

# 2009

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## SUMMARY OF BENEFITS

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### Group Health Plan Gold Advantage Option 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.

H2663\_SOB\_09010

CMS Approval Date: 9/17/08



## Section 1- INTRODUCTION TO SUMMARY OF BENEFITS



Gold Advantage Options 1 & 2

January 1, 2009 – December 31, 2009

Thank you for your interest in Gold Advantage Options 1 & 2. Our plan is offered by Group Health Plan, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. 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 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 Gold Advantage Options 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 Gold Advantage Options 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 Gold Advantage Options 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, Callaway, Miller, Moniteau, Montgomery Counties, MO. You must live in one of these areas to join the plan.

### WHO IS ELIGIBLE TO JOIN GOLD ADVANTAGE OPTIONS 1 & 2?

You can join Gold Advantage Options 1 & 2 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 Gold Advantage Options 1 & 2 unless they are members of our organization and have been since their dialysis began.

### CAN I CHOOSE MY DOCTORS?

Gold Advantage Options 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 [www.advantraplans.com](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 Gold Advantage Options 1 & 2 nor the Original Medicare Plan will pay for these services.

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

Gold Advantage Options 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?

Gold Advantage Options 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 [www.advantraplans.com](http://www.advantraplans.com). Our customer service number is listed at the end of this introduction.

### **WHAT IS A PRESCRIPTION DRUG FORMULARY?**

Gold Advantage Options 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 [www.advantraplans.com](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 Gold Advantage Options 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 Gold Advantage Options 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
- 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 Gold Advantage Options 1 & 2.

Visit us at [www.advantraplans.com](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 [www.medicare.gov](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	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
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**IMPORTANT INFORMATION**

<p>1 - Premium and Other Important Information</p>	<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><b>General</b></p> <p>\$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p><b>In-Network</b></p> <p>\$2,800 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"> <li>- Inpatient Hospital Care</li> <li>- Skilled Nursing Facility</li> <li>- Outpatient Services/Surgery</li> <li>- Ambulance Services</li> <li>- Emergency Care</li> <li>- Urgently Needed Care</li> <li>- Outpatient Rehabilitation Services</li> <li>- Durable Medical Equipment</li> <li>- Prosthetic Devices</li> <li>- Diagnostic Tests, X-Rays and Lab Services</li> <li>- Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>- Cardiac Rehabilitation Services</li> <li>- Renal Dialysis</li> </ul>	<p><b>General</b></p> <p>\$44 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p><b>In-Network</b></p> <p>\$1,800 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"> <li>- Inpatient Hospital Care</li> <li>- Skilled Nursing Facility</li> <li>- Outpatient Services/Surgery</li> <li>- Ambulance Services</li> <li>- Emergency Care</li> <li>- Urgently Needed Care</li> <li>- Outpatient Rehabilitation Services</li> <li>- Durable Medical Equipment</li> <li>- Prosthetic Devices</li> <li>- Diagnostic Tests, X-Rays and Lab Services</li> <li>- Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>- Cardiac Rehabilitation Services</li> <li>- Renal Dialysis.</li> </ul>
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Section 2 Summary of Benefits			
Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
		Contact plan for a detailed list of non-covered services.	
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.	<b>In-network</b>  You must go to network doctors, specialists, and hospitals.  Referral required for network hospitals and specialists (for certain benefits).  You may have to pay a separate copay for certain doctor office visits.	<b>In-network</b>  You must go to network doctors, specialists, and hospitals.  Referral required for network hospitals and specialists (for certain benefits).  You may have to pay a separate copay for certain doctor office visits.

## SUMMARY OF BENEFITS

### INPATIENT CARE

3 - Inpatient Hospital Care  (includes Substance Abuse and Rehabilitation Services)	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.  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	<b>In-Network</b>  For Medicare-covered hospital stays:  Days 1 - 7: \$285 copay per day.  Days 8 - 90: \$0 copay per day.  \$0 copay for additional hospital days.  \$1,995 out of pocket limit every stay.  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.	<b>In-Network</b>  For Medicare-covered hospital stays:  Days 1 - 6: \$260 copay per day  Days 7 - 90: \$0 copay per day  \$0 copay for additional hospital days  \$1,560 out of pocket limit every stay.  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.
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Section 2 Summary of Benefits			
Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
	benefit period. There is no limit to the number of 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><b>In-Network</b></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><b>In-Network</b></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</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></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><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>For SNF stays:</p> <p>Days 1 - 5: \$0 copay per day</p> <p>Days 6 - 23: \$100 copay per day</p> <p>Days 24 - 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>

