

January 1, 2015 – December 31, 2015

# Summary of Benefits

Advantra Gold (HMO)  
H3959-002

Advantra Silver (HMO)  
H3959-011

# 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 **Advantra Gold (HMO) or Advantra Silver (HMO)**).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Advantra Gold (HMO) and Advantra Silver (HMO)** 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 **Advantra Gold (HMO) and Advantra Silver (HMO)**
- 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 Advantra Gold (HMO) and Advantra Silver (HMO)

### 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.

## Advantra Gold (HMO) and Advantra Silver (HMO) 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 **Advantra Gold (HMO)**, 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.

To join **Advantra Silver (HMO)**, 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, 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, Lebanon, Lehigh, Luzerne, Lycoming, Mercer, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Union, Venango, Washington, Wayne, Westmoreland, Wyoming, and York.

### **Which doctors, hospitals, and pharmacies can I use?**

**Advantra Gold (HMO) and Advantra Silver (HMO)** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plans may not pay for these services.

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

	<b>Advantra Gold (HMO)</b>	<b>Advantra Silver (HMO)</b>
<b>MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES</b>		
<b>How much is the monthly premium?</b>	\$110 per month. In addition, you must keep paying your Medicare Part B premium.	\$0 per month. In addition, you must keep paying your Medicare Part B premium.
<b>How much is the deductible?</b>	This plan has deductibles for some hospital and medical services.  This plan does not have a deductible for Part D prescription drugs.	This plan does not have a deductible.
<b>Is there any limit on how much I will pay for my covered services?</b>	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.  Your yearly limit(s) in this plan: <ul style="list-style-type: none"> <li>• \$6,700 for services you receive from in-network providers.</li> </ul> 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.  Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	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.  Your yearly limit(s) in this plan: <ul style="list-style-type: none"> <li>• \$6,700 for services you receive from in-network providers.</li> </ul> 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.  Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
<b>Is there a limit on how much the plan will pay?</b>	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

	<b>Advantra Gold (HMO)</b>	<b>Advantra Silver (HMO)</b>
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HealthAmerica 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 <sup>1</sup> MAY REQUIRE PRIOR AUTHORIZATION.
- SERVICES WITH A <sup>2</sup> MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.

### OUTPATIENT CARE AND SERVICES

Acupuncture and Other Alternative Therapies	Not covered	Not covered
Ambulance <sup>1</sup>	<p>\$200 copay</p> <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>	<p>\$275 copay</p> <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>
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay
Dental Services	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$40 copay after you pay your deductible</p> <p>Preventive dental services:</p>	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$45 copay</p> <p>Preventive dental services:</p> <ul style="list-style-type: none"> <li>• Cleaning: You pay nothing</li> </ul>

	<b>Advantra Gold (HMO)</b>	<b>Advantra Silver (HMO)</b>
Dental Services	<ul style="list-style-type: none"> <li>• Cleaning (for up to 2 every year): You pay nothing</li> <li>• Dental x-ray(s) (for up to 1 every year): You pay nothing</li> <li>• Oral exam (for up to 2 every year): You pay nothing</li> </ul> <p>Our plan pays up to \$1,000 every year for most dental services.</p> <p>Benefit covers fillings and simple extractions.</p>	<ul style="list-style-type: none"> <li>• Dental x-ray(s): You pay nothing</li> <li>• Oral exam: You pay nothing</li> </ul> <p>Our plan pays up to \$150 every year for preventive dental services.</p> <p>There are no frequency limits to benefit. The provider must be a licensed dentist.</p>
Diabetes Supplies and Services <sup>1</sup>	<p>Diabetes monitoring supplies: 0-20% of the cost, depending on the supply</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: 20% of the cost</p> <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 30 days (any brand), and blood glucose monitors (any brand) in excess of one per year.</p>	<p>Diabetes monitoring supplies: 0-20% of the cost, depending on the supply</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: 20% of the cost</p> <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 30 days (any brand), and blood glucose monitors (any brand) in excess of one per year.</p>
Diagnostic Tests, Lab and Radiology Services, and X-Rays <sup>1</sup>	<p>Diagnostic radiology services (such as MRIs, CT scans): \$195 copay</p> <p>Diagnostic tests and procedures: You pay nothing</p> <p>Lab services: You pay nothing</p> <p>Outpatient x-rays: \$20 copay</p>	<p>Diagnostic radiology services (such as MRIs, CT scans): \$295 copay</p> <p>Diagnostic tests and procedures: \$30 copay</p> <p>Lab services: \$30 copay</p> <p>Outpatient x-rays: \$40 copay</p>

