

January 1, 2015 – December 31, 2015

Summary of Benefits

AdvantraOne (PPO)
H5522-017

Advantra Silver (PPO)
H5522-005

Summary of Benefits

January 1, 2015 – December 31, 2015

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **AdvantraOne (PPO) or Advantra Silver (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **AdvantraOne (PPO) and Advantra Silver (PPO)** cover and what you pay.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <http://www.medicare.gov>.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **AdvantraOne (PPO) and Advantra Silver (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-855-338-9566, TTY: 711.

Things to Know About AdvantraOne (PPO) and Advantra Silver (PPO)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

AdvantraOne (PPO) and Advantra Silver (PPO) Phone Numbers and Website

- If you are a member of one of these plans, call toll-free 1-800-290-0190, TTY: 711.
- If you are not a member of one of these plans, call toll-free 1-855-338-9566, TTY: 711.
- Our website: <http://www.pa.chcadvantra.com>

Who can join?

To join **AdvantraOne (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Pennsylvania: Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Butler, Cameron, Carbon, Centre, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Fayette,

Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lycoming, Mercer, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Union, Venango, Washington, Wayne, Westmoreland, Wyoming, and York.

To join **Advantra Silver (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Pennsylvania: Armstrong, Beaver, Bedford, Butler, Cameron, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, Mercer, Somerset, Venango, Washington, and Westmoreland.

Which doctors, hospitals, and pharmacies can I use?

AdvantraOne (PPO) and Advantra Silver (PPO) have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plans' provider directory at our website (<http://www.providerdirectory.coventry-medicare.com>).

You can see our plans' pharmacy directory at our website (<http://www.pharmacylocator.coventry-medicare.com>).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is covered by Original Medicare*.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, <http://www.PAFormulary.coventry-medicare.com>.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plans group each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Summary of Benefits

January 1, 2015 – December 31, 2015

	AdvantraOne (PPO)	Advantra Silver (PPO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	<p>\$29 per month. In addition, you must keep paying your Medicare Part B premium.</p> <p>HealthAmerica will reduce your Medicare Part B premium by up to \$50.</p>	<p>\$64 per month. In addition, you must keep paying your Medicare Part B premium.</p>
How much is the deductible?	<p>This plan has deductibles for some hospital and medical services.</p> <p>\$1,000 per year for out-of-network services.</p> <p>This plan does not have a deductible for Part D prescription drugs.</p>	<p>This plan has deductibles for some hospital and medical services.</p> <p>\$1,500 per year for out-of-network services.</p> <p>This plan does not have a deductible for Part D prescription drugs.</p>
Is there any limit on how much I will pay for my covered services?	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$6,700 for services you receive from in-network providers. • \$10,000 for services you receive from any provider. <p>Your limit for services received from in-network providers will count toward this limit.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$6,700 for services you receive from in-network providers. • \$10,000 for services you receive from any provider. <p>Your limit for services received from in-network providers will count toward this limit.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p>

	AdvantraOne (PPO)	Advantra Silver (PPO)
Is there any limit on how much I will pay for my covered services?	Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	No. There are no limits on how much our plan will pay.	No. There are no limits on how much our plan will pay.

HealthAssurance Pennsylvania, Inc. is a Coordinated Care plan with a Medicare contract. Enrollment in our Plan depends on contract renewal.

COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE:

- SERVICES WITH A ¹ MAY REQUIRE PRIOR AUTHORIZATION.
- SERVICES WITH A ² MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.

