your plan for details.

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## PATIENT MEDICAL SERVICES AND SUPPLIES

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 20% of the cost for each Medicare-covered item.  Authorization rules may apply for services. Contact your plans for details.	You pay 20% of the cost for durable medical equipment purchased out of network.  Authorization rules may apply for services. Contact your plans for details.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 20% of the cost for each Medicare-covered item.	You pay 20% of the cost for prosthetic devices purchased out of network.
20 - Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self-management training)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$0-\$15 for Medicare-covered Diabetes self-monitoring training.  You pay 20% of the cost for each Medicare-covered Diabetes Supply item.  See page 27 Diabetes Monitoring for additional information.	You pay 20% of the cost for each Diabetes Supply item purchased out-of-network.

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## PATIENT MEDICAL SERVICES AND SUPPLIES

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
21 - Diagnostic Tests, X-Rays, and Lab Services	<p>You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2)</p> <p>There is no copayment for Medicare-approved lab services.</p>	<p>There is no copayment for the following Medicare-covered service(s):</p> <ul style="list-style-type: none"> <li>- Clinical/diagnostic lab service</li> <li>- Radiation therapy</li> </ul> <p>You pay:</p> <ul style="list-style-type: none"> <li>- \$15 for each Medicare-covered X-ray visit</li> </ul> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>- 20% of the cost for each out of network Clinical/diagnostic lab services</li> <li>- \$25 for out-of-network X-ray Services</li> </ul> <p>Authorization rules may apply for services. Contact plan for details.</p>

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## PREVENTIVE SERVICES

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
22 - Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for each Medicare-covered Bone Mass Measurement.	You pay 20% of the cost for out-of-network services.
23 - Colorectal Screening Exams (for people with Medicare age 50 and older.)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for each Medicare-covered Bone Mass Measurement.  See page 27 -Colorectal Screenings for additional information.	You pay 20% of the cost for out-of-network services.  See page 27 -Colorectal Screenings for additional information.
24 – Immunizations (flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, pneumonia vaccine)	There is no copayment for the pneumonia and flu vaccines.  You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2)  You may only need the pneumonia vaccine once in your lifetime.  Please contact your doctor for further details.	There is no copayment for the pneumonia and flu vaccines.  No referral necessary for Medicare-covered influenza and pneumococcal vaccines.  Referral required for other immunizations. Please check with your plan for details.  There is no copayment for the Hepatitis B vaccine.	You pay 20% of the cost for out-of-network services.  No referral necessary for Medicare-covered influenza and pneumococcal vaccines.  Referral required for other immunizations. Please check with your plan for details.  There is no copayment for the Hepatitis B vaccine.

(1) Each year, you pay a total of one \$131 deductible.

(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

## PREVENTIVE SERVICES

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
25 - Mammograms (annual screening)  (for women with Medicare age 40 and older)	You pay 20% of Medicare-approved amounts. (2)  No referral necessary for Medicare-covered screenings.	There is no copayment for:  Medicare-covered screening mammograms.  Additional screening mammograms up to 1 mammogram(s) every year.	You pay 20% of the cost for out-of-network services.  Additional screening mammograms up to 1 mammogram(s) every year.
26 - Pap Smears and Pelvic Exams (for women with Medicare)	There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2)  You pay 20% of Medicare-approved amounts for Pelvic Exams.(2)	There is no copayment for:  - Medicare-covered Pap Smears and Pelvic Exams  Additional Pap Smears and Pelvic Exams up to 1 Pap Smear(s) and Pelvic Exam(s) every year	You pay 20% of the cost for out-of-network services.  Additional Pap Smears and Pelvic Exams up to 1 Pap Smear(s) and Pelvic Exam(s) every year
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (2)	There is no copayment for Medicare-covered Prostate Cancer Screening exams.	You pay 20% of the cost for out-of-network services.

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- (2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more. If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

## MEDICARE PART D PRESCRIPTION DRUG PROGRAM

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
<p>28 - Prescription Drugs</p> <p>Drugs covered under Medicare Part B (Original Medicare)</p> <p>Drugs Covered under Medicare Part D (Prescription Drug benefit)</p>	<p>You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.</p>	<p>You pay 100% for most prescription drugs.</p> <p>You pay 20% for the cost for Part B covered drugs.</p> <p>This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected 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 <a href="http://www.preferredcare.org">www.preferredcare.org</a> . People who have limited incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact plan for details.</p>	<p>You pay 100% for most prescription drugs.</p> <p>Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the Plan's service area where there is no network pharmacy.</p> <p>See page 27 – Professionally Administered Medications for additional information.</p>