	<b>Advantra Gold (HMO)</b>	<b>Advantra Silver (HMO)</b>
Diagnostic Tests, Lab and Radiology Services, and X-Rays <sup>1</sup>	Therapeutic radiology services (such as radiation treatment for cancer): \$60 copay	Therapeutic radiology services (such as radiation treatment for cancer): \$60 copay
Doctor's Office Visits	Primary care physician visit: \$5 copay Specialist visit: \$40 copay	Primary care physician visit: \$20 copay Specialist visit: \$45 copay
Durable Medical Equipment ( <i>wheelchairs, oxygen, etc.</i> ) <sup>1</sup>	20% of the cost	20% of the cost
Emergency Care	\$65 copay 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.	\$65 copay 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.
Foot Care ( <i>podiatry services</i> )	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$40 copay Routine foot care (for up to 1 visit(s) every three months): \$40 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$45 copay Routine foot care (for up to 1 visit(s) every three months): \$45 copay
Hearing Services	Exam to diagnose and treat hearing and balance issues: \$40 copay Routine hearing exam (for up to 1 every year): You pay nothing	Exam to diagnose and treat hearing and balance issues: \$45 copay Routine hearing exam (for up to 1 every year): You pay nothing

	<b>Advantra Gold (HMO)</b>	<b>Advantra Silver (HMO)</b>
Hearing Services	<p>Hearing aid fitting/evaluation (for up to 1 every year): You pay nothing</p> <p>Hearing aid: You pay nothing</p> <p>Our plan pays up to \$1,000 every year for hearing aids.</p> <p>Benefit covers \$500 per hearing aid.</p>	
Home Health Care <sup>1</sup>	You pay nothing	You pay nothing
Mental Health Care <sup>1</sup>	<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"> <li>• \$350 copay per stay</li> </ul> <p>Outpatient group therapy visit: \$40 copay</p> <p>Outpatient individual therapy visit: \$40 copay</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"> <li>• \$152 copay per day for days 1 through 10</li> <li>• You pay nothing per day for days 11 through 90</li> </ul> <p>Outpatient group therapy visit: \$40 copay</p> <p>Outpatient individual therapy visit: \$40 copay</p>

	<b>Advantra Gold (HMO)</b>	<b>Advantra Silver (HMO)</b>
Outpatient Rehabilitation <sup>1</sup>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$35 copay</p> <p>Physical therapy and speech and language therapy visit: \$35 copay</p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$35 copay</p> <p>Physical therapy and speech and language therapy visit: \$40 copay</p>
Outpatient Substance Abuse <sup>1</sup>	<p>Group therapy visit: \$40 copay</p> <p>Individual therapy visit: \$40 copay</p>	<p>Group therapy visit: \$45 copay</p> <p>Individual therapy visit: \$45 copay</p>
Outpatient Surgery <sup>1</sup>	<p>Ambulatory surgical center: \$265 copay</p> <p>Outpatient hospital: \$0-265 copay, depending on the service</p> <p>Outpatient services that are preventive have no copay. Maximum copayment applies to outpatient surgical procedures only.</p>	<p>Ambulatory surgical center: \$325 copay</p> <p>Outpatient hospital: \$0-350 copay, depending on the service</p> <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 ( <i>braces, artificial limbs, etc.</i> ) <sup>1</sup>	<p>Prosthetic devices: 20% of the cost</p> <p>Related medical supplies: 20% of the cost</p>	<p>Prosthetic devices: 20% of the cost</p> <p>Related medical supplies: 20% of the cost</p>
Renal Dialysis <sup>1</sup>	You pay nothing	\$15 copay
Transportation	Not covered	Not covered

	<b>Advantira Gold (HMO)</b>	<b>Advantira Silver (HMO)</b>
<b>Urgent Care</b>	<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>
<b>Vision Services</b>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$40 copay</p> <p>Routine eye exam (for up to 1 every year): You pay nothing</p> <p>Contact lenses (for up to 1 every two years): You pay nothing</p> <p>Eyeglasses (frames and lenses) (for up to 1 every two years): You pay nothing</p> <p>Eyeglasses or contact lenses after cataract surgery: You pay nothing</p> <p>Our plan pays up to \$150 every two years for contact lenses and eyeglasses (frames and lenses).</p>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$45 copay</p> <p>Routine eye exam (for up to 1 every year): You pay nothing</p> <p>Eyeglasses or contact lenses after cataract surgery: You pay nothing</p>
<b>Preventive Care</b>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p>

