

2009

SUMMARY OF BENEFITS

PersonalCare
Advantra Gold and Advantra Silver

H7301

**SECTION 1 –
INTRODUCTION TO SUMMARY OF BENEFITS
Advantra Gold H7301-001
Advantra Silver H7301-002
January 1, 2009 – December 31, 2009**



Thank you for your interest in PersonalCare Advantra Gold and Advantra Silver. Our plans are offered by Personal Care Insurance of Illinois, a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call PersonalCare Advantra Gold and Advantra Silver 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 PersonalCare Advantra Gold or Advantra Silver. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call PersonalCare Advantra Gold or Advantra Silver at the 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 PersonalCare Advantra Gold, Advantra Silver 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 PERSONALCARE ADVANTRA GOLD AND ADVANTRA SILVER 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: Boone, Champaign, Coles, Douglas, Marshall, Moultrie, Ogle,

Peoria, Piatt, Stark, Stephenson, Tazewell, Winnebago, McLean, Woodford Counties, IL. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN PERSONALCARE Gold and Advantra Silver?

You can join PersonalCare Advantra Gold or Advantra Silver if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in PersonalCare Advantra Gold and Advantra Silver unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

PersonalCare Advantra Gold and Advantra Silver have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside 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 www.pcadvantra.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?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

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

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PersonalCare Advantra Gold and Advantra Silver do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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

PersonalCare Advantra Gold and Advantra Silver have 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 www.pcadvantra.com. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

PersonalCare Advantra Gold and Advantra Silver use 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 www.pcadvantra.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 PersonalCare Advantra Gold or Advantra Silver, 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 PersonalCare Advantra Gold or Advantra Silver, 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

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participate but it is recommended that you take full advantage of this covered service if you are selected. Contact PersonalCare Advantra Gold or Advantra Silver 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 PersonalCare Advantra Gold or Advantra Silver 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 PersonalCare Advantra for more information about PersonalCare Advantra Gold and Advantra Silver.

Visit us at www.pcadvantra.com or, call us:

Customer Service Hours:

Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. - 8:00 p.m. Central
Saturday, 9:00 a.m. - 3:00 p.m. Central

Current members should call toll-free (866)-784-4916 for questions related to the Medicare Advantage Program.
(TTY/TDD (866)-784-4931)

Prospective members should call toll-free (888)-690-7894 for questions related to the Medicare Advantage Program.

Medicare Prescription Drug (Part D) Customer Service Days and Hours of Operation

24 hours a day; seven (7) days a week, including holidays

Current members should call toll-free (800)-707-9372 for questions related to the Medicare Part D Prescription Drug program.

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Prospective members should call toll-free (800)-707-9372 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-236-1068

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
Or, visit www.medicare.gov on the web.

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

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If you have any questions about this plan's benefits or costs, please contact PersonalCare Advantra for details.			
Benefit	Original Medicare	PersonalCare Advantra Gold	PersonalCare Advantra Silver
OTHER IMPORTANT INFORMATION			
1 - Premium and Other Important Information	<p>In 2008 the monthly Part B Premium was \$96.40 and will change for 2009 and the yearly Part B deductible amount was \$135 and will change for 2009.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>General \$69 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$1,200 in-network out-of-pocket limit.</p> <p>Not all plan services are covered under the out-of-pocket limit. The following copayments are excluded from the out-of-pocket limit: Dental, Vision, Hearing and Part D.</p> <p>See page 31 for additional information about Premium and Other Important Information.</p>	<p>General Zero monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$2,500 in-network out-of-pocket limit.</p> <p>Not all plan services are covered under the out-of-pocket limit. The following copayments are excluded from the out-of-pocket limit: Dental, Vision, Hearing and Part D.</p> <p>See page 31 for additional information about Premium and Other Important Information.</p>
2 - Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	<p>In-Network 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 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>
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INPATIENT CARE			
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	<p>In 2008 the amounts for each benefit period (3) were: Days 1 - 60: \$1024 deductible Days 61 - 90: \$256 per day Days 91 - 150: \$512 per lifetime reserve day These</p>	<p>In-Network \$400 copay for each Medicare-covered hospital stay</p> <p>\$0 copay for additional hospital days</p>	<p>In-Network For Medicare-covered hospital stays:</p> <p>Days 1 - 5: \$175 copay per day</p>

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	<p>amounts will change for 2009.</p> <p>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 benefit periods you can have.</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>Out-of-Network 20% of the cost for each hospital stay.</p>	<p>Days 6 - 90: \$0 copay per day</p> <p>No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 20% of the cost for each hospital stay.</p>
<p>4 - Inpatient Mental Health Care</p>	<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 \$400 copay for each Medicare-covered hospital stay</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>Out-of-Network 20% of the cost for each hospital stay.</p>	<p>In-Network For hospital stays:</p> <p>Days 1 - 5: \$175 copay per day</p> <p>Days 6 - 90: \$0 copay per day</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>Out-of-Network 20% of the cost for each</p>

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			hospital stay. See page 31 for additional information about Inpatient Mental Health Care.
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In 2008 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: \$128 per day These amounts will change for 2009. 100 days per benefit period. 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.	General Authorization rules may apply. In-Network For SNF stays: Days 1 - 20: \$0 copay per day Days 21 - 100: \$100 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required. Out-of-Network 20% of the cost for each SNF stay.	General Authorization rules may apply. In-Network For SNF stays: Days 1 - 20: \$0 copay per day Days 21 - 100: \$100 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required. Out-of-Network 20% of the cost for each SNF stay.
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. Out-of-Network 20% for home health visits.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits. Out-of-Network 20% for home health visits.

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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	<p>General See "Physical Exams," for more information.</p> <p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$30 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$20 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network 20% for each primary care doctor visit. 20% for each specialist visit.</p>	<p>General See "Physical Exams," for more information.</p> <p>In-Network \$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$30 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$30 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network 20% for each primary care doctor visit. 20% for each specialist visit.</p>
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.	<p>In-Network \$20 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p> <p>Out-of-Network 20% of the cost for chiropractic benefits.</p>	<p>In-Network \$30 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p> <p>Out-of-Network 20% of the cost for chiropractic benefits.</p>

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<p>10 - Podiatry Services</p>	<p>Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$20 copay for each Medicare-covered visit.</p> <p>\$20 copay for up to 2 routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network 20% of the cost for podiatry benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for each Medicare-covered visit.</p> <p>\$30 copay for up to 2 routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network 20% of the cost for podiatry benefits.</p>
<p>11 - Outpatient Mental Health Care</p>	<p>50% coinsurance for most outpatient mental health services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$20 copay for each Medicare-covered individual or group therapy visit.</p> <p>Out-of-Network 20% of the cost for Mental Health benefits.</p> <p>20% of the cost for Mental Health benefits with a psychiatrist.</p> <p>See page 31 for additional information about Outpatient Mental Health Care.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for each Medicare-covered individual or group therapy visit.</p> <p>Out-of-Network 20% of the cost for Mental Health benefits.</p> <p>20% of the cost for Mental Health benefits with a psychiatrist.</p> <p>See page 31 for additional information about Outpatient Mental Health Care.</p>

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<p>12 - Outpatient Substance Abuse Care</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$20 copay for Medicare-covered individual or group visits.</p> <p>Out-of-Network 20% of the cost for outpatient substance abuse benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual or group visits.</p> <p>Out-of-Network 20% of the cost for outpatient substance abuse benefits.</p>
<p>13 - Outpatient Services/Surgery</p>	<p>20% coinsurance for the doctor</p> <p>20% of outpatient facility charges</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$100 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network 20% of the cost for ambulatory surgical center benefits.</p> <p>20% of the cost for outpatient hospital facility benefits.</p> <p>See page 32 for additional information about Outpatient Services/Surgery.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$150 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network 20% of the cost for ambulatory surgical center benefits.</p> <p>20% of the cost for outpatient hospital facility benefits.</p> <p>See page 32 for additional information about Outpatient Services/Surgery.</p>

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<p>14 - Ambulance Services (medically necessary ambulance services)</p>	<p>20% coinsurance</p>	<p>In-Network \$25 copay for Medicare-covered ambulance benefits. Out-of-Network \$25 copay for ambulance benefits.</p>	<p>In-Network \$100 copay for Medicare-covered ambulance benefits. Out-of-Network \$100 copay for ambulance benefits.</p>
<p>15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>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.</p>	<p>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 See page 31 for additional information about Worldwide coverage.</p>	<p>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 See page 31 for additional information about Worldwide coverage.</p>
<p>16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$30 copay for Medicare-covered urgently needed care visits.</p>	<p>General \$30 copay for Medicare-covered urgently needed care visits.</p>

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<p>17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>	<p>In-Network \$20 copay for Medicare-covered Occupational Therapy visits. \$20 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. Out-of-Network 20% of the cost for Occupational Therapy benefits. 20% of the cost for Physical and/or Speech/Language Therapy visits.</p>	<p>In-Network \$30 copay for Medicare-covered Occupational Therapy visits. \$30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. Out-of-Network 20% of the cost for Occupational Therapy benefits. 20% of the cost for Physical and/or Speech/Language Therapy visits.</p>
<p>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</p>			
<p>18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply. In-Network 10% of the cost for Medicare-covered items. Out-of-Network 20% of the cost for durable medical equipment.</p>	<p>General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items. Out-of-Network 20% of the cost for durable medical equipment.</p>
<p>19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply. In-Network 10% of the cost for Medicare-covered items. Out-of-Network 20% of the cost for prosthetic devices.</p>	<p>General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items. Out-of-Network 20% of the cost for prosthetic devices.</p>

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<p>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance</p> <p>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.</p>	<p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>10% of the cost for Diabetes supplies.</p> <p>Out-of-Network 20% of the cost for Diabetes self-monitoring training.</p> <p>20% of the cost for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p> <p>See page 32 for additional information about Diabetes Services.</p>	<p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p> <p>Out-of-Network 20% of the cost for Diabetes self-monitoring training.</p> <p>20% of the cost for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p> <p>See page 32 for additional information about Diabetes Services.</p>
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<p>21 - Diagnostic Tests, X-Rays, and Lab Services</p>	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <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>General Authorization rules may apply.</p> <p>In-Network \$10 copay for Medicare-covered lab services.</p> <p>\$0 copay for Medicare-covered diagnostic procedures and tests.</p> <p>\$10 copay for Medicare-covered X-rays.</p> <p>\$50 copay for Medicare-covered diagnostic radiology services.</p> <p>10% of the cost for Medicare-covered therapeutic radiology services.</p> <p>Out-of-Network 20% of the cost for diagnostic procedures, tests, and lab services.</p> <p>20% of the cost for therapeutic radiology services</p> <p>20% of the cost for outpatient x-rays.</p> <p>20% of the cost for diagnostic radiology services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered lab services.</p> <p>\$30 copay for Medicare-covered diagnostic procedures and tests.</p> <p>\$25 copay for Medicare-covered X-rays.</p> <p>\$100 copay or 20% of the cost for Medicare-covered diagnostic radiology services.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p> <p>Out-of-Network 20% of the cost for diagnostic procedures, tests, and lab services.</p> <p>20% of the cost for therapeutic radiology services</p> <p>20% of the cost for outpatient x-rays.</p> <p>20% of the cost for diagnostic radiology services</p>
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PREVENTIVE SERVICES			
<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>In-Network \$0 copay for Medicare-covered bone mass measurement</p> <p>Out-of-Network 20% of the cost for Medicare-covered bone mass measurement.</p>	<p>In-Network \$0 copay for Medicare-covered bone mass measurement</p> <p>Out-of-Network 20% of the cost 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>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Out-of-Network 20% of the cost for colorectal screenings.</p>	<p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Out-of-Network 20% of the cost for 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 Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>Out-of-Network 20% of the cost for immunizations.</p> <p>See page 32 for additional information about Immunizations.</p>	<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>Out-of-Network 20% of the cost for immunizations.</p> <p>See page 32 for additional information about Immunizations.</p>