Initial Coverage Limit		your plan) reach \$2,400, you pay 100% of your prescription drug costs until your yearly out of pocket drug costs reach \$3,850.	
Catastrophic Coverage		<p>After your yearly out-of-pocket drug costs reach \$ 3850 you pay the greater of:</p> <ul style="list-style-type: none"> <li>– \$ 2.15 for generic (including brand drugs treated as generic) and \$ 5.35 for all other drugs, or</li> <li>– 5 % coinsurance.</li> </ul>	
General Information		<p>You may incur a cost in addition to the copay if you select a higher cost drug when a lesser cost drug is available. In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition. Certain prescription drugs will have maximum quantity limits. Contact plan for details. Your provider must get prior authorization from Preferred Care Gold for certain prescription drugs. Covered Part D drugs are available at out of network pharmacies in special circumstances including illness while traveling outside of the plan's service where there is no network pharmacy. You may also incur an additional cost for drugs received at an out of network pharmacy. Please contact plan for further details</p>	See page 27 – Professionally Administered Medications for additional information.

**PREVENTIVE SERVICES**

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
29 - Dental Services	In general, you pay 100% for dental services.	<p>There is no copayment for the following:</p> <ul style="list-style-type: none"> <li>- oral exams up to 2 visit(s) every year</li> <li>- cleanings up to 2 visit(s) every year</li> <li>- dental x-rays up to 1 visit(s) every year.</li> </ul> <p>You are covered up to \$300 for in-network and out-of-network dental services every year.</p> <p>Additional comprehensive dental benefits are available. Contact plan for details.</p>	<p>There is no copayment for the following:</p> <ul style="list-style-type: none"> <li>- oral exams up to 2 visit(s) every year</li> <li>- cleanings up to 2 visit(s) every year</li> <li>- dental x-rays up to 1 visit(s) every year.</li> </ul> <p>You are covered up to \$300 for in-network and out-of-network dental services every year.</p> <p>Additional comprehensive dental benefits are available. Contact plan for details.</p>

## ADDITIONAL BENEFITS

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
30 - Hearing Services	<p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)</p>	<p>There is no copayment for hearing aids.</p> <p>You pay:</p> <p>\$15 for each Medicare-covered hearing exam (diagnostic hearing exams)</p> <p>\$15 for each routine hearing test up to 1 test every year.</p> <p>You are covered up to \$600 for hearing aids every three years.</p> <p>See Page 27 - Hearing Services for additional information.</p>	<p>You pay:</p> <p>\$25 for out-of-network hearing exams.</p> <p>You are covered up to \$600 for hearing aids every three years.</p> <p>See Page 27 - Hearing Services for additional information.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

## ADDITIONAL BENEFITS

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
<b>31 - Vision Services</b>	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)</p> <p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)</p> <p>You pay 100% for routine eye exams and glasses.</p>	<p>There is no copayment for the following items:</p> <ul style="list-style-type: none"> <li>- Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery)</li> <li>- Glasses, limited to 1 pair(s) of glasses</li> <li>- Contacts, limited to 1 pair(s) of contacts</li> </ul> <p>You pay:</p> <ul style="list-style-type: none"> <li>- \$15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye)</li> <li>- \$10 for each Routine eye exam, limited to 1 exam(s) every year</li> </ul> <p>You are covered up to \$100 for eye wear every year. Additional vision benefits are available.</p> <p>See Page 27 – eye wear (Vision Services) for additional information.</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>- 20% of the cost for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery)</li> </ul> <p>You pay:</p> <ul style="list-style-type: none"> <li>- \$25 for out-of-network eye exams.</li> </ul> <p>Additional vision benefits are available.</p> <p>See Page 27 – eye wear (Vision Services) for additional information.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

## ADDITIONAL BENEFITS

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

	<b>Original Medicare</b>	<b>Preferred Care GoldAnywhere In-Network</b>	<b>Preferred Care GoldAnywhere Out-of-Network</b>
32 - Physical Exams	<p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay 20% of the Medicare-approved amount. (1)(2)</p>	<p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay \$10 for Medicare covered services.</p>	<p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay \$25 for each out-of-network Medicare covered services.</p>
33- Health/Wellness education	<p>You pay 100%.</p>	<p>You are covered for the following:</p> <ul style="list-style-type: none"> <li>• Written health education materials, including Newsletter</li> <li>• Nutritional Training</li> <li>• Smoking Cessation</li> <li>• Health Club Membership/Fitness Classes</li> <li>• Other Wellness Services</li> </ul> <p>See page 28 - Health/Wellness Education for additional information.</p>	

