

2009

SUMMARY OF BENEFITS

Group Health Plan AdvantraExtra Diabetes 1 & 2

H2663

Advantra and Gold Advantage are products of Group Health Plan, Inc., a plan with a Medicare Advantage Prescription Drug contract. All Medicare beneficiaries in the GHP service area may apply. You must continue to pay your Medicare Part B premium.



Section 1- INTRODUCTION TO SUMMARY OF BENEFITS



AdvantraExtra Diabetes 1 & 2

January 1, 2009 – December 31, 2009

Thank you for your interest in AdvantraExtra 1 and 2 Diabetes. Our plan is offered by Group Health Plan., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria. All cost sharing in this summary of benefits is based on your level of Medicaid eligibility. If you have been diagnosed with Endocrine/Metabolic: Diabetes you may be eligible to join this plan. Please call Group Health Plan to find out if you are eligible to join. Our number is listed at the end of this introduction. This Summary of Benefits tells you some 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 Group Health Plan 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 AdvantraExtra Diabetes 1 & 2. 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 Group 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 AdvantraExtra Diabetes 1 & 2 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 AdvantraExtra Diabetes 1 & 2 AVAILABLE?

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information. The service area for this plan includes: Calhoun, Jersey, Madison, Monroe, St. Clair Counties, IL; Cole, Franklin, Gasconade, Jefferson, Lincoln, Osage, St. Charles, St. Louis, St. Louis City, Warren Counties, MO. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN ADVANTRAEXTRA 1 & 2?

You can join AdvantraExtra 1 or 2 Diabetes if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. You must have been diagnosed by your doctor with Endocrine/Metabolic: Diabetes to join this plan. Please call plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

AdvantraExtra Diabetes 1 & 2 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 or for an up-to-date list, visit us at <http://www.advantraplans.com>. Our customer service number is listed at the end of this introduction.

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 AdvantraExtra Diabetes 1 & 2 nor the Original Medicare Plan will pay for these services.

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

AdvantraExtra Diabetes 1 & 2 does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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

AdvantraExtra Diabetes 1 & 2 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 pharmacy directory or visit us at <http://www.advantraplans.com>. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

AdvantraExtra Diabetes 1 & 2 uses a formulary. A formulary is a list of drugs covered by your plan to meet patient 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 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 <http://www.advantraplans.com>.

If you are currently taking a drug that is not on our formulary or subject to additional requirements 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 costs at the pharmacy will be lower. When you join AdvantraExtra Diabetes 1 & 2, 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.

As a member of AdvantraExtra Diabetes 1 & 2, 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 a prescription drug.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may 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 Group Health Plan for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Group 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 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.

Please call Group Health Plan for more information about AdvantraExtra Diabetes 1 & 2.

Visit us at <http://www.advantraplans.com> or, call us:

Customer Service Hours and Medicare Prescription Drug (Part D):

Members

Monday – Sunday, 8:00 a.m. - 8:00 p.m.

Toll-free: (800) 533-0367

TTY/TDD (1-877-231-0573) for the hearing impaired

Prospective Members

Monday – Sunday, 8:00 a.m. - 8:00 p.m.

Toll-free: (800) 533-0362

TTY/TDD: (1-877-486-2048) for the hearing impaired

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 <http://www.medicare.gov> on the web.

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

If you have any questions about this plan's benefits or costs, please contact Group Health Plan for details.

