Gundersen Lutheran®

HEALTH PLAN

# Senior Preferred Summary of Benefits

Effective January 1, 2009

ELITE

ELITE - D

VALUE

VALUE - D

*"Achieving the finest patient care requires continuous effort and study by individuals devoted to the advancement of medical science and practice."*

—Adolph Gundersen, MD 1923

H5262 07-80b
CMS Approval Date: 9/25/08

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# Gundersen Lutheran℠ HEALTH PLAN

Thank you for your interest in Senior Preferred! Gundersen Lutheran Health Plan, a Medicare Advantage Health Maintenance Organization (HMO), offers four Senior Preferred plans. This brochure summarizes some features of these four plans. This brochure does not list every service that we cover, or list every limitation or exclusion. To get a complete list of our benefits, please call Gundersen Lutheran Health Plan to request a copy of the "Evidence of Coverage."

## YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare Advantage health plan, like Senior Preferred. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

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

## HOW CAN I COMPARE MY OPTIONS?

You can compare all four Senior Preferred Plans, and the Original Medicare Plan, using the following Summary of Benefits starting on page 7 of this brochure. The chart in this brochure lists some important health benefits. For each benefit, you can see what our plans cover and what the Original Medicare Plan covers. Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

## WHERE IS SENIOR PREFERRED AVAILABLE?

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

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

Partial Counties by zip code:

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

## WHO IS ELIGIBLE TO JOIN SENIOR PREFERRED?

You can join Senior Preferred if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease may not be eligible to enroll in Senior Preferred unless they are members of our organization and have been since their dialysis began.

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**CAN I CHOOSE MY DOCTORS?**
Gundersen Lutheran Health Plan has formed a network of providers, specialists, and hospitals. You can only use providers who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list, or visit us at www.glhealthplan.org. Our Customer Service number is listed at the end of this introduction.

**WHAT HAPPENS IF I GO TO A DOCTOR WHO IS NOT IN YOUR NETWORK?**
If you choose to go to a provider outside of our network, you must pay for these services yourself. Neither Gundersen Lutheran Health Plan nor the Original Medicare Plan will pay for these services. Senior Preferred provides coverage for services that are urgent or emergent.

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

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

**WHAT IS A PRESCRIPTION DRUG FORMULARY?**
Senior Preferred **EliteD** and **ValueD** use a formulary. A formulary is a list of drugs covered by us to meet member needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you annually, and you can also see our complete formulary on our Web site at www.glhealthplan.org.

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

**WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?**
Gundersen Lutheran Health Plan has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List or visit us at www.glhealthplan.org. Our Customer Service number is listed at the end of this introduction.

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

If you decide to become a member of Senior Preferred **EliteD** or **ValueD**, and 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 Senior Preferred, 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 TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?**

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact Gundersen Lutheran Health Plan for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor's supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs provided through DME.

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

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

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

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If we decide not to continue, we 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.

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As a member of Senior Preferred, 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. As a member of **EliteD** or **ValueD**, 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.

Please call Gundersen Lutheran Health Plan for more information about this plan.

Visit us at www.glhealthplan.org or call our Customer Service Representatives, Monday through Sunday, 8 a.m. until 8 p.m. Central Standard Time. Office hours are Monday through Friday, 8 a.m. until 5 p.m. Central Standard Time.

**Current Members:**

For questions related to **Medicare Advantage and/or Medicare Part D Prescription Drug Program**, please call: **(800) 394-5566** or (**608) 775-8077** (TTY/TDD (800) 947-3529).

**Prospective Members:**

For questions related to **Medicare Advantage and/or Medicare Part D Prescription Drug Program**, please call: **(800) 370-9718** (TTY/TDD (800) 947-3529).

For more information about Medicare, please call Medicare at
1-800-MEDICARE (1-800-633-4227) (TTY/TDD (877) 486-2048.
You can call 24 hours a day, 7 days a week, or visit their website at www.medicare.gov.

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

# RIGHTS FOR SENIOR PREFERRED MEMBERS

**WHAT TO DO IF YOU HAVE A COMPLAINT**

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

## Part C – Medical Care

**COVERAGE DETERMINATION**

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

**WHAT IS AN APPEAL?**

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

*EXAMPLES OF THIS:*

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

**WHAT IS A GRIEVANCE?**

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

*EXAMPLES OF THIS:*

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

# Part D – Drug Coverage

## COVERAGE DETERMINATION

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

## WHAT IS AN EXCEPTION?

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

*EXAMPLES OF THIS:*

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

## WHAT IS AN APPEAL?

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

*EXAMPLES OF THIS:*

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

## WHAT IS A GRIEVANCE?

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

*EXAMPLES OF THIS:*

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

**Summary of Benefits for all plans offered by Senior Preferred**
If you have any questions about this plan's benefits or costs, please contact Gundersen Lutheran Health Plan, Inc. at (800)-394-5566 (current members) and (800)-370-9718 (for prospective members).

