



**Introduction to the Summary of Benefits Report
For Preferred Care Gold
January 1, 2008 — December 31, 2008
GREATER ROCHESTER AREA**

Thank you for your interest in Preferred Care Gold. Our plan is offered by Rochester Area HMO/ DBA Preferred Care, a Medicare Advantage Health Maintenance Organization (HMO). 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 Gold 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 Gold. 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 Gold at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Preferred Care Gold 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 GOLD AVAILABLE?

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

WHO IS ELIGIBLE TO JOIN PREFERRED CARE GOLD?

You can join Preferred Care Gold 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 Care Gold unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Preferred Care Gold has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or visit us at www.preferredcare.org. Our Member Services number is listed at the end of this introduction.

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

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Preferred Care Gold nor the Original Medicare Plan will pay for these services.

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

Preferred Care Gold 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 Gold 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. Our Member Services number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Preferred Care Gold uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.preferredcare.org.

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

HOW CAN I GET EXTRA HELP WITH 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 Gold, 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 Gold, 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 Gold for more details.

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

Visit us at **www.preferredcare.org** or, call us:

Member Services hours:

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

From November 15 – March 1,
representatives also are available Saturday and Sunday
from 8:00 a.m. to 8:00 p.m.

Current members should call **(585) 327-2480**. TTY: **(800) 252-2452**.
Prospective members should call **(585) 327-5760**. TTY: **(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** 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).

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|-----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 - Premium and Other Important Information | <p>You pay the Medicare Part B Premium of \$96.40 monthly. \$135.00 yearly Medicare Part B deductible. 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 have to pay a higher premium because of their yearly income (over \$82,000 for singles, \$164,000 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 \$51.70 each month with Medicare Part D. You also continue to pay the Medicare Part B premium of \$96.40 each month.</p> <p>Unless otherwise noted, out-of-network services are not covered.</p> | <p>You pay \$21.70 each month without Medicare Part D.</p> <p>You also continue to pay the Medicare Part B premium of \$96.40 each month.</p> <p>Unless otherwise noted, out-of-network services are not covered.</p> |
| 2 - Doctor and Hospital Choice (For more information, see Emergency #15 and Urgently Needed Care - #16.) | <p>You may go to any doctor, specialist or hospital that accepts Medicare.</p> | <p>You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits). You may have to pay separate copay for certain doctor office visits.</p> | |

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).