<b>Section 2 Summary of Benefits</b>			
<b>Benefit</b>	<b>Original Medicare</b>	<b>Gold Advantage Option 1 PBP 005</b>	<b>Gold Advantage Option 2 PBP 007</b>
	periods you can have.		
6 - Home Health Care  (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	<b>General</b>  Authorization rules may apply. <b>In-Network</b>  \$0 copay for Medicare-covered home health visits.	<b>General</b>  Authorization rules may apply. <b>In-Network</b>  \$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.	<b>General</b>  You must get care from a Medicare-certified hospice.	<b>General</b>  You must get care from a Medicare-certified hospice.
<b>OUTPATIENT CARE</b>			
8 - Doctor Office Visits	20% coinsurance	<b>General</b>  See "Physical Exams," for more information.  Authorization rules may apply. <b>In-Network</b>  \$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.*  \$30 copay for each specialist visit for Medicare-covered benefits.	<b>General</b>  See "Physical Exams," for more information.  Authorization rules may apply. <b>In-Network</b>  \$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*  \$25 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	<b>General</b>  Authorization rules may apply. <b>In-Network</b>  \$30 copay for Medicare-covered visits.	<b>General</b>  Authorization rules may apply. <b>In-Network</b>  \$25 copay for Medicare-covered visits.

Section 2 Summary of Benefits			
Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
	qualified providers.	Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.	Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or 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.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$30 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.
11 - Outpatient Mental Health Care	50% coinsurance for most outpatient mental health services.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$30 copay for each Medicare-covered individual therapy visit. \$20 copay for each Medicare-covered group therapy visit.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$30 copay for Medicare-covered individual therapy visit. \$20 copay for Medicare-covered group therapy visit.
12 - Outpatient Substance Abuse Care	20% coinsurance	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$30 copay for each Medicare-covered individual therapy visit. \$20 copay for each Medicare-covered group therapy visit.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$30 copay for each Medicare-covered individual therapy visit. \$20 copay for each Medicare-covered group therapy visit.

Section 2 Summary of Benefits			
Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
13 - Outpatient Services/Surgery	20% coinsurance for the doctor  20% of outpatient facility charges	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$150 copay for each Medicare-covered ambulatory surgical center visit. \$250 copay or 20% of the cost for each Medicare-covered outpatient hospital facility visit.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$150 copay for each Medicare-covered ambulatory surgical center visit. \$200 copay or 20% of the cost for each Medicare-covered outpatient hospital facility visit.
14 - Ambulance Services  (medically necessary ambulance services)	20% coinsurance	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$150 copay for Medicare-covered ambulance benefits.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$150 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.	<b>In-Network</b> \$50 copay for Medicare-covered emergency room visits. <b>Out-of-Network</b> Worldwide coverage. <b>In and Out-of-Network</b> If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.	<b>In-Network</b> \$50 copay for Medicare-covered emergency room visits. <b>Out-of-Network</b> Worldwide coverage. <b>In and Out-of-Network</b> 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	20% coinsurance, or a set copay  NOT covered outside the	<b>General</b> \$25 copay for Medicare-covered urgently needed	<b>General</b> \$25 copay for Medicare-covered urgently needed

<b>Section 2 Summary of Benefits</b>			
<b>Benefit</b>	<b>Original Medicare</b>	<b>Gold Advantage Option 1 PBP 005</b>	<b>Gold Advantage Option 2 PBP 007</b>
out of the service area.)	U.S. except under limited circumstances.	care visits.	care visits.
17 - Outpatient Rehabilitation Services  (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	<b>General</b> Authorization rules may apply. <b>In-Network</b> 20% of the cost for Medicare-covered Occupational Therapy visits. 20% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.	<b>General</b> Authorization rules may apply. <b>In-Network</b> 15% of the cost for Medicare-covered Occupational Therapy visits. 15% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>			
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	<b>General</b> Authorization rules may apply. <b>In-Network</b> 20% of the cost for Medicare-covered items.	<b>General</b> Authorization rules may apply. <b>In-Network</b> 20% of the cost for Medicare-covered items.
19 - Prosthetic Devices  (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	<b>General</b> Authorization rules may apply. <b>In-Network</b> 20% of the cost for Medicare-covered items.	<b>General</b> Authorization rules may apply. <b>In-Network</b> 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	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition

Section 2 Summary of Benefits			
Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
	by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	Therapy for Diabetes. 20% of the cost for Diabetes supplies.	Therapy for Diabetes. 20% of the cost 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  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.	<b>General</b> Authorization rules may apply. <b>In-Network</b> 0% of the cost for Medicare-covered lab services. 20% of the cost for Medicare-covered diagnostic procedures and tests. \$15 copay for Medicare-covered X-rays. 20% of the cost for Medicare-covered diagnostic radiology services. 20% of the cost for Medicare-covered therapeutic radiology services.	<b>General</b> Authorization rules may apply. <b>In-Network</b> 0% of the cost for Medicare-covered lab services. 20% of the cost for Medicare-covered diagnostic procedures and tests. \$15 copay for Medicare-covered X-rays. 20% of the cost for Medicare-covered diagnostic radiology services. 20% of the cost for Medicare-covered therapeutic radiology services.
<b>PREVENTIVE CARE</b>			
22 - Bone Mass Measurement  (for people with Medicare who are at risk)	20% coinsurance  Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement.
23 - Colorectal Screening Exams  (for people with Medicare)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	<b>General</b> Authorization rules may apply.	<b>General</b> Authorization rules may apply.