OUTPATIENT CARE AND SERVICES

Acupuncture and Other Alternative Therapies	Not covered	Not covered
Ambulance ¹	<ul style="list-style-type: none"> • In-network: \$300 copay • Out-of-network: 40% of the cost <p>If you are admitted to the hospital, you do not have to pay for the ambulance services.</p> <p>Non-emergency transportation requires prior authorization.</p>	<ul style="list-style-type: none"> • In-network: \$225 copay • Out-of-network: \$350 copay <p>If you are admitted to the hospital, you do not have to pay for the ambulance services.</p> <p>Non-emergency transportation requires prior authorization.</p>

	AdvantraOne (PPO)	Advantra Silver (PPO)
Chiropractic Care	<p>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):</p> <ul style="list-style-type: none"> • In-network: \$20 copay • Out-of-network: 20% of the cost 	<p>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):</p> <ul style="list-style-type: none"> • In-network: \$20 copay • Out-of-network: 30% of the cost
Dental Services	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <ul style="list-style-type: none"> • In-network: \$50 copay • Out-of-network: 40% of the cost 	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <ul style="list-style-type: none"> • In-network: \$45 copay • Out-of-network: 30% of the cost
Diabetes Supplies and Services ¹	<p>Diabetes monitoring supplies:</p> <ul style="list-style-type: none"> • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 25% of the cost <p>Diabetes self-management training:</p> <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 40% of the cost <p>Therapeutic shoes or inserts:</p> <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 25% of the cost <p>Prior authorization is required for blood glucose test strips and blood glucose monitors other than One Touch/Lifescan, test strips in excess of 100 strips per</p>	<p>Diabetes monitoring supplies:</p> <ul style="list-style-type: none"> • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 30% of the cost <p>Diabetes self-management training:</p> <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 25% of the cost <p>Therapeutic shoes or inserts:</p> <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 30% of the cost <p>Prior authorization is required for blood glucose test strips and blood glucose monitors other than One Touch/Lifescan, test strips in excess of 100 strips per</p>

	AdvantraOne (PPO)	Advantra Silver (PPO)
Diabetes Supplies and Services ¹	30 days (any brand), and blood glucose monitors (any brand) in excess of one per year.	30 days (any brand), and blood glucose monitors (any brand) in excess of one per year.
Diagnostic Tests, Lab and Radiology Services, and X-Rays ¹	<p>Diagnostic radiology services (such as MRIs, CT scans):</p> <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 40% of the cost <p>Diagnostic tests and procedures:</p> <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: 40% of the cost <p>Lab services:</p> <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: 40% of the cost <p>Outpatient x-rays:</p> <ul style="list-style-type: none"> • In-network: \$60 copay • Out-of-network: 40% of the cost <p>Therapeutic radiology services (such as radiation treatment for cancer):</p> <ul style="list-style-type: none"> • In-network: \$60 copay • Out-of-network: 40% of the cost 	<p>Diagnostic radiology services (such as MRIs, CT scans):</p> <ul style="list-style-type: none"> • In-network: \$225 copay • Out-of-network: 30% of the cost <p>Diagnostic tests and procedures:</p> <ul style="list-style-type: none"> • In-network: \$15 copay • Out-of-network: 30% of the cost <p>Lab services:</p> <ul style="list-style-type: none"> • In-network: \$15 copay • Out-of-network: 30% of the cost <p>Outpatient x-rays:</p> <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: 30% of the cost <p>Therapeutic radiology services (such as radiation treatment for cancer):</p> <ul style="list-style-type: none"> • In-network: \$60 copay • Out-of-network: 30% of the cost
Doctor's Office Visits	<p>Primary care physician visit:</p> <ul style="list-style-type: none"> • In-network: \$20 copay • Out-of-network: 20% of the cost <p>Specialist visit:</p>	<p>Primary care physician visit:</p> <ul style="list-style-type: none"> • In-network: \$10 copay • Out-of-network: 30% of the cost <p>Specialist visit:</p>

