

Introduction to the Summary of Benefits for Valley Advantage Gold January 1, 2007 - December 31, 2007 Counties: Hidalgo, Cameron, Willacy

Thank you for your interest in Valley Advantage Gold. Our plan is offered by Valley Baptist Health Plans, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you about some of the features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Valley Advantage 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 Valley Advantage 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 Valley Advantage 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 Valley Advantage 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 VALLEY ADVANTAGE GOLD AVAILABLE?

The service area for this plan includes: Cameron, Hidalgo, Willacy Counties, TX. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN VALLEY ADVANTAGE GOLD?

You can join Valley Advantage 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 not eligible to enroll in Valley Advantage Gold.

CAN I CHOOSE MY DOCTORS?

Valley Advantage 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.valleybaptisthealthplans.com. Our customer service number is listed at the end of this introduction.

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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 Valley Baptist Health Plans nor the Original Medicare Plan will pay for these services.

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

Valley Advantage Gold does cover both Medicare Part B prescription drugs and Part D prescription drugs.

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

Valley Advantage 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.valleybaptisthealthplans.com. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

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

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

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

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and cost at the pharmacy will be lower. When you join Valley Advantage 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.

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As a member of Valley Advantage 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 prescription drug.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

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

Please call Valley Baptist Health Plans, Inc. for more information about this plan.
Visit us at www.valleybaptisthealthplans.com or, call us:

Customer Service Hours:
7 days a week, 8:00 a.m. - 8:00 p.m. Central.

Current and Prospective members should call (800)-829-6440 for questions related to the Medicare Advantage program. (TTY/TDD (800)-562-5259).

Current and Prospective members should call (800)-829-6440 for questions related to the Medicare Part D Prescription Drug Program. (TTY/TDD (800)-562-5259)

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.

Valley Advantage Gold

2007 Summary of Benefits

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BENEFIT CATEGORY	ORIGINAL MEDICARE	VALLEY ADVANTAGE GOLD
IMPORTANT INFORMATION		
1- Premium and Other Important Information	You pay the 2007 Medicare Part B of \$93.50 each month.	<p>You pay \$ 117.60 each month for your plan benefits including your Medicare Part D prescription benefits. You also continue to pay the Medicare Part B premium of \$93.50 each month.</p> <p>There is a \$ 3100 maximum out-of-pocket limit every year for Medicare-covered plan services.</p>
2- Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	<p>You must go to network doctors, specialists, and hospitals.</p> <p>You need a referral to go to network hospitals and certain doctors, including specialists for certain services.</p> <p>A separate doctor office visit copayment may apply for certain services.</p>

- (1) Each year, you pay a total of \$131 deductible.
- (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 or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into 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.

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SUMMARY OF BENEFITS		
<p>INPATIENT CARE 3- Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p>	<p>You pay for each benefit period (3): an initial deductible of \$992 - Days 61 - 90: \$248 each day - Days 91 - 150: \$496 each lifetime reserve day (4)</p> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)</p>	<p>You pay \$ 100 for each Medicare-covered stay at a network hospital.</p> <p>There is no copayment for additional days received at a network hospital.</p> <p>You are covered for unlimited days each benefit period.</p> <p>Except in an emergency, your provider must obtain authorization from Valley Baptist Health Plans.</p>
<p>4- Inpatient Mental Health Care</p>	<p>You pay the same deductible and co-payments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p>	<p>You pay \$ 100 for each Medicare-covered stay at a network hospital.</p>

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		<p>Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your provider must obtain authorization from Valley Baptist Health Plans.</p>
<p>5- Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>You pay for each benefit period (3), following at least a 3-day covered hospital stay: - Day 1 - 20: \$0 for each day - Days 21 - 100: \$124 for each day.</p> <p>There is a limit of 100 days for each benefit period. (3)</p>	<p>You pay:</p> <ul style="list-style-type: none"> - \$ 0 each day for day(s) 1-24 - \$ 25 each day for day(s) 25-100 for a Medicare-covered stay at a Skilled Nursing Facility. <p>A 3-day prior hospital stay is required.</p>

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		<p>You are covered for 100 days each benefit period.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
<p>6- Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>There is no co-payment for all covered home health visits.</p>	<p>There is no copayment for Medicare-covered home health visits.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
<p>7- Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must receive care from a Medicare-certified hospice.</p>	<p>You must receive care from a Medicare-certified hospice.</p>

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OUTPATIENT CARE		
8- Doctor Office Visits	You pay 20% of Medicare-approved amounts. (1)(2)	<p>You pay \$ 10 for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay \$ 25 for each specialist visit for Medicare-covered services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p> <p>See 32 - Physical Exams for more information.</p>
9- Chiropractic Services	<p>You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.</p> <p>You pay 100% for routine care.</p>	<p>You pay \$ 25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p> <p>Authorization rules may apply for services. Contact plan for details.</p>

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	You pay 20% of the Medicare-approved amounts. (1)(2)	
10- Podiatry Services	<p>You pay 20% of the Medicare-approved amounts. (1)(2)</p> <p>You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>You pay 100% for routine care.</p>	<p>You pay \$ 25 for each Medicare-covered visit (medically necessary foot care).</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
11- Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)	<p>For Medicare-covered Mental Health services, you pay \$ 25 for each individual/group therapy visit.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
12- Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts. (1)(2)	<p>For Medicare-covered services, you pay \$ 25 for each individual/group visit.</p> <p>Except in an emergency, your provider must obtain authorization from Valley Baptist Health Plans.</p>