<b>Section 2 Summary of Benefits</b>			
<b>Benefit</b>	<b>Original Medicare</b>	<b>Gold Advantage Option 1 PBP 005</b>	<b>Gold Advantage Option 2 PBP 007</b>
age 50 and older)		<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.	<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.
24 - Immunizations  (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines  20% coinsurance for Hepatitis B vaccine  You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay 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.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered screening mammograms.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$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	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams.	<b>General</b> Authorization rules may apply. <b>In-Network</b> \$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	<b>General</b> Authorization rules may apply. <b>In-Network</b>	<b>General</b> Authorization rules may apply. <b>In-Network</b>

<b>Section 2 Summary of Benefits</b>			
<b>Benefit</b>	<b>Original Medicare</b>	<b>Gold Advantage Option 1 PBP 005</b>	<b>Gold Advantage Option 2 PBP 007</b>
	<p>services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	\$0 copay for Medicare-covered prostate cancer screening.	\$0 copay for Medicare-covered prostate cancer screening.
28 - End-Stage Renal Disease	<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><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>20% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>20% of the cost for renal dialysis</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal 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><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b></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><b>Drugs Covered under Medicare Part D</b></p>	<p><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b></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><b>Drugs Covered under Medicare Part D</b></p>

**Section 2 Summary of Benefits**

Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
		<p><b>General</b></p> <p>This plan uses a formulary.</p> <p>The plan will send you the formulary. You can also see the formulary at <a href="http://www.ghpmedicare.com">www.ghpmedicare.com</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>-have limited incomes,</li> <li>-live in long term care facilities, or</li> <li>-have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <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</p>	<p><b>General</b></p> <p>This plan uses a formulary.</p> <p>The plan will send you the formulary. You can also see the formulary at <a href="http://www.ghpmedicare.com">www.ghpmedicare.com</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>-have limited incomes,</li> <li>-live in long term care facilities, or</li> <li>-have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <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</p>

**Section 2 Summary of Benefits**

Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
		<p>condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Gold Advantage Option 1 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 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>condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Gold Advantage Option 2 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 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>

**Section 2 Summary of Benefits**

Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
		<p><b>In-Network</b></p> <p>\$0 deductible.</p> <p><b>Initial Coverage</b></p> <p>You pay the following until total yearly drug costs reach \$2,700:</p> <p><b>Retail Pharmacy</b></p> <p>Preferred Generic</p> <ul style="list-style-type: none"> <li>- \$2 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$4 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p>Preferred Brand</p> <ul style="list-style-type: none"> <li>- \$34 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$68 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> <li>- \$70 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$210 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul>	<p><b>In-Network</b></p> <p>\$0 deductible.</p> <p><b>Initial Coverage</b></p> <p>You pay the following until total yearly drug costs reach \$2,700:</p> <p><b>Retail Pharmacy</b></p> <p>Preferred Generic</p> <ul style="list-style-type: none"> <li>- \$2 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$4 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p>Preferred Brand</p> <ul style="list-style-type: none"> <li>- \$34 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$68 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> <li>- \$70 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$210 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul>

**Section 2 Summary of Benefits**

Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
		<p>Specialty</p> <p>- 30% coinsurance for a one-month (30-day) supply of drugs in this tier.</p> <p><b>Long Term Care Pharmacy</b></p> <p>Preferred Generic</p> <p>- \$2 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Preferred Brand</p> <p>- \$34 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><b>Mail Order</b></p> <p>Preferred Generic</p> <p>- \$4 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Preferred Brand</p>	<p>Specialty</p> <p>- 30% coinsurance for a one-month (30-day) supply of drugs in this tier.</p> <p><b>Long Term Care Pharmacy</b></p> <p>Preferred Generic</p> <p>- \$2 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Preferred Brand</p> <p>- \$34 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><b>Mail Order</b></p> <p>Preferred Generic</p> <p>- \$4 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	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
		<p>- \$68 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><b>Coverage Gap</b></p> <p>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><b>Catastrophic Coverage</b></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><b>Out-of-Network</b></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</p>	<p>- \$68 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><b>Coverage Gap</b></p> <p>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><b>Catastrophic Coverage</b></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><b>Out-of-Network</b></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</p>