| IMPORTANT INFORMATION | | Original Medicare | Senior Preferred Elite |
|---|---|---|---|
| | **Premium and Other Important Information** | You pay the Medicare Part B premium of $96.40 each month. This is the 2009 premium.<br><br>Most people will pay the standard monthly Part B premium. However, starting January 1, 2007, some people are required to pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. | You pay $70.00 each month for Senior Preferred Elite benefits.<br><br>You also continue to pay the Medicare Part B premium of $96.40 each month.<br><br>There is a $2,500.00 maximum out-of-pocket limit every year for Medicare covered services when received in-network only. |
| | **Doctor and Hospital Choice**<br>(For more information, see Emergency and Urgently Needed Care | You may go to any doctor, specialist or hospital that accepts Medicare. | You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals.<br><br>A separate doctor office visit copayment may apply for certain services. |
| **INPATIENT CARE** | **Inpatient Hospital Care** | You pay for each benefit period (3):<br>• Days 1–60: an initial deductible of $1,068<br>• Days 61–90: $267each day.<br>• Days 91–150: $534 each lifetime reserve days (4)<br><br>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days (4). | If you receive inpatient care at a non-plan hospital and choose not to return to the network after your emergency condition is stabilized, you may be responsible for payment.<br><br>There is no copayment for inpatient hospital services received at a network hospital.<br><br>You are covered for unlimited days each benefit period based on medical necessity. |
| | **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 based on medical necessity. |

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

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

| IMPORTANT INFORMATION | Senior Preferred EliteD | Senior Preferred Value | Senior Preferred ValueD |
|---|---|---|---|
| | You pay $97.00 each month for Senior Preferred EliteD benefits and no additional premium for your Medicare Part D prescription benefits.<br><br>You also continue to pay the Medicare Part B premium of $96.40 each month.<br><br>There is a $2,500.00 maximum out-of-pocket limit every year for Medicare covered services when received in-network only. | You pay $0.00 each month for Senior Preferred Value benefits.<br><br>You also continue to pay the Medicare Part B premium of $96.40 each month.<br><br>There is a $2,500.00 maximum out-of-pocket limit every year for Medicare covered services when received in-network only. | You pay $27.00 each month for Senior Preferred ValueD benefits and no additional premium for your Medicare Part D prescription benefits.<br><br>You also continue to pay the Medicare Part B premium of $96.40 each month.<br><br>There is a $2,500.00 maximum out-of-pocket limit every year for Medicare covered services when received in-network only. |
| | You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals.<br><br>A separate doctor office visit copayment may apply for certain services. | You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals.<br><br>A separate doctor office visit copayment may apply for certain services. | You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals.<br><br>A separate doctor office visit copayment may apply for certain services. |
| **INPATIENT CARE** | If you receive inpatient care at a non-plan hospital and choose not to return to the network after your emergency condition is stabilized, you may be responsible for payment.<br><br>There is no copayment for inpatient hospital services received at a network hospital.<br><br>You are covered for unlimited days each benefit period based on medical necessity. | If you receive inpatient care at a non-Plan hospital and choose not to return to the network after your emergency condition is stabilized, you may be responsible for payment.<br><br>There is a $200.00 copayment for inpatient hospital services received at a network hospital.<br><br>You are covered for unlimited days each benefit period based on medical necessity. | If you receive inpatient care at a non-plan hospital and choose not to return to the network after your emergency condition is stabilized, you may be responsible for payment.<br><br>There is a $200.00 copayment for inpatient hospital services received at a network hospital.<br><br>You are covered for unlimited days each benefit period based on medical necessity. |
| | There is no copayment for services received at a network hospital based on medical necessity. | There is a $200.00 copayment for services received at a network hospital.<br><br>There is no copayment for additional days received at a network hospital based on medical necessity. | There is a $200.00 copayment for services received at a network hospital.<br><br>There is no copayment for additional days received at a network hospital based on medical necessity. |