Section 2 Summary of Benefits			
Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
IMPORTANT INFORMATION			
1 - Premium and Other Important Information	<p>In 2009 the monthly Part B Premium is \$96.40 and the yearly Part B deductible amount is \$135.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>General</p> <p>\$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network</p> <p>\$3,900 in-network out-of-pocket limit.</p> <p>Not all plan services are covered under the out-of-pocket limit. The maximum out-of-pocket limit every year for the following plan services:</p> <ul style="list-style-type: none"> - Inpatient Hospital Care - Skilled Nursing Facility - Outpatient Services/Surgery - Ambulance Services - Emergency Care - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diagnostic Tests, X-Rays and Lab Services - Comprehensive Outpatient Rehabilitation Facility (CORF) - Cardiac Rehabilitation Services - Renal Dialysis <p>Contact plan for a detailed list of non-covered services.</p>	<p>General</p> <p>\$69 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network</p> <p>\$1,500 in-network out-of-pocket limit.</p> <p>Not all plan services are covered under the out-of-pocket limit. The maximum out-of-pocket limit every year for the following plan services:</p> <ul style="list-style-type: none"> - Inpatient Hospital Care - Skilled Nursing Facility - Outpatient Services/Surgery - Ambulance Services - Emergency Care - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diagnostic Tests, X-Rays and Lab Services - Comprehensive Outpatient Rehabilitation Facility (CORF) - Cardiac Rehabilitation Services - Renal Dialysis <p>Contact plan for a detailed list of non-covered services.</p>

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<p>2 - Doctor and Hospital Choice</p> <p>(For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-network</p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p> <p>You may have to pay a separate copay for certain doctor office visits.</p>	<p>In-network</p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p> <p>You may have to pay a separate copay for certain doctor office visits.</p>

SUMMARY OF BENEFITS

INPATIENT CARE

<p>3 - Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2009 the amounts for each benefit period were: Days 1 - 60: \$1068 deductible Days 61 - 90: \$267 per day Days 91 - 150: \$534 per lifetime reserve day Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. 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</p>	<p>In-Network</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$255 copay per day.</p> <p>Days 6 - 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days.</p> <p>\$1,275 out of pocket limit every stay.</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$205 copay per day</p> <p>Days 6 - 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>\$1,025 out of pocket limit every stay.</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
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	benefit periods you can have.		
4 - Inpatient Mental Health Care	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p>In-Network</p> <p>For hospital stays:</p> <p>Days 1 - 5: \$300 copay per day.</p> <p>Days 6 - 90: \$0 copay per day</p> <p>\$2,000 out of pocket limit every year.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network</p> <p>For hospital stays:</p> <p>Days 1 - 5: \$300 copay per day</p> <p>Days 6 - 90: \$0 copay per day</p> <p>\$2,000 out of pocket limit every year.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day Days 21 - 100: \$133.50 per day.</p> <p>100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. 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.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>For SNF stays:</p> <p>Days 1 - 5: \$0 copay per day.</p> <p>Days 6 - 30: \$100 copay per day.</p> <p>Days 31 - 100: \$0 copay per day.</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>For SNF stays:</p> <p>Days 1 - 5: \$0 copay per day</p> <p>Days 6 - 25: \$75 copay per day</p> <p>Days 26 - 100: \$0 copay per day</p> <p>Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p>

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6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.
OUTPATIENT CARE			
8 - Doctor Office Visits	20% coinsurance	General See "Physical Exams," for more information. Authorization rules may apply. In-Network \$15 copay for each primary care doctor visit for Medicare-covered benefits. \$0 copay for the cost of each in-area, network urgent care Medicare-covered visit.* \$10 to \$30 copay for each specialist visit for Medicare-covered benefits.	General See "Physical Exams," for more information. Authorization rules may apply. In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits. \$0 copay for the cost of each in-area, network urgent care Medicare-covered visit* \$10 to \$20 copay for each specialist visit for Medicare-covered benefits.
9 - Chiropractic Services	Routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	General Authorization rules may apply. In-Network \$30 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or	General Authorization rules may apply. In-Network \$20 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or

Section 2 Summary of Benefits			
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		misalignment of a joint or body part.	misalignment of a joint or body part.
10 - Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$10 copay for each Medicare-covered visit.</p> <p>\$10 copay for up to 6 routine visit(s) every year Medicare-covered podiatry benefits are for medically-necessary foot care.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$10 copay for each Medicare-covered visit.</p> <p>\$10 copay for up to 6 routine visit(s) every year Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
11 - Outpatient Mental Health Care	50% coinsurance for most outpatient mental health services.	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$30 copay for each Medicare-covered individual therapy visit.</p> <p>\$20 copay for each Medicare-covered group therapy visit.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$30 copay for Medicare-covered individual therapy visit.</p> <p>\$20 copay for Medicare-covered group therapy visit.</p>
12 - Outpatient Substance Abuse Care	20% coinsurance	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$30 copay for each Medicare-covered individual therapy visit.</p> <p>\$20 copay for each Medicare-covered group therapy visit.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$30 copay for each Medicare-covered individual therapy visit.</p> <p>\$20 copay for each Medicare-covered group therapy visit.</p>
13 - Outpatient Services/Surgery	20% coinsurance for the doctor 20% of outpatient facility charges	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$250 copay for each Medicare-covered ambulatory</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$250 copay for each Medicare-covered ambulatory</p>