## Preferred Care GoldAnywhere Benefit Explanations

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

Feature	Preferred Care GoldAnywhere:
Colorectal Screening	Copayments are based on the type of provider: <ul style="list-style-type: none"> <li>• You pay \$10 if performed by an in-network provider.</li> <li>• You pay \$15 if performed by an in-network specialist.</li> <li>• You pay \$25 if performed by an out-of-network provider.</li> </ul>
Diabetes Monitoring	<p><b>In-network</b></p> <ul style="list-style-type: none"> <li>• You pay \$15 for self-management training.</li> <li>• You pay \$15 for 60-minute session with a dietician or nurse diabetes educator.</li> <li>• You pay \$0 for up to three follow-up sessions with the dietician or nurse diabetes educator.</li> </ul> <p><b>Out-of-network</b></p> <ul style="list-style-type: none"> <li>• You pay 20% for self-management training.</li> <li>• You pay 20% for 60-minute session with a dietician or nurse diabetes educator.</li> <li>• You pay \$0 for up to three follow-up sessions with the dietician or nurse diabetes educator.</li> <li>• Insulin pump requires prior authorization.</li> </ul>
Eye Wear (Vision Services)	<ul style="list-style-type: none"> <li>• Preferred Care will pay for the first \$100 on eye wear, contacts, frames, and lenses per calendar year.</li> <li>• You pay 100% of the cost over \$100.</li> <li>• 20% of the costs for Medicare-covered eye wear (post cataract surgery).</li> </ul>
Hearing Services	Preferred Care will pay for the first \$600 on hearing aids and related items (purchase, repair, and refurbishment) every 3 calendar years. You pay 100% of the cost over \$600.
Home Health Care	Benefit renews each calendar year. <ul style="list-style-type: none"> <li>• <b>In-network:</b> You pay \$0 per date of service for visits 1-20.</li> <li>• <b>In-network:</b> You pay \$15 per date of service for visits 21 and greater.</li> <li>• <b>Out-of-network:</b> You pay 20 % for out of network home health visits.</li> </ul>
Professionally Administered Medications	Professionally administered medications, that is, medication which requires administration in an office or facility setting from a professionally licensed provider (including chemotherapy) are subject to an additional \$15 copayment for <b>in-network</b> and \$25 copay for <b>out-of-network</b> .
Prosthetic Devices and Medical Supplies	<ul style="list-style-type: none"> <li>• There is no copay for internal prosthetics (e.g., cardiac pacemakers, heart valve replacement, and artificial joints).</li> <li>• There is a 20% coinsurance for external prosthetics.</li> <li>• There is a 20% coinsurance for Medical Supplies.</li> </ul>

**Preferred Care GoldAnywhere**

**SPECIAL FEATURES**

If you have any questions about this plan's benefits or costs, please contact Preferred Care at (585) 327-2480 (for current members) and (585) 327-5760 (for prospective members).

Feature	Preferred Care GoldAnywhere:
Health and Wellness	<p>Health Dollars - Preferred Care pays up to \$50 toward tuition for selected classes and programs that are designed to help you get and stay healthy, fit and well. Classes include weight management programs such as Weight Watchers and Think Light Low Fat Living Plan; exercise classes include weight management programs such as healthy heart and diabetes exercise programs, water and low-back exercise classes, and general education classes such as first aid and CPR. Copayments vary depending on the class.</p> <p>You're in Charge – You pay \$0 for classes that include Living a Healthy Life with a Chronic Condition; Safe Stepping Fall Prevention Workshop; Food, Fluid and Feelings; Addressing Nutritional Needs to Help Manage Congestive Heart Failure; and Medicine Bag Review. No charge for classes, newsletter or Care Management programs.</p> <p>The Silver Sneaker Fitness Program - provides more physical fitness classes throughout the communities and all the benefits of a fitness center membership, free to all Gold members, at participating health and fitness centers. No charge for the program and classes</p> <p>Living Well - quarterly newsletter gives you information to keep you healthy.</p> <p>Care Management - Our care management programs can help you maintain your health for chronic conditions such as congestive heart failure, kidney disease and cancer.</p>

**Exclusions & Non-covered Services:** Excluded from coverage are such services as cosmetic surgery, custodial care, dental care, non-standard and unevaluated treatments and services provided in conjunction with a non-covered service, among others. Unless expressly indicated in the contract, all non-medically necessary services are not covered. For a complete listing of exclusions and non-covered services, or for more information on covered benefits, please call Member Services at the phone numbers listed on page 3.