| IMPORTANT INFORMATION | | Original Medicare | Senior Preferred Elite |
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| | **Skilled Nursing Facility**<br>Covered services include, but are not limited to, the following:<br>• Semiprivate room (or a private room if medically necessary).<br>• Meals, including special diets.<br>• Regular nursing services.<br>• Physical therapy, occupational therapy, and speech therapy.<br>• Drugs (This includes substances that are naturally present in the body, such as blood clotting factors).<br>• Blood - including storage and administration.<br>• Medical and surgical supplies.<br>• Laboratory tests.<br>• X-rays and other radiology services.<br>• Use of appliances such as wheelchairs.<br>• Physician services. | You pay for each benefit period (3), following at least a 3-day covered hospital stay:<br>• Days 1–20: $0 for each day.<br>• Days 21–100: $133.50 for each day.<br>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period. (3) | You pay:<br>• 10% of the cost each day for day(s) 1–20.<br>• 0% of the cost each day(s) 21–100.<br>No prior hospital stay is required.<br>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs. (3)<br>Prior Authorization is required. |
| | **Swing Bed**<br>Facility charges and costs associated with an approved swing bed stay when meeting the following criteria:<br>• Your physician must certify your stay as medically necessary and daily skilled needs are identified;<br>• You must be confined and receive treatment for which you were hospitalized;<br>• Intensity and frequency of services requires 24-hour nursing intervention;<br>• Frequent or daily physician monitoring is needed;<br>• Services will likely be for a short-term period and may not exceed seven days; and<br>• There is likely no further need for skilled nursing services post discharge. | You pay for each benefit period (3), following at least a 3-day covered hospital stay:<br>• Days 1–0: $0 for each day.<br>• Days 21–100: $133.50 for each day.<br>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period. (3) | You pay:<br>• 10% of the cost each day for day(s) 1–20.<br>• 0% of the cost each day(s) 21–100.<br>No prior hospital stay is required.<br>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs. (3)<br>Prior Authorization is required. |

| IMPORTANT INFORMATION | Senior Preferred EliteD | Senior Preferred Value | Senior Preferred ValueD |
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| | You pay:<br>• 10% of the cost each day for day(s) 1–20.<br>• 0% of the cost each day(s) 21-100.<br>No prior hospital stay is required.<br>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.<br>Prior Authorization is required. | You pay:<br>• 10% of the cost each day for day(s) 1–20.<br>• 0% of the cost each day(s) 21–100.<br>No prior hospital stay is required.<br>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.<br>Prior Authorization is required. | You pay:<br>• 10% of the cost each day for day(s) 1–20.<br>• 0% of the cost each day(s) 21-100.<br>No prior hospital stay is required.<br>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.<br>Prior Authorization is required. |
| | You pay:<br>• 10% of the cost each day for day(s) 1–20.<br>• 0% of the cost each day(s) 21–100.<br>No prior hospital stay is required.<br>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.<br>Prior Authorization is required. | You pay:<br>• 10% of the cost each day for day(s) 1–20.<br>• 0% of the cost each day(s) 21-100.<br>No prior hospital stay is required.<br>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.<br>Prior Authorization is required. | You pay:<br>• 10% of the cost each day for day(s) 1–20.<br>• 0% of the cost each day(s) 21–100.<br>No prior hospital stay is required.<br>There is a combined limit (Skilled Nursing Facility and Swing Bed) of 100 days for each benefit period based on medical necessity and skilled nursing needs.<br>Prior Authorization is required. |

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

| IMPORTANT INFORMATION | Senior Preferred EliteD | Senior Preferred Value | Senior Preferred ValueD |
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| | There is no copayment for covered home health visits. | There is no copayment for covered home health visits. | There is no copayment for covered home health visits. |
| | When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by Medicare, not our Plan.<br>You pay $15 for the consultation service. | When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by Medicare, not our Plan.<br>You pay $30 for the consultation service. | When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by Medicare, not our Plan.<br>You pay $30 for the consultation service. |
| **DOCTOR SERVICES / OUTPATIENT CARE** | You pay $15 for each primary care physician office visit for covered services.<br>You pay $15 for each specialist visit for covered services. | You pay $30 for each primary care physician office visit for covered services.<br>You pay $30 for each specialist visit for covered services. | You pay $30 for each primary care physician office visit for covered services.<br>You pay $30 for each specialist visit for covered services. |
| | You pay $15 for each covered visit.<br>There is no copayment for lab and x-ray.<br>Coverage does not include maintenance therapy. | You pay $30 for each covered visit.<br>You pay 10% of the cost for each lab or x-ray service.<br>Coverage does not include maintenance therapy. | You pay $30 for each covered visit.<br>You pay 10% of the cost for each lab or x-ray service.<br>Coverage does not include maintenance therapy. |
| | You pay $15 for each covered visit (medically necessary foot care). | You pay $30 for each covered visit (medically necessary foot care). | You pay $30 for each covered visit (medically necessary foot care). |
| | For covered Mental Health services, you pay $15 for each individual/ group therapy visit.<br>There is no copayment for covered partial hospitalization services.<br>Coverage does not include maintenance or activity therapy. | For covered Mental Health services, you pay $30 for each individual/ group therapy visit.<br>There is no copayment for covered partial hospitalization services.<br>Coverage does not include maintenance or activity therapy. | For covered Mental Health services, you pay $30 for each individual/ group therapy visit.<br>There is no copayment for covered partial hospitalization services.<br>Coverage does not include maintenance or activity therapy. |
| | For covered services you pay $15 for each individual/group visit. | For covered services you pay $30 for each individual/group visit. | For covered services you pay $30 for each individual/group visit. |

| IMPORTANT INFORMATION | | Original Medicare | Senior Preferred Elite |
|---|---|---|---|
| | **Outpatient Services/Surgery** | You pay 20% of Medicare-approved amounts for the doctor. (1)(2)<br>You pay 20% of outpatient facility charges. (1)(2) | There is no copayment for each covered visit to an ambulatory surgical center.<br>There is no copayment for each covered visit to an outpatient hospital facility.<br>Prior authorization may be required. |
| | **Ambulance Services**<br>(Medically necessary ambulance Services) | You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2) | There is no copayment for covered ambulance services. |
| | **Emergency Care**<br>(You may go to any emergency room if you reasonably believe you need emergency care.) | You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2)<br>You pay 20% of doctor charges. (1)(2)<br>NOT covered outside the U.S. except under limited circumstances. | You pay $50 for each covered emergency room visit; You do not pay this amount if you are admitted to the hospital within the next three days for the same condition.<br>* Worldwide Coverage |
| | **Urgently Needed Care**<br>(This is NOT emergency care, and in most cases, is out of the service area.) | You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2)<br>NOT covered outside the U.S. except under limited circumstances. | You pay $15 for each covered urgently needed care visit.<br>* Worldwide Coverage |
| | **Outpatient Rehabilitation Services**<br>(Occupational Therapy, Physical Therapy, Speech and Language Therapy, Cardiac or Pulmonary Rehabilitation Therapy) | You pay 20% of Medicare-approved amounts. (1)(2) | You pay $15 daily for each covered Occupational, Physical and/or Speech/Language Therapy visit.<br>You pay $10 for each covered Cardiac or Pulmonary Rehabilitation Therapy visit. |
| | **Durable Medical Equipment**<br>(Includes Wheelchairs, oxygen, etc.) | You pay 20% of Medicare-approved amounts (1)(2) | You pay 10% of the cost for each covered item.<br>Prior Authorization is required for purchases and repairs over $1,000, and all rentals. |
| | **Prosthetic Devices**<br>(Include braces, artificial limbs and eyes, etc.) | You pay 20% of Medicare-approved amounts. (1)(2) | You pay 10% of the cost for each covered item.<br>Prior Authorization is required for purchases and repairs over $1,000, and all rentals. |

| IMPORTANT INFORMATION | Senior Preferred EliteD | Senior Preferred Value | Senior Preferred ValueD |
|---|---|---|---|
| | There is no copayment for each covered visit to an ambulatory surgical center.<br>There is no copayment for each covered visit to an outpatient hospital facility.<br>Prior authorization may be required. | There is a $75 copayment for each covered visit to an ambulatory surgical center.<br>There is a $75 copayment for each covered visit to an outpatient hospital facility.<br>Prior authorization may be required. | There is a $75 copayment for each covered visit to an ambulatory surgical center.<br>There is a $75 copayment for each covered visit to an outpatient hospital facility.<br>Prior authorization may be required. |
| | There is no copayment for covered ambulance services. | There is no copayment for covered ambulance services. | There is no copayment for covered ambulance services. |
| | You pay $50 for each covered emergency room visit; You do not pay this amount if you are admitted to the hospital within the next three days for the same condition.<br>* Worldwide Coverage | You pay $50 for each covered emergency room visit; You do not pay this amount if you are admitted to the hospital within the next three days for the same condition.<br>* Worldwide Coverage | You pay $50 for each covered emergency room visit; You do not pay this amount if you are admitted to the hospital within the next three days for the same condition.<br>* Worldwide Coverage |
| | You pay $15 for each covered urgently needed care visit.<br>* Worldwide Coverage | You pay $30 for each covered urgently needed care visit.<br>* Worldwide Coverage | You pay $30 for each covered urgently needed care visit.<br>* Worldwide Coverage |
| | You pay $15 daily for each covered Occupational, Physical and/or Speech/Language Therapy visit.<br>You pay $10 for each covered Cardiac or Pulmonary Rehabilitation Therapy visit. | You pay $30 daily for each covered Occupational, Physical and/or Speech/Language Therapy visit.<br>You pay $15 for each covered Cardiac or Pulmonary Rehabilitation Therapy visit. | You pay $30 daily for each covered Occupational, Physical and/or Speech/Language Therapy visit.<br>You pay $15 for each covered Cardiac or Pulmonary Rehabilitation Therapy visit. |
| | You pay 10% of the cost for each covered item.<br>Prior Authorization is required for purchases and repairs over $1,000, and all rentals. | You pay 20% of the cost for each Covered item.<br>Prior Authorization is required for purchases and repairs over $1,000, and all rentals. | You pay 20% of the cost for each Covered item.<br>Prior Authorization is required for purchases and repairs over $1,000, and all rentals. |
| | You pay 10% of the cost for each covered item.<br>Prior Authorization is required for purchases and repairs over $ 1,000, and all rentals. | You pay 20% of the cost for each covered item.<br>Prior Authorization is required for purchases and repairs over $ 1,000, and all rentals. | You pay 20% of the cost for each covered item.<br>Prior Authorization is required for purchases and repairs over $ 1,000, and all rentals. |