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <p>3 - Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p> | <p>For each benefit period:</p> <p>Days 1-60: \$1,024 deductible.</p> <p>Days 61-90: \$256 per day.</p> <p>Days 91-150: \$512 per lifetime reserve day.</p> <p>Please 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 or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p> | <p>\$100 copay for each Medicare-covered hospital stay.</p> <p>\$0 copay for additional hospital days.</p> <p>\$300 out of pocket limit every year.</p> <p>There is no limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> | |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <p>4 - Inpatient Mental Health Care</p> | <p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p> <p>190 day limit in a Psychiatric Hospital.</p> | <p>\$100 copay for each Medicare-covered hospital stay.</p> <p>\$300 out of pocket limit every year.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> | |
| <p>5 - Skilled Nursing Facility</p> <p>(in a Medicare-certified skilled nursing facility)</p> | <p>For each benefit period after at least a 3-day covered hospital stay:</p> <p>Days 1-20: \$0 per day.</p> <p>Days 21-100: \$128 per day.</p> <p>100 days for each benefit period.</p> <p>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.</p> <p>You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p> | <p>For Medicare-covered SNF stays:</p> <p>Days 1 - 15: \$0 copay per day.</p> <p>Days 16 - 100: \$65 copay per day.</p> <p>100 days covered for each benefit period.</p> <p>3-day prior Inpatient Hospital stay is required. Prior authorization is required.</p> | |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| <p>6 - Home Health Care</p> <p>(Includes medically necessary intermittent Skilled Nursing care, home health aide service and rehabilitation services, etc.)</p> | <p>\$0 copay.</p> | <p>For Medicare covered home health visits:</p> <p>Days 1-20: \$0 copay.</p> <p>Days 21+: \$20 copay.</p> <p>Authorization rules may apply.</p> | |
| <p>7 - Hospice</p> | <p>You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.</p> | <p>You must get care from a Medicare-certified hospice.</p> | |
| <p>Outpatient Care</p> | | | |
| <p>8 - Doctor Office Visits</p> | <p>20% coinsurance.</p> | <p>\$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$20 copay for each specialist visit for Medicare-covered benefits.</p> <p>Authorization rules may apply.</p> <p>See “Physical Exams” for more information.</p> | |
| <p>9 - Chiropractic Services</p> | <p>Routine care not covered.</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractor or other qualified provider.</p> | <p>\$20 copay for Medicare-covered visits for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p> <p>Authorization rules may apply.</p> | |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 10 - Podiatry Services | <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>Routine care is not covered.</p> | <p>\$20 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.</p> <p>\$250 limit every 3 calendar years on custom made inserts.</p> <p>20% of the cost for diabetic related shoe inserts.</p> | |
| 11- Outpatient Mental Health Care | <p>50% coinsurance for most outpatient mental health services.</p> | <p>\$20 copay for each Medicare-covered individual or group therapy visit.</p> <p>Authorization rules may apply.</p> | |
| 12 - Outpatient Substance Abuse Care | <p>20% coinsurance.</p> | <p>50% of the cost for in- and out-of-network Medicare-covered individual or group therapy visit.</p> <p>Authorization rules may apply.</p> | |
| 13 - Outpatient Services / Surgery | <p>20% coinsurance for the doctor.</p> <p>20% of the outpatient facility.</p> | <p>\$75 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$75 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Authorization rules may apply.</p> | |
| 14 - Ambulance Services (medically necessary ambulance services) | <p>20% coinsurance.</p> | <p>\$50 copay for Medicare-covered ambulance benefits.</p> <p>Prior authorization is required for non-emergency, long distance and air ambulance.</p> | |
| 15 - Emergency Care | <p>20% coinsurance for the doctor.</p> <p>20% of facility charge, or a set copay per emergency room visit.</p> | <p>\$50 for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p> | |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 15 - Emergency Care (continued) (You may go to any emergency room if you reasonably believe you need emergency care.) | You don't have to pay the emergency room copay if you are admitted to the hospital 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. | \$20 copay for Medicare-covered urgently needed care visits. Worldwide coverage. | |
| 17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy) | 20% coinsurance. | \$20 copay for Medicare-covered Occupational Therapy visits. \$20 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. | |
| Outpatient Medical Services and Supplies | | | |
| 18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.) | 20% coinsurance. | 20% of the cost for Medicare-covered items. Authorization rules may apply. | |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.) | 20% coinsurance. | 20% of the cost of Medicare-covered items. | |
| 20 - Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self-management training) | 20% coinsurance. | \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for diabetes. 20% of the cost for Diabetes supplies. | |
| 21 - Diagnostic Tests, X-rays, and Lab 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 Improvement Amendments (CLIA) certified laboratory that participates in Medicare. | \$0 copay for Medicare-covered: <ul style="list-style-type: none"> - lab services. - diagnostic procedures and tests. \$20 for Medicare covered X-rays. \$20 copay for Medicare-covered diagnostic radiology services. \$20 copay for Medicare-covered therapeutic radiology services. Authorization rules may apply. | |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 21 - Diagnostic Tests, X-Rays, and Lab Services Continued | Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover routine screening tests, like checking your cholesterol. | | |
| Preventative Services | | | |
| 22 - Bone Mass Measurement (for people with Medicare who are at risk) | 20% coinsurance. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. | \$0 copay. | |
| 23 - Colorectal Screening Exams (for people with Medicare age 50 and older.) | 20% coinsurance. Covered when you are high risk or when you are age 50 and older. | \$0 copay for Medicare-covered colorectal screenings. | |
| 24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine) | \$0 copay for Flu and Pneumonia vaccines. 20% coinsurance for Hepatitis B vaccine. You may only need the pneumonia vaccine once in your lifetime. Call your doctor for more information. | \$0 copay for Flu and Pneumonia vaccines \$0 copay for Hepatitis B vaccine. Office visit copay may apply for other immunizations. No referral needed for Flu and Pneumonia vaccines. | |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <p>25 - Mammograms (annual screening)</p> <p>(for women with Medicare age 40 and older)</p> | <p>20% coinsurance No referral needed.</p> <p>Covered once a year for all women with Medicare age 40 and older.</p> <p>One baseline mammogram covered for woman with Medicare between age 35 and 39.</p> | <p>\$0 copay for Medicare-covered screening mammograms.</p> | |
| <p>26 - Pap Smears and Pelvic Exams (for women with Medicare)</p> | <p>\$0 copay for Pap smears.</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>20% coinsurance for Pelvic Exams.</p> | <p>\$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>- up to 1 additional pap smear and pelvic exam every year.</p> | |
| <p>27 - Prostate Cancer Screening Exams (for men with Medicare, age 50 and older)</p> | <p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p> | <p>\$0 copay for Medicare-covered prostate cancer screening.</p> | |
| <p>28 - End Stage Renal Dialysis</p> | <p>20% coinsurance for dialysis.</p> | <p>\$0 copay for dialysis and Nutritional Therapy for Renal Disease.</p> <p>Authorizations rules may apply.</p> | |

MEDICARE PRESCRIPTION DRUG PLAN

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).

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <p>29 – Prescription Drugs</p> <p>(Drugs covered under Medicare Part B)</p> | <p>Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)</p> | <p>20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs.)</p> <p>20% of the cost for Part B-covered chemotherapy drugs.</p> | |
| <p>Drugs covered under Medicare Part D</p> | <p>Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)</p> | <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.preferredcare.org on the Web. Different out-of-pocket costs may apply for people who:</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Services). <p>The plan offers national in-network prescription coverage. This means that you will pay the same 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).</p> | <p>This plan does not cover Part D prescription drugs.</p> |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <p>29 - Prescription Drugs covered under Medicare Part D (continued)</p> | <p>Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)</p> | <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Preferred Care Gold for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to the special handling requirements of these drugs. These drugs are listed on the plan's Web site, formulary, and 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 copay amount for that drug, you will pay the actual cost, not the higher copay amount. You may have to pay more than your copay if you choose to use a higher cost drug when a lower cost drug is available.</p> | <p>This plan does not cover Part D prescription drugs.</p> |
| <p>In-Network Deductible</p> | | <p>\$0 generic drug deductible.</p> <p>\$275 deductible on brand name drugs.</p> | |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <p>Long Term Care Pharmacy</p> | <p>Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)</p> | <p>Tier 1</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (34-day) supply of drugs. <p>Tier 2</p> <ul style="list-style-type: none"> - \$45 copay for a one-month (34-day) supply of drugs. <p>Tier 3</p> <ul style="list-style-type: none"> - 25% coinsurance for a one-month (34-day) supply of drugs. | <p>This plan does not cover Part D prescription drugs.</p> |
| <p>Mail Order</p> | <p>Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)</p> | <p>Tier 1</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (34-day) supply of drugs. - \$10 copay for a three-month (90-day) supply of drugs. <p>Tier 2</p> <ul style="list-style-type: none"> - \$90 copay for a one-month (34-day) supply of drugs. - \$90 copay for a three-month (90-day) supply of drugs. | <p>This plan does not cover Part D prescription drugs.</p> |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| Mail Order (continued) | | Tier 3 <ul style="list-style-type: none"> - 25% coinsurance for a one-month (34-day) supply of drugs. - 25% coinsurance for a three-month (90-day) supply of drugs. | This plan does not cover Part D prescription drugs. |
| Coverage Gap | Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.) | After your total yearly drug costs reach \$2,510, you pay 100% until your yearly out-of-pocket drug costs reach \$4,050. | This plan does not cover Part D prescription drugs. |
| Catastrophic Coverage | | After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of: <ul style="list-style-type: none"> - \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or - 5% coinsurance. | This plan does not cover Part D prescription drugs. |
| Out-of-Network | | Plan drugs may be covered in special circumstance, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may pay more than the copay if you get your drugs at an out-of-network pharmacy. | This plan does not cover Part D prescription drugs. |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| Out-of-Network Initial Coverage | Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.) | <p>After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$,2510:</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (34-day) supply of drugs. <p>Tier 2</p> <ul style="list-style-type: none"> - \$45 copay for a one-month (34-day) supply of drugs. <p>Tier 3</p> <ul style="list-style-type: none"> - 25% coinsurance for a one-month (34-day supply of drugs). | This plan does not cover Part D prescription drugs. |
| Out-of-Network Catastrophic Coverage | | <p>After your yearly out-of-pocket drug cost reach \$4050, you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or - 5% coinsurance. | This plan does not cover Part D prescription drugs. |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 30 - Dental Services | Preventive dental services (such as cleanings) are not covered. | \$0 copay for the following preventive dental benefits: <ul style="list-style-type: none"> - up to 2 oral exam(s) every year. - up to 2 cleaning(s) every year. - up to 2 dental x-ray(s) every year \$300 limit for preventive dental benefits every year. | |
| 31 - Hearing Services | Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams. | \$20 copay for diagnostic hearing exams. \$20 copay for up to 1 routine hearing test(s) every year. \$600 limit for routine hearing aids every three years. | |
| 32 - Vision Services | 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk. | 20% coinsurance for one pair of eye glasses or contact lenses after each cataract surgery. \$20 copay for exams to diagnose and treat diseases and conditions of the eye. \$15 copay for up to 1 routine eye exam every year. \$100 limit for eye wear every year. | |
| 33 - Physical Exams | 20% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage. When you get Medicare Part B, you can get a one time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests. | \$15 copay for routine exams. Limited to 1 exam every year. \$15 copay for Medicare-covered benefits. | |

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|-----------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <p>Health/Wellness education</p> | <p>Not covered.</p> | <p>HealthDollarssm – 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; exercise classes 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>Wellness Center – You pay \$0 for classes that include Living a Healthy Life with a Chronic Condition; Safe Stepping Fall Prevention Workshop; Addressing Nutritional Needs to Help Manage Congestive Heart Failure; and Medicine Bag Review. No charge for classes and programs.</p> <p>The SilverSneakers[®] 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 – free 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. No charge for Care Management programs.</p> <p>24-Hour Nurse Line – available 7 days a week to answer your medical questions.</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).

| Benefit Category | Original Medicare | Preferred Care Gold with Part D drugs | Preferred Care Gold without Part D drugs |
|------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| Travel Benefit | Not covered. | <p>Urgent care, emergency care, and renal dialysis will continue to be covered worldwide and <u>will not</u> be subject to the Travel Benefit copay or maximum.</p> <p>Preferred Care Gold's Travel Benefit provides coverage for many types of medical care when you are traveling outside of Preferred Care Gold's ten-county service area for up to six (6) months. While this added benefit allows more freedom, there is a 30% coinsurance, and \$3,000 annual maximum benefit for services covered by the Travel Benefit. Any unused portion of this benefit cannot carry over from one calendar year to the next.</p> <p><u>Some Medical Services covered under the Travel Benefit:</u></p> <ul style="list-style-type: none"> • Office visits • Hospitalization (Preferred Care Gold approval required) • Home health care (Preferred Care Gold approval required) • Outpatient surgery (Preferred Care Gold Approval required) • Lab & X-ray • Mammograms • Durable medical equipment • Physical, Speech & Occupational Therapies <p><u>Medical Services NOT covered under the Travel Benefit:</u></p> <ul style="list-style-type: none"> • Skilled nursing facility • Mental health services • Substance abuse services • Diabetic supplies • Routine Dental Service • Hearing aids and routine hearing exams | |

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 4.



H3305 PCG 774 (08/07)

PC510222