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

	<b>Advantra Gold (HMO)</b>	<b>Advantra Silver (HMO)</b>
<b>Hospice</b>	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.
<b>INPATIENT CARE</b>		
<b>Inpatient Hospital Care<sup>1</sup></b>	Our plan covers an unlimited number of days for an inpatient hospital stay. <ul style="list-style-type: none"> <li>• \$275 copay per stay</li> <li>• You pay nothing per day for days 91 and beyond</li> </ul>	Our plan covers an unlimited number of days for an inpatient hospital stay. <ul style="list-style-type: none"> <li>• \$195 copay per day for days 1 through 9</li> <li>• You pay nothing per day for days 10 through 90</li> <li>• You pay nothing per day for days 91 and beyond</li> </ul>
<b>Inpatient Mental Health Care</b>	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.
<b>Skilled Nursing Facility (SNF)<sup>1</sup></b>	Our plan covers up to 100 days in a SNF. <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1 through 20</li> <li>• \$156 copay per day for days 21 through 100</li> </ul>	Our plan covers up to 100 days in a SNF. <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1 through 20</li> <li>• \$156 copay per day for days 21 through 100</li> </ul>
<b>PRESCRIPTION DRUG BENEFITS</b>		
<b>How much do I pay?</b>	For Part B drugs such as chemotherapy drugs <sup>1</sup> : 20% of the cost Other Part B drugs <sup>1</sup> : 20% of the cost	For Part B drugs such as chemotherapy drugs <sup>1</sup> : 20% of the cost Other Part B drugs <sup>1</sup> : 20% of the cost
<b>Initial Coverage</b>	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 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.

	<b>Advantra Gold (HMO)</b>	<b>Advantra Silver (HMO)</b>																																																
<b>Initial Coverage</b>	You may get your drugs at network retail pharmacies and mail order pharmacies.	You may get your drugs at network retail pharmacies and mail order pharmacies.																																																
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	<b>Advantra Gold (HMO)</b>				<b>Advantra Silver (HMO)</b>			
<b>Initial Coverage</b>	Tier	One-month supply	Two-month supply	Three-month supply	Tier	One-month supply	Two-month supply	Three-month supply
	Tier 2 (Non-Preferred Generic)	\$20 copay	\$40 copay	\$50 copay	Tier 2 (Non-Preferred Generic)	\$22 copay	\$44 copay	\$55 copay
	Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$112.50 copay	Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$112.50 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
	Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered	Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered
	<b>Standard Mail Order Cost-Sharing</b>				<b>Standard Mail Order Cost-Sharing</b>			
	Tier	One-month supply	Two-month supply	Three-month supply	Tier	One-month supply	Two-month supply	Three-month supply
	Tier 1 (Preferred Generic)	\$5 copay	\$10 copay	\$12.50 copay	Tier 1 (Preferred Generic)	\$7 copay	\$14 copay	\$17.50 copay
	Tier 2 (Non-Preferred Generic)	\$10 copay	\$20 copay	\$25 copay	Tier 2 (Non-Preferred Generic)	\$12 copay	\$24 copay	\$30 copay
	Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$112.50 copay	Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$112.50 copay

	<b>Advantra Gold (HMO)</b>				<b>Advantra Silver (HMO)</b>			
<b>Initial Coverage</b>	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
	<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>				<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>			
<b>Coverage Gap</b>	<p>Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$2,960.</p> <p>After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total \$4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>				<p>Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$2,960.</p> <p>After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total \$4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>			

	<b>Advantra Gold (HMO)</b>	<b>Advantra Silver (HMO)</b>																									
<b>Coverage Gap</b>	<p>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.</p> <p><b>Preferred Retail Cost-Sharing</b></p> <table border="1"> <thead> <tr> <th>Tier</th> <th>Drugs Covered</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>All</td> <td>\$5 copay</td> <td>\$10 copay</td> <td>\$12.50 copay</td> </tr> <tr> <td>Tier 2 (Non-Preferred Generic)</td> <td>All</td> <td>\$10 copay</td> <td>\$20 copay</td> <td>\$25 copay</td> </tr> </tbody> </table> <p><b>Standard Retail Cost-Sharing</b></p> <table border="1"> <thead> <tr> <th>Tier</th> <th>Drugs Covered</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>All</td> <td>\$10 copay</td> <td>\$20 copay</td> <td>\$25 copay</td> </tr> </tbody> </table>	Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply	Tier 1 (Preferred Generic)	All	\$5 copay	\$10 copay	\$12.50 copay	Tier 2 (Non-Preferred Generic)	All	\$10 copay	\$20 copay	\$25 copay	Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply	Tier 1 (Preferred Generic)	All	\$10 copay	\$20 copay	\$25 copay	
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	Tier 2 (Non-Preferred Generic)	All	\$20 copay	\$40 copay	\$50 copay					
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	Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply					
Tier 1 (Preferred Generic)	All	\$5 copay	\$10 copay	\$12.50 copay						
Tier 2 (Non-Preferred Generic)	All	\$10 copay	\$20 copay	\$25 copay						
<b>Catastrophic Coverage</b>	<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"> <li>• 5% of the cost, or</li> </ul>					<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"> <li>• 5% of the cost, or</li> </ul>				

	<b>Advantra Gold (HMO)</b>	<b>Advantra Silver (HMO)</b>
<b>Catastrophic Coverage</b>	<ul style="list-style-type: none"><li>• \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs.</li></ul>	<ul style="list-style-type: none"><li>• \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs.</li></ul>