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13- Outpatient Services/Surgery	<p>You pay 20% of Medicare-approved amounts for the doctor. (1)(2)</p> <p>You pay 20% of outpatient facility charges. (1)(2)</p>	<p>You pay \$ 75 for each Medicare-covered visit to an ambulatory surgical center.</p> <p>You pay \$ 75 for each Medicare-covered visit to an outpatient hospital facility.</p> <p>An additional facility charge may be included in the cost for services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
14- Ambulance Services (medically necessary ambulance services)	<p>You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)</p>	<p>You pay \$ 50 for Medicare-covered ambulance services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
15- Emergency Care	<p>You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the</p>	<p>You pay \$ 50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition.</p>

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(You may go to any emergency room if you reasonably believe you need emergency care.)	emergency room visit. (1)(2) Your pay 20% of doctor charges. (1)(2) NOT covered outside the U.S. except under limited circumstances.	NOT covered outside of 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.)	You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay \$ 25 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition. NOT covered outside the U.S. except under limited circumstances.
17- Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$ 25 for each Medicare-covered Occupational Therapy visit. You pay \$ 10 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. Authorization rules may apply for services. Contact plan for details.

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OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18- Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Medicare-covered items. Authorization rules may apply for services. Contact your plan for details.
19- Prosthetic Devices (including braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Medicare-covered items. Authorization rules may apply for services. Contact plan for details.
20- Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests and self-management training)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for Diabetes self-monitoring training. There is no copayment for Diabetes supplies. Authorization rules may apply for services. Contact plan for details.

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21- Diagnostic Tests, X-Rays, and Lab Services	<p>You Pay 20% of Medicare-approved amounts, except for approved lab service. (1)(2)</p> <p>There is no co-payment for Medicare-approved lab services.</p>	<p>There is no copayment for the following Medicare-covered services(s):</p> <ul style="list-style-type: none"> -clinical/diagnostic lab services -radiation therapy -X-ray visits <p>Authorization rules may apply for services. Contact plan for details.</p>
PREVENTIVE SERVICES		
<p>22- Bone Mass Measurements</p> <p>(for people with Medicare who are at risk)</p>	<p>You pay 20% of Medicare-approved amounts. (1) (2)</p>	<p>There is no co-payment for each Medicare-covered Bone Mass Measurement.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
<p>23- Colorectal Screening Exams</p> <p>(for people with Medicare age 50 and older)</p>	<p>You pay 20% of Medicare-approved amounts. (1) (2)</p>	<p>There is no co-payment for Medicare-covered Colorectal Screening Exams.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>

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<p>24- Immunizations</p> <p>(Flu vaccine, Hepatitis B vaccine-for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>There is no co-payment for the Pneumonia and Flu vaccines.</p> <p>You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2)</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.</p>	<p>There is no co-payment for the Pneumonia and Flu vaccines.</p> <p>No referral necessary for Medicare-covered influenza and pneumonia vaccines.</p> <p>There is no co-payment for the Hepatitis B vaccine.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
<p>25- Mammograms (Annual Screening)</p> <p>(for women with Medicare age 40 and older)</p>	<p>You pay 20% of Medicare-approved amounts. (2)</p> <p>No referral necessary for Medicare-covered screenings.</p>	<p>There is no copayment for Medicare-covered Screening Mammograms.</p> <p>Authorization rules may apply for services. Contact plan for details.</p> <p>No referral necessary for Medicare-covered screenings.</p>

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<p>26- Pap Smears and Pelvic Exams (for women with Medicare)</p>	<p>There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2) You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)</p>	<p>There is no copayment for: -Medicare-covered Pap Smears and Pelvic Exams -additional Pap Smears and Pelvic Exams up to 1 Pap Smear and Pelvic exam every two years. Authorization rules may apply for services. Contact plan for details.</p>
<p>27- Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (1)(2)</p>	<p>There is no copayment for Medicare-covered Prostate Cancer Screening exams. Authorization rules may apply for services. Contact plan for details.</p>
<p>28- Prescription Drugs Drugs covered under Medicare Part B (Original Medicare)</p>	<p>You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.</p>	<p>You pay 5 % of the cost for Part B-covered drugs.</p>

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		pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy. Please contact the plan for details
29- Dental Services	In general, you pay 100% for preventive dental services.	In general, you pay 100% for preventive dental services. Authorization rules may apply for services. Contact plan for details.
30- Hearing Services	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1) (2)	You pay 100% for hearing aids. You pay: -\$ 25 for each Medicare-covered hearing exam (diagnostic hearing exams). -\$ 25 for each routine hearing test up to 1 test every year. -\$ 25 for each fitting-evaluation for a hearing aid up to 1 fitting-evaluation every year.

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BENEFIT CATEGORY	ORIGINAL MEDICARE	VALLEY ADVANTAGE GOLD
		Authorization rules may apply for services. Contact plan for details.
31- Vision Services	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)</p> <p>Your pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)</p> <p>You pay 100% for routine eye exams and glasses.</p>	<p>There is no co-payment for the following items:</p> <p>-Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery)</p> <p>You pay:</p> <p>-\$ 25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye)</p> <p>-\$ 25 for each Routine eye exam, limited to 1 exam every year</p>
32- 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	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

- (1) Each year, you pay a total of \$131 deductible.
- (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 or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into 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.

If you have any questions about this plan’s benefits or costs, please contact Valley Baptist Health Plans.

BENEFIT CATEGORY	ORIGINAL MEDICARE	VALLEY ADVANTAGE GOLD
	<p>the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay 20% of the Medicare-approved amount. (1)(2)</p>	<p>of your new Part B coverage. This will not include laboratory test. Please contact your plan for further details.</p> <p>There is no copayment for routine physical exams.</p> <p>You are covered up to 1 exam(s) every year.</p>
Health/Wellness Education	You pay 100%	<p>You are covered for the following:</p> <ul style="list-style-type: none"> -Written health education materials, including Newsletter Other Wellness Services

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

(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 or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into 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.