| IMPORTANT INFORMATION | | Original Medicare | Senior Preferred Elite |
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| | **Diabetes Self-Monitoring, Training and Supplies**<br>(Includes coverage for glucose monitors, test strips, lancets, screening tests and self-management training.) | You pay 20% of Medicare-approved amounts. (1)(2) | You pay $15 for covered Diabetes self-monitoring training.<br>You pay 10% of the cost for each covered Diabetes supply item.<br>There is no copayment for covered diabetic screening tests. |
| | **Medical Nutrition Therapy** | You pay 20% of Medicare-approved amounts. (1)(2) | You pay $15 for each covered Medical Nutrition Therapy visit. |
| | **Diagnostic Tests, X-Rays and Lab Services** | You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2)<br>There is no copayment for Medicare-approved lab services. | There is no copayment for Covered Services. |
| **PREVENTIVE CARE AND SCREENING TESTS** | **Abdominal Aorta Ultrasound Screening** | You pay 20% of Medicare-approved amounts. (1)(2) | There is no copayment for 1 screening Abdominal Aorta Ultrasound per lifetime. |
| | **Bone-Mass Measurements**<br>(For People with Medicare who are at risk.) | You pay 20% of Medicare-approved amounts. (1)(2) | There is no copayment for each covered Bone Mass Measurement. |
| | **Colorectal Screening** | You pay 20% of Medicare-approved amounts. (1)(2) | There is no copayment for covered colorectal screening exams. |
| | **Immunizations**<br>(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.<br>You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2)<br>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.<br>Flu and Pneumonia vaccines by any qualified practitioner are covered.<br>There is no copayment for the Hepatitis B vaccine. |
| | **Mammography Screening**<br>(Annual Screening) | You pay 20% of Medicare-approved amounts. (2)<br>No referral necessary for Medicare-covered screenings. | There is no copayment for 1 screening mammogram every calendar year. |
| | **Pap Smears, Pelvic Exams and Clinical Breast Exams**<br>(For women with Medicare) | There is no copayment for a pap smear once every 2 years, annually for beneficiaries at high risk. (2)<br>You pay 20% of Medicare-approved amounts for Pelvic Exams. (2) | There is no copayment for 1 screening pap smear, pelvic exam and clinical breast exam every calendar year. |

| IMPORTANT INFORMATION | Senior Preferred EliteD | Senior Preferred Value | Senior Preferred ValueD |
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| | You pay $15 for covered Diabetes self-monitoring training.<br>You pay 10% of the cost for each covered Diabetes supply item.<br>There is no copayment for covered diabetic screening tests. | You pay $30 for covered Diabetes self-monitoring training.<br>You pay 20% of the cost for each covered Diabetes supply item.<br>There is no copayment for covered diabetic screening tests. | You pay $30 for covered Diabetes self-monitoring training.<br>You pay 20% of the cost for each covered Diabetes supply item.<br>There is no copayment for covered diabetic screening tests. |
| | You pay $15 for each covered Medical Nutrition Therapy visit. | You pay $30 for each covered Medical Nutrition Therapy visit. | You pay $30 for each covered Medical Nutrition Therapy visit. |
| | There is no copayment for covered Services. | You pay:<br>• 10% of the cost for each covered clinical/diagnostic lab service.<br>• 10% of the cost for each covered radiation therapy service.<br>• 10% of the costs for each covered x-ray visit. | You pay:<br>• 10% of the cost for each covered clinical/diagnostic lab service.<br>• 10% of the cost for each covered radiation therapy service.<br>• 10% of the cost for each covered x-ray visits. |
| **PREVENTIVE CARE AND SCREENING TESTS** | There is no copayment for 1 screening Abdominal Aorta Ultrasound per lifetime. | There is no copayment for 1 screening Abdominal Aorta Ultrasound per lifetime. | There is no copayment for 1 screening Abdominal Aorta Ultrasound per lifetime. |
| | There is no copayment for each covered Bone Mass Measurement. | There is no copayment for each covered Bone Mass Measurement. | There is no copayment for each covered Bone Mass Measurement. |
| | There is no copayment for covered colorectal screening exams. | There is no copayment for covered colorectal screening exams. | There is no copayment for covered colorectal screening exams. |
| | There is no copayment for the Pneumonia and Flu vaccines.<br>Flu and Pneumonia vaccines by any qualified practitioner are covered.<br>There is no copayment for the Hepatitis B vaccine. | There is no copayment for the Pneumonia and Flu vaccines.<br>Flu and Pneumonia vaccines by any qualified practitioner are covered.<br>There is no copayment for the Hepatitis B vaccine. | There is no copayment for the Pneumonia and Flu vaccines.<br>Flu and Pneumonia vaccines qualified practitioner are covered.<br>There is no copayment for the Hepatitis B vaccine. |
| | There is no copayment for 1 screening mammogram every calendar year. | There is no copayment for 1 screening mammogram every calendar year. | There is no copayment for 1 screening mammogram every calendar year. |
| | There is no copayment for 1 screening pap smear, pelvic exam and clinical breast exam every calendar year. | There is no copayment for 1 screening pap smear, pelvic exam and clinical breast exam every calendar year. | There is no copayment for 1 screening pap smear, pelvic exam and clinical breast exam every calendar year. |

| IMPORTANT INFORMATION | | Original Medicare | Senior Preferred Elite |
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| | **Prostate Cancer Screening Exams**<br>(For men with Medicare age 50 and older). | There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (1)(2) | There is no copayment for 1 screening Prostate Cancer exam every calendar year. |
| | **Cardiovascular Screening Blood Tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).** | You pay 20% of Medicare-approved amounts for cholesterol and other lipid or triglyceride levels. (1)(2) | There is no copayment for covered tests. |
| | **Physical Exams** | 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 new Part B coverage.<br>This will not include laboratory tests. Please contact your plan for further details.<br>You pay 20% of the Medicare-approved amount. (1)(2) | There is no copayment for routine physical exams. If the exam is for the treatment of a suspected or existing condition, $15 office copay may apply. |
| | **Tobacco/Smoking Cessation** | You pay 20% of Medicare-approved amounts. (1)(2) | You pay a $15 copayment for each tobacco counseling session.<br>Reimbursement of approved smoking cessation program up to a maximum of $75.00 upon receipt of your program completion certificate and proof of payment. Limited to 2 programs per calendar year. |

| IMPORTANT INFORMATION | Senior Preferred EliteD | Senior Preferred Value | Senior Preferred ValueD |
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| | There is no copayment for 1 screening Prostate Cancer exam every calendar year. | There is no copayment for 1 screening Prostate Cancer exam every calendar year. | There is no copayment for 1 screening Prostate Cancer exam every calendar year. |
| | There is no copayment for covered tests. | There is no copayment for covered tests. | There is no copayment for covered tests. |
| | There is no copayment for routine physical exams. If the exam is for the treatment of a suspected or existing condition, $15 office copay may apply. | There is no copayment for routine physical exams. If the exam is for the treatment of a suspected or existing condition, $30 office copay may apply. | There is no copayment for routine physical exams. If the exam is for the treatment of a suspected or existing condition, $30 office copay may apply. |
| | You pay a $15 copayment for each tobacco counseling session.<br><br>Reimbursement of approved smoking cessation program up to a maximum of $75.00 upon receipt of your program completion certificate and proof of payment. Limited to 2 programs per calendar year.<br><br>• Medications for tobacco/smoking cessation that require a prescription, limited to 180 days per calendar year.<br><br>• Nicotine inhalation system or nasal spray that requires a prescription is covered for 90 days, per calendar year. An additional 90 days may be covered, upon submission of your smoking cessation program completion certificate. | You pay a $30 copayment for each tobacco counseling session.<br><br>Reimbursement of approved smoking cessation program up to a maximum of $75.00 upon receipt of your program completion certificate and proof of payment. Limited to 2 programs per calendar year. | You pay a $30 copayment for each tobacco counseling session.<br><br>Reimbursement of approved smoking cessation program up to a maximum of $75.00 upon receipt of your program completion certificate and proof of payment. Limited to 2 programs per calendar year.<br><br>• Medications for tobacco/smoking cessation that require a prescription, limited to 180 days per calendar year.<br><br>• Nicotine inhalation system or nasal spray that requires a prescription is covered for 90 days, per calendar year. An additional 90 days may be covered, upon submission of your smoking cessation program completion certificate. |

| IMPORTANT INFORMATION | | Original Medicare | Senior Preferred Elite |
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| | **Dental Services** | In general, you pay 100% for preventive dental services. | In general, you pay 100% for preventive dental services.<br>You pay $15 for each covered dental exam. |
| | **Hearing Services**<br>(You pay 100% for Hearing Aids). | You pay 100% for routine hearing exams and hearing aids.<br>You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2) | There is no copayment for the following services:<br>• Covered hearing tests (diagnostic hearing tests).<br>• Routine hearing tests up to 1 test every calendar year. |
| | **Vision Care** | You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)<br>For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)<br>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)<br>You pay 100% for routine eye exams and glasses. | There is no copayment for the following items:<br>• Covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery and a $300.00 limit for routine eyewear every year (for frames, lenses, and eyewear upgrades at participating network providers).<br>• First Routine Eye Exam each calendar year.<br>You pay:<br>• Any amount over the allowable amount for frames.<br>• $15 for each covered eye exam (diagnosis and treatment for diseases and conditions of the eye).<br>• $15 for each annual glaucoma exam. |
| | **Health and Wellness Education**<br>The following is available to you at no cost:<br>• Health Education Classes<br>• Newsletter<br>• Nurse Advisor Line<br>• Disease Management<br>• Case Management | You pay 100%. | There is no copayment for these services. |

| IMPORTANT INFORMATION | Senior Preferred EliteD | Senior Preferred Value | Senior Preferred ValueD |
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| | In general, you pay 100% for preventive dental services.<br>You pay $15 for each covered dental exam. | In general, you pay 100% for preventive dental services.<br>You pay $30 for each covered dental exam. | In general, you pay 100% for preventive dental services.<br>You pay $30 for each covered dental exam. |
| | There is no copayment for the following services:<br>• Covered hearing tests (diagnostic hearing tests).<br>• Routine hearing tests up to 1 test every calendar year. | There is no copayment for the following services:<br>• Covered hearing tests (diagnostic hearing tests).<br>• Routine hearing tests up to 1 test every calendar year. | There is no copayment for the following services:<br>• Covered hearing tests (diagnostic hearing tests).<br>• Routine hearing tests up to 1 test every calendar year. |
| | There is no copayment for the following items:<br>• Covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery and a $300.00 limit for routine eyewear every year (for frames, lenses, and eyewear upgrades at participating network providers).<br>• First Routine Eye Exam each calendar year.<br>You pay:<br>• Any amount over the allowable amount for frames.<br>• $15 for each covered eye exam (diagnosis and treatment for diseases and conditions of the eye).<br>• $15 for each annual glaucoma exam. | There is no copayment for the following items:<br>• Covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery and a $100.00 limit for routine eyewear every year (for frames, lenses, and eyewear upgrades at participating network providers).<br>• First Routine Eye Exam each calendar year.<br>You pay:<br>• Any amount over the allowable amount for frames.<br>• $30 for each covered eye exam (diagnosis and treatment for diseases and conditions of the eye).<br>• $30 for each annual glaucoma exam. | There is no copayment for the following items:<br>• Covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery and a $100.00 limit for routine eyewear every year (for frames, lenses, and eyewear upgrades at participating network providers).<br>• First Routine Eye Exam each calendar year.<br>You pay:<br>• Any amount over the Medicare allowable amount for frames.<br>• $30 for each covered eye exam (diagnosis and treatment for diseases and conditions of the eye).<br>• $30 for each annual glaucoma exam. |
| | There is no copayment for these services. | There is no copayment for these services. | There is no copayment for these services. |

| IMPORTANT INFORMATION | | Original Medicare | Senior Preferred Elite |
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| **PART D DRUG BENEFIT** | **Prescription Drugs** | You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program. | You pay 100% for most prescription drugs. This Plan does not cover Medicare Part D prescription drugs or vaccines.<br><br>There is no benefit limit on drugs covered under Original Medicare. Some quantity limits may apply. |

| IMPORTANT INFORMATION | Senior Preferred EliteD | Senior Preferred Value | Senior Preferred ValueD |
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| **PART D DRUG BENEFIT** | This plan uses a formulary. A formulary is a list of drugs covered by us to meet our member's needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.glhealthplan.org.<br><br>People who have limited incomes, who live in long term care facilities, or who have access to Indian/Tribal/ Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact Gundersen Lutheran Health Plan at 800/897-1923 or 608/775-8007 (TTY/TDD 800-947-3529) for details.<br><br>There is no deductible.<br><br>Before the total yearly drug costs (paid by both you and Senior Preferred EliteD) reach $2,700, you pay the following for prescription drugs:<br>• $6 for a one-month (30 day) supply of Generic (Tier 1).<br>• $28 for a one-month (30) day supply of Formulary Preferred Brand Drugs (Tier 2).<br>• $87 for a one-month (30 day) supply of Formulary Non-Preferred Brand Drugs (Tier 3).<br>• 33% coinsurance for a one-month (30 day) supply of Specialty High Cost Drugs (Tier 4).<br>• $18 for a three-month (90 day) supply of Generic Drugs. | You pay 100% for most prescription drugs. This Plan does not cover Medicare Part D prescription drugs or vaccines.<br><br>There is no benefit limit on drugs covered under Original Medicare. Some quantity limits may apply. | This plan uses a formulary. A formulary is a list of drugs covered by us to meet our member's needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.glhealthplan.org.<br><br>People who have limited incomes, who live in long term care facilities, or who have access to Indian/Tribal/ Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact Gundersen Lutheran Health Plan at 800/897-1923 or 608/775-8007 (TTY/TDD 800-947-3529) for details.<br><br>There is no deductible.<br><br>Before the total yearly drug costs (paid by both you and Senior Preferred ValueD) reach $2,700, you pay the following for prescription drugs:<br>• $7 for a one-month (30 day) supply of Generic (Tier 1).<br>• $29 for a one-month (30) day supply of Formulary Preferred Brand Drugs (Tier 2).<br>• $87 for a one-month (30 day) supply of Formulary Non-Preferred Brand Drugs (Tier 3).<br>• 33% coinsurance for a one-month (30 day) supply of Specialty High Cost Drugs (Tier 4).<br>• $21 for a three-month (90 day) supply of Generic Drugs. |

| IMPORTANT INFORMATION | | Original Medicare | Senior Preferred Elite |
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1. Each year, you pay a total of one $135.00 deductible (for 2009).