	AdvantraOne (PPO)	Advantra Silver (PPO)
Doctor's Office Visits	<ul style="list-style-type: none"> • In-network: \$50 copay • Out-of-network: 20% of the cost 	<ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 30% of the cost
Durable Medical Equipment (<i>wheelchairs, oxygen, etc.</i>) ¹	<ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 25% of the cost 	<ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 30% of the cost
Emergency Care	<p>\$65 copay</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p>	<p>\$65 copay</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p>
Foot Care (<i>podiatry services</i>)	<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:</p> <ul style="list-style-type: none"> • In-network: \$50 copay • Out-of-network: 20% of the cost <p>Routine foot care (for up to 4 visit(s) every three months):</p> <ul style="list-style-type: none"> • In-network: \$50 copay • Out-of-network: 20% of the cost 	<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 30% of the cost <p>Routine foot care (for up to 4 visit(s) every three months):</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 30% of the cost
Hearing Services	<p>Exam to diagnose and treat hearing and balance issues:</p> <ul style="list-style-type: none"> • In-network: \$50 copay • Out-of-network: 40% of the cost 	<p>Exam to diagnose and treat hearing and balance issues:</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 30% of the cost

	AdvantraOne (PPO)	Advantra Silver (PPO)
Hearing Services	Routine hearing exam (for up to 1 every year): <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 40% of the cost 	Routine hearing exam (for up to 1 every year): <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 30% of the cost
Home Health Care ¹	<ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: You pay nothing 	<ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: You pay nothing
Mental Health Care ¹	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> • In-network: <ul style="list-style-type: none"> ◦ \$165 copay per day for days 1 through 9 ◦ You pay nothing per day for days 10 through 90 • Out-of-network: <ul style="list-style-type: none"> ◦ 45% of the cost per stay <p>Outpatient group therapy visit:</p>	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> • In-network: <ul style="list-style-type: none"> ◦ \$500 copay per stay • Out-of-network: <ul style="list-style-type: none"> ◦ 30% of the cost per stay <p>Outpatient group therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$40 copay

	AdvantraOne (PPO)	Advantra Silver (PPO)
Mental Health Care ¹	<ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 20% of the cost <p>Outpatient individual therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 20% of the cost 	<ul style="list-style-type: none"> • Out-of-network: 45% of the cost <p>Outpatient individual therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 45% of the cost
Outpatient Rehabilitation ¹	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):</p> <ul style="list-style-type: none"> • In-network: \$20 copay • Out-of-network: 40% of the cost <p>Occupational therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 20% of the cost <p>Physical therapy and speech and language therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 20% of the cost 	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):</p> <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 30% of the cost <p>Occupational therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: 30% of the cost <p>Physical therapy and speech and language therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: 30% of the cost
Outpatient Substance Abuse ¹	<p>Group therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$45 copay • Out-of-network: 45% of the cost <p>Individual therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$45 copay • Out-of-network: 45% of the cost 	<p>Group therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 45% of the cost <p>Individual therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 45% of the cost

	AdvantraOne (PPO)	Advantra Silver (PPO)
Outpatient Surgery ¹	<p>Ambulatory surgical center:</p> <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 40% of the cost <p>Outpatient hospital:</p> <ul style="list-style-type: none"> • In-network: 0-20% of the cost, depending on the service • Out-of-network: 40% of the cost <p>Outpatient services that are preventive have no copay. Maximum copayment applies to outpatient surgical procedures only.</p>	<p>Ambulatory surgical center:</p> <ul style="list-style-type: none"> • In-network: \$300 copay • Out-of-network: 30% of the cost <p>Outpatient hospital:</p> <ul style="list-style-type: none"> • In-network: \$0-300 copay, depending on the service • Out-of-network: 30% of the cost <p>Outpatient services that are preventive have no copay. Maximum copayment applies to outpatient surgical procedures only.</p>
Over-the-Counter Items	Not Covered	Not Covered
Prosthetic Devices (braces, artificial limbs, etc.) ¹	<p>Prosthetic devices:</p> <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 25% of the cost <p>Related medical supplies:</p> <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 25% of the cost 	<p>Prosthetic devices:</p> <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 30% of the cost <p>Related medical supplies:</p> <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 30% of the cost
Renal Dialysis ¹	<ul style="list-style-type: none"> • In-network: \$15 copay • Out-of-network: 40% of the cost 	<ul style="list-style-type: none"> • In-network: \$10 copay • Out-of-network: 30% of the cost
Transportation	Not covered	Not covered