**Section 2 Summary of Benefits**

Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
		<p>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 Gold Advantage Option 1.</p> <p><b>Out-of-Network Initial Coverage</b></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><b>Out-of-Network Pharmacy</b></p> <p>Preferred Generic</p> <p>- \$2 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Preferred Brand</p> <p>- \$34 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>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 Gold Advantage Option 2.</p> <p><b>Out-of-Network Initial Coverage</b></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><b>Out-of-Network Pharmacy</b></p> <p>Preferred Generic</p> <p>- \$2 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>Preferred Brand</p> <p>- \$34 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>

**Section 2 Summary of Benefits**

Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
		<p>Specialty</p> <p>- 30% coinsurance for a one-month (30-day) supply of drugs in this tier.</p> <p><b>Out-of-Network Coverage Gap</b></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 Gold Advantage Option 1 for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Gold Advantage Option 1 so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Out-of-Network Catastrophic Coverage</b></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> <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>Specialty</p> <p>- 30% coinsurance for a one-month (30-day) supply of drugs in this tier.</p> <p><b>Out-of-Network Coverage Gap</b></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 Gold Advantage Option 2 for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Gold, Advantage Option 2 so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Out-of-Network Catastrophic Coverage</b></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> <p>- A \$ 2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or</p>

Section 2 Summary of Benefits			
Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
		- 5% coinsurance.	5% coinsurance.
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p><b>In-Network</b></p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>- up to 1 oral exam(s) every six months.</li> <li>- up to 1 cleaning(s) every six months.</li> <li>- up to 1 dental x-ray(s) every year.</li> </ul> <p>\$30 copay for Medicare-covered dental benefits.</p> <p>\$500 limit for dental benefits every year.</p> <p><b>Out-Of-Network</b></p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>- up to 1 oral exam(s) every six months.</li> <li>- up to 1 cleaning(s) every six months.</li> <li>- up to 1 dental x-ray(s) every year.</li> </ul> <p>\$500 limit for dental benefits every year.</p>	<p><b>In-Network</b></p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>- up to 1 oral exam(s) every six months.</li> <li>- up to 1 cleaning(s) every six months.</li> <li>- up to 1 dental x-ray(s) every year.</li> </ul> <p>\$25 copay for Medicare-covered dental benefits.</p> <p>\$500 limit for dental benefits every year.</p> <p><b>Out-Of-Network</b></p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>- up to 1 oral exam(s) every six months.</li> <li>- up to 1 cleaning(s) every six months.</li> <li>- up to 1 dental x-ray(s) every year.</li> </ul> <p>\$500 limit for dental benefits every year.</p>
31 - Hearing Services	Routine hearing exams and hearing aids not covered.  20% coinsurance for diagnostic hearing exams.	<p><b>General</b></p> <p>Authorization rules may apply.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p>

Section 2 Summary of Benefits			
Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
		<p><b>In-Network</b></p> <p>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><b>In-Network</b></p> <p>Hearing aids not covered.</p> <p>- \$25 copay for Medicare-covered diagnostic hearing exams.</p> <p>- \$25 copay for up to 1 routine hearing test(s) every year.</p>
32 - Vision Services	<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><b>In-Network</b></p> <p>- \$15 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>- \$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>- \$25 copay for up to 1 routine eye exam(s) every year.</p> <p>- \$15 copay for up to 1 pair(s) of glasses every two years.</p>	<p><b>In-Network</b></p> <p>- \$15 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>- \$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>- \$25 copay for up to 1 routine eye exam(s) every year.</p> <p>- \$15 copay for up to 1 pair(s) of glasses every two years.</p>
33 - Physical Exams	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage</p> <p>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.</p>	<p><b>In-Network</b></p> <p>\$10 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$10 copay for Medicare-covered benefits.</p>	<p><b>In-Network</b></p> <p>\$10 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$10 copay for Medicare-covered benefits.</p>
Health/Wellness Education	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a</p>	<p><b>General</b></p> <p>Authorization rules may</p>	<p><b>General</b></p> <p>Authorization rules may</p>

Section 2 Summary of Benefits			
Benefit	Original Medicare	Gold Advantage Option 1 PBP 005	Gold Advantage Option 2 PBP 007
	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.	<p>apply.</p> <p><b>In-Network</b></p> <p>This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletters</li> <li>- Health Club Membership/Fitness Classes</li> </ul>	<p>apply.</p> <p><b>In-Network</b></p> <p>This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletters</li> </ul>
Transportation (Routine)	Not covered.	<p><b>In-Network</b></p> <p>\$0 copay for up to 24 one-way trip(s) to plan-approved location every year.</p>	<p><b>In-Network</b></p> <p>\$0 copay for up to 24 one-way trip(s) to plan-approved location every year.</p>
Acupuncture	Not covered.	<p><b>In-Network</b></p> <p>This plan does not cover Acupuncture.</p>	<p><b>In-Network</b></p> <p>This plan does not cover Acupuncture.</p>









