

# Silver Rx (PPO SNP)

# Select Counties Within Missouri

Benefits	What You Pay With Silver Rx	What You Pay With Silver Rx With Medicare And Full Medicaid
Monthly Plan Premium	\$32.10	<b>\$0</b>
Maximum Out-of-Pocket	\$6,700	<b>\$6,700</b>
Primary Care Physician Visit	20% coinsurance	<b>\$0</b> copayment
Specialist Visits	20% coinsurance	<b>\$0</b> copayment
Inpatient Hospital Care	\$1,156 deductible Days 1-60: \$0 Days 61-90: \$289 Days 91-150: \$578 (per Lifetime Reserve Day)	<b>\$0</b>
Emergency Care	20% coinsurance (up to \$65)	<b>\$0</b> copayment
Durable Medical Equipment (DME)	20% coinsurance	<b>\$0</b> copayment
Prescription Drug Coverage (30-day supply):		
Annual Deductible	\$205	<b>\$0</b>
Generic	\$10	<b>\$0/\$1.10/\$2.60</b>
Preferred Brand	\$45	<b>\$0/\$3.30/\$6.50</b>
Non-Preferred Brand	\$95	<b>\$0/\$3.30/\$6.50</b>
Specialty	27%	<b>\$0/\$3.30/\$6.50</b>
Preventive Services	\$0 copayment	<b>\$0</b> copayment
Diabetes:		
• Self-Monitoring	\$0 copayment	<b>\$0</b> copayment
• Supplies	20% coinsurance	<b>\$0</b> copayment
Routine Podiatry	\$0 copayment (up to 6 visits per year)	<b>\$0</b> copayment (up to 6 visits per year)
Transportation	\$0 copayment (up to 24 one-way trips to plan-approved locations per year)	<b>\$0</b> copayment (up to 24 one-way trips to plan-approved locations per year)
Vision Services:		
• Routine Eye Exam (1) per year	0% coinsurance in-network/20% coinsurance out-of-network	<b>\$0</b> copayment in-network/20% coinsurance out-of-network
• Annual Glaucoma Screening	\$0 copayment	<b>\$0</b> copayment
• Diagnosis and Treatment for diseases/conditions of the eye	20% coinsurance	<b>0%</b> coinsurance
• Contact lenses, eyeglasses (lenses and frames)	\$200 yearly allowance	<b>\$200</b> yearly allowance
Preventive Dental covers: Up to (1) of each of the following		
• Office Visit (1) per year	\$15 copayment	<b>\$0</b> copayment
• Oral Exam (1) per year		
• Cleaning (1) per year		
• Dental x-rays (1) per year		
Dentures – 2 dental plates, full or partial once every 3 years	0% coinsurance/20% coinsurance out-of-network	<b>0%</b> coinsurance/20% coinsurance out-of-network
Over-The-Counter Benefits	\$19 monthly allowance	<b>\$19</b> monthly allowance

Cost sharing is the same in and out of network except for dental care (dentures) and routine eye exams. In 2012 the annual Part B deductible amount is \$140.