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<p>25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p>	<p>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.</p>	<p>In-Network \$0 copay for Medicare-covered screening mammograms. Out-of-Network 20% of the cost for screening mammograms.</p>	<p>In-Network \$0 copay for Medicare-covered screening mammograms. Out-of-Network 20% of the cost for screening mammograms.</p>
<p>26 - Pap Smears and Pelvic Exams (for women with Medicare)</p>	<p>\$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</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams. Out-of-Network 20% of the cost for pap smears and pelvic exams.</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams. Out-of-Network 20% of the cost for pap smears and pelvic exams.</p>
<p>27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>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.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening. Out-of-Network 20% of the cost for prostate cancer screening.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening. Out-of-Network 20% of the cost for prostate cancer screening.</p>

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<p>28 - End-Stage Renal Disease</p>	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>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.</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>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for renal dialysis</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease</p> <p>Out-of-Network 20% of the cost for renal dialysis.</p> <p>20% of the cost for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for renal dialysis</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease</p> <p>Out-of-Network 20% of the cost for renal dialysis.</p> <p>20% of the cost for Nutrition Therapy for End-Stage Renal Disease.</p>
<p>29 - Prescription Drugs</p>	<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 General 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 General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.pcadvantra.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p>	<p>Drugs covered under Medicare Part B General 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 General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.pcadvantra.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p>

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		<p>-have limited incomes, -live in long term care facilities, or -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). 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 PersonalCare Advantra Silver for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and</p>	<p>-have limited incomes, -live in long term care facilities, or -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). 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 PersonalCare Advantra Silver for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and</p>
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		<p>work just as well. 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 \$0 deductible.</p> <p>Some covered drugs don't count toward your out-of-pocket drug costs.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,700:</p> <p>Retail Pharmacy Preferred Generic - \$5 copay for a one-month (30-day) supply of drugs in this tier - \$10 copay for a three-month (90-day) supply of</p>	<p>work just as well. 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 \$0 deductible.</p> <p>Some covered drugs don't count toward your out-of-pocket drug costs.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,700:</p> <p>Retail Pharmacy Preferred Generic - \$5 copay for a one-month (30-day) supply of drugs in this tier - \$10 copay for a three-month (90-day) supply of</p>
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		<p>drugs in this tier</p> <p>Preferred Brand - \$25 copay for a one-month (30-day) supply of drugs in this tier - \$50 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Non-Preferred Generic/Non-Preferred Brand - \$60 copay for a one-month (30-day) supply of drugs in this tier - \$180 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Specialty - Generic and Brand - 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>Long Term Care Pharmacy Preferred Generic - \$5 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Preferred Brand - \$25 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Non-Preferred Generic/Non-Preferred Brand - \$60 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Specialty - Generic and Brand - 30% coinsurance for a</p>	<p>drugs in this tier</p> <p>Preferred Brand - \$25 copay for a one-month (30-day) supply of drugs in this tier - \$50 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Non-Preferred Generic/Non-Preferred Brand - \$60 copay for a one-month (30-day) supply of drugs in this tier - \$180 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Specialty - Generic and Brand - 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>Long Term Care Pharmacy Preferred Generic - \$5 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Preferred Brand - \$25 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Non-Preferred Generic/Non-Preferred Brand - \$60 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Specialty - Generic and Brand - 30% coinsurance for a</p>
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		<p>one-month (31-day) supply of drugs in this tier</p> <p>Mail Order Preferred Generic - \$10 copay for a three-month (90-day) supply of drugs in this tier Preferred Brand - \$50 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Non-Preferred Generic/Non-Preferred Brand - \$180 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Coverage Gap The plan covers All Preferred Generics through the coverage gap.</p> <p>You pay the following:</p> <p>Retail Pharmacy Preferred Generic - \$5 copay for a one-month (30-day) supply of all drugs covered in this tier - \$10 copay for a three-month (90-day) supply of all drugs covered in this tier</p> <p>Long Term Care Pharmacy Preferred Generic - \$5 copay for a one-month (31-day) supply of all drugs</p> <p>Mail Order Preferred Generic - \$10 copay for a three-month (90-day) supply of</p>	<p>one-month (31-day) supply of drugs in this tier</p> <p>Mail Order Preferred Generic - \$10 copay for a three-month (90-day) supply of drugs in this tier Preferred Brand - \$50 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Non-Preferred Generic/Non-Preferred Brand - \$180 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Coverage Gap The plan covers All Preferred Generics through the coverage gap.</p> <p>You pay the following:</p> <p>Retail Pharmacy Preferred Generic - \$5 copay for a one-month (30-day) supply of all drugs covered in this tier - \$10 copay for a three-month (90-day) supply of all drugs covered in this tier</p> <p>Long Term Care Pharmacy Preferred Generic - \$5 copay for a one-month (31-day) supply of all drugs</p> <p>Mail Order Preferred Generic - \$10 copay for a three-month (90-day) supply of</p>
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		<p>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 After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of: - 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> <p>Out-of-Network 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 PersonalCare Advantra Silver.</p> <p>Out-of-Network Initial Coverage</p>	<p>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 After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of: - 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> <p>Out-of-Network 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 PersonalCare Advantra Silver.</p> <p>Out-of-Network Initial Coverage</p>
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		<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 Preferred Generic - \$5 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Preferred Brand - \$25 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Non-Preferred Generic/Non-Preferred Brand - \$60 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Specialty - Generic and Brand - 30% coinsurance for a one-month (30-day) supply of drugs in this tier Out-of-Network Coverage Gap The plan covers All Preferred Generics through the gap.</p> <p>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 - \$5 copay for a one-month (30-day) supply of all drugs covered in this tier</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 Preferred Generic - \$5 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Preferred Brand - \$25 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Non-Preferred Generic/Non-Preferred Brand - \$60 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Specialty - Generic and Brand - 30% coinsurance for a one-month (30-day) supply of drugs in this tier Out-of-Network Coverage Gap The plan covers All Preferred Generics through the gap.</p> <p>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 - \$5 copay for a one-month (30-day) supply of all drugs covered in this tier</p>
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		<p>Preferred Brand -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 PersonalCare Advantra Silver for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to PersonalCare Advantra Silver 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 -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 PersonalCare Advantra Silver for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to PersonalCare Advantra Silver so we can add the amounts you spent out-of-network to your total out-</p>	<p>Preferred Brand -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 PersonalCare Advantra Silver for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to PersonalCare Advantra Silver 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 -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 PersonalCare Advantra Silver for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to PersonalCare Advantra Silver so we can add the amounts you spent out-of-</p>
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		<p>of-pocket costs for the year.</p> <p>Specialty - Generic and Brand -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 PersonalCare Advantra Silver for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to PersonalCare Advantra Silver so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage 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: - 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> <p>See page 33 for additional information about Prescription Drugs.</p>	<p>of-pocket costs for the year.</p> <p>Specialty - Generic and Brand -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 PersonalCare Advantra Silver for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to PersonalCare Advantra Silver so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage 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: - 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> <p>See page 33 for additional information about Prescription Drugs.</p>
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<p>30 - Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$20 copay for Medicare-covered dental benefits.</p> <ul style="list-style-type: none"> - 50% of the cost for up to 2 oral exam(s) every year - 50% of the cost for up to 2 cleaning(s) every year - 50% of the cost for up to 1 dental x-ray visit(s) every year <p>Out-of-Network 20% of the cost for comprehensive dental benefits.</p> <p>In and Out-of-Network \$500 limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.</p> <p>See page 32 for additional information about Dental Services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered dental benefits.</p> <ul style="list-style-type: none"> - 50% of the cost for up to 2 oral exam(s) every year - 50% of the cost for up to 2 cleaning(s) every year - 50% of the cost for up to 1 dental x-ray visit(s) every year <p>Out-of-Network 20% of the cost for comprehensive dental benefits.</p> <p>In and Out-of-Network \$500 limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.</p> <p>See page 32 for additional information about Dental Services.</p>
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<p>31 - Hearing Services</p>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network \$0 copay for up to 1 hearing aid(s) every three years.</p> <p>- \$20 copay for Medicare-covered diagnostic hearing exams</p> <p>- \$20 copay for up to 1 routine hearing test(s) every year</p> <p>\$500 limit for hearing aids every three years.</p> <p>Out-of-Network 20% of the cost for hearing exams.</p> <p>See page 32 for additional information about Hearing Services.</p>	<p>In-Network Hearing aids not covered.</p> <p>- \$30 copay for Medicare-covered diagnostic hearing exams</p> <p>- \$30 copay for up to 1 routine hearing test(s) every year</p> <p>Out-of-Network 20% of the cost for hearing exams.</p> <p>See page 32 for additional information about Hearing Services.</p>
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<p>32 - Vision Services</p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network \$0 copay for - one pair of eyeglasses or contact lenses after cataract surgery</p> <p>- up to 1 pair(s) of contacts every year</p> <p>- up to 1 pair(s) of lenses every year</p> <p>- \$20 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>- \$20 copay for up to 1 routine eye exam(s) every year</p> <p>\$100 limit for eye wear every year</p> <p>Out-of-Network 20% of the cost for eye exams.</p> <p>20% of the cost for eye wear.</p> <p>See page 32 for additional information about Vision Services.</p>	<p>In-Network \$0 copay for - one pair of eyeglasses or contact lenses after cataract surgery</p> <p>- \$30 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>- \$30 copay for up to 1 routine eye exam(s) every year</p> <p>Out-of-Network 20% of the cost for eye exams.</p> <p>20% of the cost for eye wear.</p> <p>See page 32 for additional information about Vision Services.</p>
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33 - Physical Exams	20% coinsurance for one exam within the first 6 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 \$10 copay for routine exams. Limited to 1 exam(s) every year. \$10 copay for Medicare-covered benefits. Out-of-Network 20% of the cost for routine exams.	In-Network \$15 copay for routine exams. Limited to 1 exam(s) every year. \$15 copay for Medicare-covered benefits. Out-of-Network 20% of the cost for routine exams.
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 may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	In-Network This plan covers the following health/wellness education benefits: - Written health education materials, including Newsletters - Health Club Membership/Fitness Classes See page 32 for additional information about Health/Wellness Education.	In-Network This plan covers the following health/wellness education benefits: - Written health education materials, including Newsletters - Health Club Membership/Fitness Classes See page 32 for additional information about Health/Wellness Education.
Transportation (Routine)	Not covered.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.
Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.	In-Network This plan does not cover Acupuncture.

SECTION 3 – PLAN SPECIFIC FEATURES

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1- PREMIUMS AND OTHER IMPORTANT INFORMATION

In PersonalCare Advantra Gold and Silver, there is a \$1500 copayment for transplants, in addition to all applicable copays. Transplants are covered only when performed at an Advantra Contracted Provider Hospital that has been approved by Medicare for this procedure. Determinations of Medical Necessity shall take into account the proposed Medicare approved procedure's stability for the potential Member recipient and availability of Medicare approved facilities for performing such procedures.

Mental Health Services: Mental Health Services require prior authorization from Mental Health Network (MH Net). Except in emergency, you must obtain authorization from MH Net, before you get this service. Failure to obtain authorization can result in significantly higher cost to you. Contact Mental Health Network (MH Net) for details at 1-800-423-8070 (TTY; 1-800-955-8771). MH Net is available to help you 24 hours a day, seven days a week.

Worldwide Emergent/Urgent Benefit

Under traditional Medicare, you are not always covered for medical emergencies or urgent care outside the United States. As a PersonalCare Advantra member, you will enjoy enhanced emergency and urgent care benefits. If you are traveling outside of the service area, or even outside of the United States, you will receive in-network benefits for covered emergency services and urgent care. Simply get the medical attention you need, and submit a claim to PersonalCare Advantra when you return from your trip.

For further information of what constitutes a medical emergency and/or urgent care, please see your Evidence of Coverage.

Authorizations

Prior authorization is the process for authorizing the non-emergency use of facilities, diagnostic testing, and other health services before care is provided. Please contact the plan for specific services that may require prior authorization before seeking treatment.

4 & 11 - INPATIENT AND OUTPATIENT MENTAL HEALTH SERVICES

The following services have a 20% Coinsurance when care is received Out-of-Network and require prior authorization from MH Net:

- Partial Hospitalization
- Mental Health Specialty Services – Non-Psychiatric
- Psychiatric Services
- Outpatient Substance Abuse Services

An in-network outpatient surgery/services copayment will apply to partial hospitalizations if admitted for surgical procedures.

A \$50 emergency room copayment will apply for partial hospitalizations if admitted through the emergency room.

SECTION 3 – PLAN SPECIFIC FEATURES

Advantra Gold and Advantra Silver
January 1, 2009 – December 31, 2009

30 - DENTAL SERVICES

With PersonalCare Advantra you have an important benefit to help you keep your teeth healthy, including at no additional cost to you an annual schedule of dental exams, cleanings and x-rays. Dental Service copayments do not apply toward your yearly out-of-pocket maximum. Use a participating dentist for the lowest cost to you. Call Coventry Dental Member Services at 1-866-690-4910 (TDD: 1-866-690-4912) or through our website at www.cvtydental.com if you need more information about your dental benefit.

20 - DIABETES SERVICES

Office visit copayments will apply when you are treated for illnesses that are not related to your preventive care during the same visit. Applicable coinsurance will be charged for diabetic supplies (i.e. test strips, lancets). A free blood glucose monitor can be provided by PersonalCare Advantra upon request.

31 & 32 - HEARING AND VISION SERVICES

Copays for Vision and Hearing Services do not apply toward your yearly out-of-pocket maximum.

24 - IMMUNIZATIONS

Office visit copayments will apply when you are treated for illnesses that are not related to your preventive care during the same visit. Zostavax, the vaccine for shingles prevention, is a Medicare Part D covered medication for PersonalCare Advantra Medicare members per the Centers for Medicare and Medicaid Services (CMS) guidelines. This means that it is covered under your pharmacy benefit. The coverage is explained under Tier 3 of PersonalCare's Medicare formularies for members age 60 and older. As part of the pharmacy benefit, members should obtain the vaccine from a PersonalCare Advantra participating Part D pharmacy provider.

HEALTH/WELLNESS – ADVANTRA FOREVER FIT

Your Advantra plan includes a health club membership at participating Advantra Forever Fit fitness centers. Membership at participating fitness centers includes gyms, exercise facilities and fitness centers that provide access to conventional and state-of-the-art exercise equipment. Membership privileges include all amenities, programs and services that are associated with membership at each fitness center, including any exercise or recreation program or class that is included as part of the monthly fitness center membership.

13 - OUTPATIENT SERVICES/SURGERY

The copayment only applies to surgical procedures performed in outpatient hospital facilities and outpatient ambulatory surgical centers.

SECTION 3 – PLAN SPECIFIC FEATURES

Advantra Gold and Advantra Silver
January 1, 2009 – December 31, 2009

29 - PRESCRIPTION DRUGS

In-Network Pharmacies

When you enroll in PersonalCare Advantra Gold or Advantra Silver plan you will have access to over 60,000 in-network pharmacies nationwide whether you are home or traveling. You must go to certain pharmacies for a very limited number of drugs, due to the special handling requirements of these drugs. These drugs are listed on our plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov.

Mail Order

You can further reduce your overall medical expenses and make fewer trips to the drug store with our expedient mail order service. You have the opportunity to pay only two copayments for a three-month supply on select preferred generics and preferred brand drugs and the convenience of having your medications delivered right to your door. Or, if you prefer, you may continue to fill prescriptions for maintenance medications at your local in-network pharmacy.

Over-the-Counter Medications

PersonalCare Advantra Gold and Advantra Silver offer certain over-the-counter medications to you at no cost as part of its utilization management program, however, a prescription from your physician is still necessary. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Some over-the-counter drugs do not count towards your out-of-pocket expenditure. In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs.

The Over-the-Counter Medications we cover as part of Step Therapy are listed below. The quantity and days supply limits may apply to the medications on this list.

Drug Name	Type	Strength
Loratadine	Tablets	10mg
Loratadine	Dissolve Tablets	10mg
Loratadine	Syrup	5mg/5 ml
Loratadine and Pseudoephedrine Sulfate	12 Hour Tablets	5mg/120mg,
Loratadine and Pseudoephedrine Sulfate	24 Hour Tablets	10mg/240mg
Cetirizine	Tablets	5mg
Cetirizine	Tablets	10 mg
Cetirizine	Syrup	1 mg/ml
Cetirizine HCL and Pseudoephedrine Hydrochloride	12 Hour Tablets	5 mg/120 mg
Prilosec OTC	Tablets	20 mg

Excluded Drugs – What Advantra Does Cover

PersonalCare Advantra Gold and Advantra Silver cover some typically excluded Medicare Part D drugs. The quantity and days supply limits may apply to the medications on this list. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drug.

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Drug Name	Type	Strength
Alprazolam	Tablets	0.25 mg; 0.5 mg ; 1 mg; 2 mg
Lorazepam	Tablets	0.5 mg; 1 mg; 2 mg
Temazepam	Tablets	15mg; 30 mg
Clonazepam	Tablets	0.5 mg; 1 mg; 2 mg
Folic Acid	Tablet	1 mg
Levitra	Tablets	2.5 mg; 5 mg; 10 mg; 20 mg
Phenobarbital	Tablets	15 mg; 16.2 mg; 30 mg; 32.4 mg; 60 mg; 97.2 mg; 100 mg

Formulary

PersonalCare Advantra Gold and Advantra Silver prescription drug plans use a drug formulary which is a list of preferred or recommended drugs that have been selected by our physicians and pharmacists based upon the safety, efficacy and cost of those drugs.

The formulary is a comprehensive list of medications used by physicians to guide their medication prescribing decisions. The formulary includes FDA-approved brand name and generic drugs.

Special Requirements on Medications

Some covered drugs may have additional requirements or limits on coverage. You can find out if your drug has any additional requirements or limits by looking in the PersonalCare Advantra Gold and Advantra Silver Formulary. These additional requirements or limits may include:

- **Prior Authorization:** PersonalCare Advantra Gold and Advantra Silver requires you or your physician to get prior authorization before you fill your prescriptions.
- **Quantity Limits:** For certain drugs, PersonalCare Advantra Gold and Advantra Silver limits the amount of the drug that it will cover.
- **Step Therapy:** In some cases, PersonalCare Advantra Gold and Advantra Silver requires that you first try certain drugs to treat your medical condition before we will cover another drug for that condition.
- **90 DAY Maintenance Supply:** PersonalCare Advantra Gold and Advantra Silver allows these medications for an extended supply up to 90 days.

For More Information

If you have any questions, please contact us at (800)-707-9372 (TTY/TDD 1-866-236-1069) 24 hours a day, seven days a week, or visit our website at www.pcadvantra.com.

For more information about Medicare, please call Medicare at 1.800.MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, seven days a week. Or, visit www.medicare.gov.

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

PersonalCare Insurance of Illinois, is a PPO plan with a Medicare contract.