Section 2 Summary of Benefits			
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		surgical center visit. \$250 copay or 20% of the cost for each Medicare-covered outpatient hospital facility visit.	surgical center visit. \$250 copay or 20% of the cost for each Medicare-covered outpatient hospital facility visit.
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	General Authorization rules may apply. In-Network \$100 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network \$100 copay for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	In-Network \$50 copay for Medicare-covered emergency room visits. Out-of-Network Worldwide coverage. In and Out-of-Network If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.	In-Network \$50 copay for Medicare-covered emergency room visits. Out-of-Network Worldwide coverage. In and Out-of-Network If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	General \$50 copay for Medicare-covered urgently needed care visits.	General \$50 copay for Medicare-covered urgently needed care visits.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered Occupational Therapy visits.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered Occupational Therapy visits.

Section 2 Summary of Benefits			
Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		20% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.	20% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.
20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	General Authorization rules may apply. In-Network \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.	General Authorization rules may apply. In-Network \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.
21 - Diagnostic Tests, X-Rays, and Lab Services	20% coinsurance for diagnostic tests and x-rays \$0 copay for Medicare-covered lab services	General Authorization rules may apply. In-Network 0% of the cost for Medicare-	General Authorization rules may apply. In-Network 0% of the cost for Medicare-

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	<p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>covered lab services.</p> <p>20% of the cost for Medicare-covered diagnostic procedures and tests.</p> <p>\$15 copay for Medicare-covered X-rays.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p>	<p>covered lab services.</p> <p>20% of the cost for Medicare-covered diagnostic procedures and tests.</p> <p>\$15 copay for Medicare-covered X-rays.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p>
PREVENTIVE CARE			
<p>22 - Bone Mass Measurement</p> <p>(for people with Medicare who are at risk)</p>	<p>20% coinsurance</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement</p>
<p>23 - Colorectal Screening Exams</p> <p>(for people with Medicare age 50 and older)</p>	<p>20% coinsurance</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings.</p>
<p>24 - Immunizations</p> <p>(Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 copay for Flu and Pneumonia vaccines</p> <p>20% coinsurance for Hepatitis B vaccine</p> <p>You may only need the</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Flu and Pneumonia vaccines.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Flu and Pneumonia vaccines.</p>

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	Pneumonia vaccine once in your lifetime. Call your doctor for more information.	\$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	\$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.
25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered screening mammograms.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered screening mammograms.
26 - Pap Smears and Pelvic Exams (for women with Medicare)	\$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered Pap smears and pelvic exams.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered Pap smears and pelvic exams.
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. \$0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered prostate cancer screening.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered prostate cancer screening.
28 - End-Stage Renal Disease	20% coinsurance for renal dialysis 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't	General Authorization rules may apply. In-Network 20% of the cost for renal dialysis. \$0 copay for Nutrition Therapy for End-Stage Renal Disease.	General Authorization rules may apply. In-Network 20% of the cost for renal dialysis \$0 copay for Nutrition Therapy for End-Stage Renal Disease.

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Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
	<p>had a kidney transplant) when referred by a doctor.</p> <p>These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>		
29 - Prescription Drugs	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General</p> <p>20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>20% of the cost for Part B-covered chemotherapy drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary.</p> <p>The plan will send you the formulary. You can also see the formulary at http://www.ghpmedicare.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or 	<p>Drugs covered under Medicare Part B</p> <p>General</p> <p>20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>20% of the cost for Part B-covered chemotherapy drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary.</p> <p>The plan will send you the formulary. You can also see the formulary at http://www.ghpmedicare.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or

Section 2 Summary of Benefits

Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>-have access to Indian/Tribal/Urban (Indian Health Service).</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC).</p> <p>This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from AdvantraExtra 1 Diabetes for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program.</p> <p>Some over-the-counter drugs are less expensive than</p>	<p>-have access to Indian/Tribal/Urban (Indian Health Service).</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC).</p> <p>This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from AdvantraExtra 2 Diabetes for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program.</p> <p>Some over-the-counter drugs are less expensive than</p>

Section 2 Summary of Benefits			
Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>prescription drugs and work just as well.</p> <p>Contact the plan for details.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>In-Network</p> <p>\$0 deductible.</p> <p>Some covered drugs don't count toward your out-of-pocket drug costs.</p> <p>Initial Coverage</p> <p>You pay the following until total yearly drug costs reach \$2,700:</p> <p>Retail Pharmacy</p> <p>Preferred Generic</p>	<p>prescription drugs and work just as well.</p> <p>Contact the plan for details.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>In-Network</p> <p>\$0 deductible.</p> <p>Some covered drugs don't count toward your out-of-pocket drug costs.</p> <p>Initial Coverage</p> <p>You pay the following until total yearly drug costs reach \$2,700:</p> <p>Retail Pharmacy</p> <p>Preferred Generic</p>

Section 2 Summary of Benefits

Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>- \$6 copay for a one-month (30-day) supply of drugs in this tier</p> <p>- \$12 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Preferred Brand</p> <p>- \$39 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$78 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic/Non-Preferred Brand</p> <p>- \$70 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$210 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Specialty</p> <p>- 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>Diabetic Needs.</p> <p>- \$0 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$0 copay for a three-month (90-day) supply of drugs in this tier.</p>	<p>- \$6 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$12 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Preferred Brand</p> <p>- \$39 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$78 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic/Non-Preferred Brand</p> <p>- \$70 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$210 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Specialty</p> <p>- 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>Diabetic Needs</p> <p>- \$0 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>- \$0 copay for a three-month (90-day) supply of drugs in this tier.</p>

Section 2 Summary of Benefits

Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>Long Term Care Pharmacy</p> <p>Preferred Generic</p> <p>- \$6 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Preferred Brand</p> <p>- \$39 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic/Non-Preferred Brand</p> <p>- \$70 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Specialty</p> <p>- 30% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>Diabetic Needs</p> <p>- \$0 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Mail Order</p> <p>Preferred Generic</p> <p>- \$12 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Preferred Brand</p>	<p>Long Term Care Pharmacy</p> <p>Preferred Generic</p> <p>- \$6 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Preferred Brand</p> <p>- \$39 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic/Non-Preferred Brand</p> <p>- \$70 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Specialty</p> <p>- 30% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>Diabetic Needs</p> <p>\$0 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Mail Order</p> <p>Preferred Generic</p> <p>- \$12 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Preferred Brand</p>

Section 2 Summary of Benefits

Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>- \$78 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic/Non-Preferred Brand</p> <p>- \$210 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Diabetic Needs</p> <p>- \$0 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Coverage Gap</p> <p>The plan covers Some Generics, Some Brands through the coverage gap. You pay the following:</p> <p>Retail Pharmacy</p> <p>Diabetic Needs</p> <p>- \$0 copay for a one-month (30-day) supply of all drugs covered in this tier.</p> <p>- \$0 copay for a three-month (90-day) supply of all drugs covered in this tier.</p> <p>Long Term Care Pharmacy</p> <p>Diabetic Needs</p> <p>- \$0 copay for a one-month (31-day) supply of all drugs.</p> <p>Mail Order</p>	<p>- \$78 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic/Non-Preferred Brand</p> <p>- \$210 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Diabetic Needs</p> <p>- \$0 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Coverage Gap</p> <p>The plan covers Some Generics, Some Brands through the coverage gap. You pay the following:</p> <p>Retail Pharmacy</p> <p>Diabetic Needs</p> <p>- \$0 copay for a one-month (30-day) supply of all drugs covered in this tier.</p> <p>- \$0 copay for a three-month (90-day) supply of all drugs covered in this tier.</p> <p>Long Term Care Pharmacy</p> <p>Diabetic Needs</p> <p>- \$0 copay for a one-month (31-day) supply of all drugs.</p> <p>Mail Order</p>

Section 2 Summary of Benefits

Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>Diabetic Needs</p> <p>- \$0 copay for a three-month (90-day) supply of all drugs covered in this tier.</p> <p>For all other covered drugs, after your total yearly drug costs reach \$2,700, you pay 100% until your yearly out-of-pocket drug costs reach \$4,350.</p> <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of:</p> <p>- A \$ 2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or</p> <p>- 5% coinsurance.</p> <p>Out-of-Network</p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from AdvantraExtra 1 Diabetes.</p>	<p>Diabetic Needs</p> <p>- \$0 copay for a three-month (90-day) supply of all drugs covered in this tier.</p> <p>For all other covered drugs, after your total yearly drug costs reach \$2,700, you pay 100% until your yearly out-of-pocket drug costs reach \$4,350.</p> <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$ 4,350, you pay the greater of:</p> <p>- A \$ 2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or</p> <p>- 5% coinsurance.</p> <p>Out-of-Network</p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from AdvantraExtra 2 Diabetes.</p>

Section 2 Summary of Benefits

Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>Out-of-Network Initial Coverage</p> <p>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,700:</p> <p>Out-of-Network Pharmacy</p> <p>Preferred Generic</p> <p>- \$6 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Preferred Brand</p> <p>- \$39 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic/Non-Preferred Brand</p> <p>- \$70 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Specialty</p> <p>- 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>Diabetic Needs.</p> <p>- \$0 copay for a one-month (30-day) supply of drugs in</p>	<p>Out-of-Network Initial Coverage</p> <p>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,700:</p> <p>Out-of-Network Pharmacy</p> <p>Preferred Generic</p> <p>- \$6 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Preferred Brand</p> <p>- \$39 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic/Non-Preferred Brand</p> <p>- \$70 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Specialty</p> <p>- 30% coinsurance for a one-month (30-day) supply of drugs in this tier.</p> <p>Diabetic Needs</p> <p>- \$0 copay for a one-month (30-day) supply of drugs in</p>

Section 2 Summary of Benefits

Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>this tier.</p> <p>Out-of-Network Coverage Gap</p> <p>The plan covers Some Generics, Some Brands through the gap. You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p>Preferred Generic</p> <p>-After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by AdvantraExtra 1 Diabetes for out-of-network purchases when you are in the coverage gap.</p> <p>However, you should still submit documentation to AdvantraExtra 1 Diabetes so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Preferred Brand</p> <p>-After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your</p>	<p>this tier.</p> <p>Out-of-Network Coverage Gap</p> <p>The plan covers Some Generics, Some Brands through the gap. You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p>Preferred Generic</p> <p>-After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by AdvantraExtra 2 Diabetes for out-of-network purchases when you are in the coverage gap.</p> <p>However, you should still submit documentation to AdvantraExtra 2 Diabetes so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Preferred Brand</p> <p>-After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your</p>

Section 2 Summary of Benefits

Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by AdvantraExtra 1 Diabetes for out-of-network purchases when you are in the coverage gap.</p> <p>However, you should still submit documentation to AdvantraExtra 1 Diabetes so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Non-Preferred Generic/Non-Preferred Brand</p> <p>-After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by AdvantraExtra 1 Diabetes for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to AdvantraExtra 1 Diabetes so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Specialty</p> <p>-After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your</p>	<p>yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by AdvantraExtra 2 Diabetes for out-of-network purchases when you are in the coverage gap.</p> <p>However, you should still submit documentation to AdvantraExtra 2 Diabetes so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Non-Preferred Generic/Non-Preferred Brand</p> <p>-After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by AdvantraExtra 2 Diabetes for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to AdvantraExtra 2 Diabetes so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Specialty</p> <p>-After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your</p>

Section 2 Summary of Benefits

Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by AdvantraExtra 1 Diabetes for out-of-network purchases when you are in the coverage gap.</p> <p>However, you should still submit documentation to AdvantraExtra 1 Diabetes so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Diabetic Needs</p> <ul style="list-style-type: none"> - \$0 copay for a one-month (30-day) supply of all drugs covered in this tier <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> - A \$ 2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or - 5% coinsurance. 	<p>yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by AdvantraExtra 2 Diabetes for out-of-network purchases when you are in the coverage gap.</p> <p>However, you should still submit documentation to AdvantraExtra 2 Diabetes so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Diabetic Needs</p> <ul style="list-style-type: none"> - \$0 copay for a one-month (30-day) supply of all drugs covered in this tier <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$ 4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> - A \$ 2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or - 5% coinsurance.
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p>In-Network</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> - up to 1 oral exam(s) every 	<p>In-Network</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> - up to 1 oral exam(s) every

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Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		<p>six months.</p> <p>- up to 1 cleaning(s) every six months.</p> <p>- up to 1 dental x-ray(s) every year.</p> <p>50% of the cost for Medicare-covered dental benefits.</p> <p>\$1,000 limit for dental benefits every year.</p> <p>Out-Of-Network</p> <p>\$0 copay for the following preventive dental benefits:</p> <p>- up to 1 oral exam(s) every six months.</p> <p>- up to 1 cleaning(s) every six months.</p> <p>- up to 1 dental x-ray(s) every year.</p> <p>50% of the cost for Medicare-covered dental benefits.</p> <p>\$1,000 limit for dental benefits every year.</p> <p>Plan offers additional comprehensive dental benefits.</p>	<p>six months.</p> <p>- up to 1 cleaning(s) every six months.</p> <p>- up to 1 dental x-ray(s) every year.</p> <p>50% of the cost for Medicare-covered dental benefits.</p> <p>\$1,000 limit for dental benefits every year.</p> <p>Out-Of-Network</p> <p>\$0 copay for the following preventive dental benefits:</p> <p>- up to 1 oral exam(s) every six months.</p> <p>- up to 1 cleaning(s) every six months.</p> <p>- up to 1 dental x-ray(s) every year.</p> <p>50% of the cost for Medicare-covered dental benefits.</p> <p>\$1,000 limit for dental benefits every year.</p> <p>Plan offers additional comprehensive dental benefits.</p>
31 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p>

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Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
		Hearing aids not covered. - \$30 copay for Medicare-covered diagnostic hearing exams. - \$30 copay for up to 1 routine hearing test(s) every year.	Hearing aids not covered. - \$20 copay for Medicare-covered diagnostic hearing exams. - \$20 copay for up to 1 routine hearing test(s) every year.
32 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	In-Network - \$15 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$25 copay for exams to diagnose and treat diseases and conditions of the eye. - \$25 copay for up to 1 routine eye exam(s) every year. - \$15 copay for up to 1 pair(s) of glasses every two years.	In-Network - \$15 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$25 copay for exams to diagnose and treat diseases and conditions of the eye. - \$25 copay for up to 1 routine eye exam(s) every year. - \$15 copay for up to 1 pair(s) of glasses every two years.
33 - Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	In-Network \$15 copay for routine exams. Limited to 1 exam(s) every year. \$15 copay for Medicare-covered benefits.	In-Network \$10 copay for routine exams. Limited to 1 exam(s) every year. \$10 copay for Medicare-covered benefits.
Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that	General Authorization rules may apply. In-Network This plan covers the following health/wellness education	General Authorization rules may apply. In-Network This plan covers the following health/wellness education

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Benefit	Original Medicare	AdvantraExtra 1 PBP 008	AdvantraExtra 2 PBP 009
	may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	benefits: - Written health education materials, including Newsletters - Additional Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline	benefits: - Written health education materials, including Newsletters - Additional Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline
Transportation (Routine)	Not covered.	In-Network \$0 copay for up to 24 one-way trip(s) to plan-approved location every year.	In-Network \$0 copay for up to 24 one-way trip(s) to plan-approved location every year.
Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.	In-Network This plan does not cover Acupuncture.