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

3. A benefit period begins the day you go to a hospital, swing bed, or skilled nursing facility. The benefit period ends when you have not received hospital, swing bed, or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

4. Lifetime reserve days can only be used once.

| IMPORTANT INFORMATION | Senior Preferred EliteD | Senior Preferred Value | Senior Preferred ValueD |
|---|---|---|---|
| | • $84 for a three-month (90 day) supply of Formulary Preferred Brand Drugs.<br>• $261 for a three-month (90 day) supply of Formulary Non-Preferred Brand Drugs.<br><br>After the total yearly drug costs (paid by both you and Senior Preferred EliteD) reach $2,700, you pay 100% of your prescription drug costs until your yearly out-of-pocket drug costs reach $4,350.<br><br>After your yearly out-of-pocket drug costs reach $4,350 you pay the greater of:<br>• $2.40 for generic (including brand drugs treated as generic) and<br>• $6.00 for all other drugs, or<br>• 5% coinsurance.<br><br>In some cases, Senior Preferred EliteD requires you to first try one drug to treat your medical condition before we will cover another drug for that condition.<br><br>Certain prescription drugs will have maximum quantity limits. Your provider must get prior authorization from Senior Preferred EliteD for certain prescription drugs. Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of our service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy. Please contact Gundersen Lutheran Health Plan for details. | | • $87 for a three-month (90 day) supply of Formulary Preferred Brand Drugs.<br>• $261 for a three-month (90 day) supply of Formulary Non-Preferred Brand Drugs.<br><br>After the total yearly drug costs (paid by both you and Senior Preferred ValueD) reach $2,700, you pay 100% of your prescription drug costs until your yearly out-of-pocket drug costs reach $4,350.<br><br>After your yearly out-of-pocket drug costs reach $4,350 you pay the greater of:<br>• $2.40 for generic (including brand drugs treated as generic) and<br>• $6.00 for all other drugs, or<br>• 5% coinsurance.<br><br>In some cases, Senior Preferred ValueD requires you to first try one drug to treat your medical condition before we will cover another drug for that condition.<br><br>Certain prescription drugs will have maximum quantity limits. Your provider must get prior authorization from Senior Preferred ValueD for certain prescription drugs. Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of our service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy. Please contact Gundersen Lutheran Health Plan for details. |

Gundersen Lutheran℠

HEALTH PLAN

# Procedures Used To Control Utilization

Gundersen Lutheran Health Plan promotes efficient management of resources for the delivery of high quality care, acceptable outcomes, and customer satisfaction. To achieve this end, Gundersen Lutheran Health Plan has employed licensed health care professionals to medically manage all services provided to their members.

**Prior Authorization**

To assure appropriate utilization of services, prior authorization mechanisms have been established for designated high risk/high cost procedures and diagnostic tests. When utilizing network providers your provider will obtain the prior authorization for you. Guidelines for determining coverage of procedures and services, as well as establishment of prior authorization requirements, are developed by the physician Medical Director of the Health Plan.

**Referral Management**

A written referral is required whenever you receive routine or elective services from non-plan providers, the exceptions being:

- renal dialysis services while you are temporarily outside the service area
- post stabilization care

These services would only be approved if capability does not exist within the Gundersen Lutheran Health Plan network.

**Concurrent Hospital Review**

Health Plan Case Managers will follow and monitor all hospital admissions to assist in identification of discharge planning needs.

**Case Management**

The Health Plan Case Management program is designed to give each member the opportunity to receive the proper treatment in the most appropriate setting. Case Management identifies cases that are likely to involve prolonged or repeated hospitalization and/or long-term comprehensive medical needs. Case Managers will work with your Personal Physician to optimize your benefits and provide medically appropriate alternatives to ensure appropriate, cost-effective care.

**Under/Over Utilization Review and Reporting**

The Gundersen Lutheran Health Plan identifies, reports and monitors under/over utilization of services by members. The Medical Management department staff reviews claims, referrals and hospital day's data to identify possible under/over utilization. The Medical Director is responsible for reviewing the data and making recommendations prior to distribution to the providers. Summarized data is forwarded and shared with applicable providers that will include opportunities for improvement.

***NOTES:***

***NOTES:***

Gundersen Lutheran℠

HEALTH PLAN

**Choose the Health Plan.**

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

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