	AdvantraOne (PPO)	Advantra Silver (PPO)
Urgent Care	<p>\$50 copay</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p> <p>The plan covers urgently needed care if you receive the care outside of the United States. Plan limits may apply.</p>	<p>\$50 copay</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p> <p>The plan covers urgently needed care if you receive the care outside of the United States. Plan limits may apply.</p>
Vision Services	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):</p> <ul style="list-style-type: none"> • In-network: \$50 copay • Out-of-network: 40% of the cost <p>Routine eye exam (for up to 1 every year):</p> <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 40% of the cost <p>Eyeglasses or contact lenses after cataract surgery:</p> <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 40% of the cost 	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 30% of the cost <p>Routine eye exam (for up to 1 every year):</p> <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 30% of the cost <p>Eyeglasses or contact lenses after cataract surgery:</p> <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 30% of the cost
Preventive Care	<ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 0-40% of the cost, depending on the service <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening 	<ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 0-25% of the cost, depending on the service <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening

	AdvantraOne (PPO)	Advantra Silver (PPO)
Preventive Care	<ul style="list-style-type: none"> • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>

	AdvantraOne (PPO)	Advantra Silver (PPO)
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
INPATIENT CARE		
Inpatient Hospital Care¹	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> • In-network: <ul style="list-style-type: none"> ◦ \$540 copay per day for days 1 through 3 ◦ You pay nothing per day for days 4 through 90 ◦ You pay nothing per day for days 91 and beyond • Out-of-network: <ul style="list-style-type: none"> ◦ 45% of the cost per stay 	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> • In-network: <ul style="list-style-type: none"> ◦ \$425 copay per stay ◦ You pay nothing per day for days 91 and beyond • Out-of-network: <ul style="list-style-type: none"> ◦ 30% of the cost per stay
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)¹	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> • In-network: <ul style="list-style-type: none"> ◦ \$0 copay per day for days 1 through 20 ◦ \$156 copay per day for days 21 through 100 • Out-of-network: <ul style="list-style-type: none"> ◦ 40% of the cost per stay 	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> • In-network: <ul style="list-style-type: none"> ◦ \$0 copay per day for days 1 through 20 ◦ \$155 copay per day for days 21 through 100 • Out-of-network: <ul style="list-style-type: none"> ◦ 30% of the cost per stay

AdvantraOne (PPO)**Advantra Silver (PPO)****PRESCRIPTION DRUG BENEFITS****How much do I pay?**

For Part B drugs such as chemotherapy drugs¹:

- In-network: 20% of the cost
- Out-of-network: 40% of the cost

Other Part B drugs¹:

- In-network: 20% of the cost
- Out-of-network: 40% of the cost

For Part B drugs such as chemotherapy drugs¹:

- In-network: 20% of the cost
- Out-of-network: 30% of the cost

Other Part B drugs¹:

- In-network: 20% of the cost
- Out-of-network: 30% of the cost

Initial Coverage

You pay the following until your total yearly drug costs reach \$2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Preferred Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$8 copay	\$16 copay	\$24 copay
Tier 2 (Non-Preferred Generic)	\$19 copay	\$38 copay	\$57 copay
Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay

You pay the following until your total yearly drug costs reach \$2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Preferred Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$5 copay	\$10 copay	\$15 copay
Tier 2 (Non-Preferred Generic)	\$6 copay	\$12 copay	\$18 copay
Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay

	AdvantraOne (PPO)				Advantra Silver (PPO)			
Initial Coverage	Tier	One-month supply	Two-month supply	Three-month supply	Tier	One-month supply	Two-month supply	Three-month supply
	Tier 4 (Non-Preferred Brand)	50% of the cost	50% of the cost	50% of the cost	Tier 4 (Non-Preferred Brand)	50% of the cost	50% of the cost	50% of the cost
	Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered	Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered
	Standard Retail Cost-Sharing				Standard Retail Cost-Sharing			
	Tier	One-month supply	Two-month supply	Three-month supply	Tier	One-month supply	Two-month supply	Three-month supply
	Tier 1 (Preferred Generic)	\$10 copay	\$20 copay	\$30 copay	Tier 1 (Preferred Generic)	\$10 copay	\$20 copay	\$30 copay
	Tier 2 (Non-Preferred Generic)	\$29 copay	\$58 copay	\$87 copay	Tier 2 (Non-Preferred Generic)	\$16 copay	\$32 copay	\$48 copay
	Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay	Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay
	Tier 4 (Non-Preferred Brand)	50% of the cost	50% of the cost	50% of the cost	Tier 4 (Non-Preferred Brand)	50% of the cost	50% of the cost	50% of the cost
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	AdvantraOne (PPO)	Advantra Silver (PPO)																																																
Initial Coverage	<p>Standard Mail Order Cost-Sharing</p> <table border="1"> <thead> <tr> <th>Tier</th> <th>One-month supply</th> <th>Two-month supply</th> <th>Three-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Preferred Generic)</td> <td>\$8 copay</td> <td>\$16 copay</td> <td>\$24 copay</td> </tr> <tr> <td>Tier 2 (Non-Preferred Generic)</td> <td>\$19 copay</td> <td>\$38 copay</td> <td>\$57 copay</td> </tr> <tr> <td>Tier 3 (Preferred Brand)</td> <td>\$45 copay</td> <td>\$90 copay</td> <td>\$135 copay</td> </tr> <tr> <td>Tier 4 (Non-Preferred Brand)</td> <td>50% of the cost</td> <td>50% of the cost</td> <td>50% of the cost</td> </tr> <tr> <td>Tier 5 (Specialty Tier)</td> <td>33% of the cost</td> <td>Not Offered</td> <td>Not Offered</td> </tr> </tbody> </table> <p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drug.</p>	Tier	One-month supply	Two-month supply	Three-month supply	Tier 1 (Preferred Generic)	\$8 copay	\$16 copay	\$24 copay	Tier 2 (Non-Preferred Generic)	\$19 copay	\$38 copay	\$57 copay	Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay	Tier 4 (Non-Preferred Brand)	50% of the cost	50% of the cost	50% of the cost	Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered	<p>Standard Mail Order Cost-Sharing</p> <table border="1"> <thead> <tr> <th>Tier</th> <th>One-month supply</th> <th>Two-month supply</th> <th>Three-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Preferred Generic)</td> <td>\$5 copay</td> <td>\$10 copay</td> <td>\$15 copay</td> </tr> <tr> <td>Tier 2 (Non-Preferred Generic)</td> <td>\$6 copay</td> <td>\$12 copay</td> <td>\$18 copay</td> </tr> <tr> <td>Tier 3 (Preferred Brand)</td> <td>\$45 copay</td> <td>\$90 copay</td> <td>\$135 copay</td> </tr> <tr> <td>Tier 4 (Non-Preferred Brand)</td> <td>50% of the cost</td> <td>50% of the cost</td> <td>50% of the cost</td> </tr> <tr> <td>Tier 5 (Specialty Tier)</td> <td>33% of the cost</td> <td>Not Offered</td> <td>Not Offered</td> </tr> </tbody> </table> <p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drug.</p>	Tier	One-month supply	Two-month supply	Three-month supply	Tier 1 (Preferred Generic)	\$5 copay	\$10 copay	\$15 copay	Tier 2 (Non-Preferred Generic)	\$6 copay	\$12 copay	\$18 copay	Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay	Tier 4 (Non-Preferred Brand)	50% of the cost	50% of the cost	50% of the cost	Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered
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Catastrophic Coverage	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs. 	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs.