

2009

SUMMARY OF BENEFITS

Advantra
Iowa

Advantra Silver (H1609-001)
Advantra Gold (H1609-003)
Advantra Platinum PPO (H1608-001)
Advantra Platinum Plus PPO (H1608-002)



SECTION 1 – INTRODUCTION TO SUMMARY OF BENEFITS

Advantra

January 1, 2009 – December 31, 2009

Thank you for your interest in Advantra. Our plan is offered by Coventry Health Care of Iowa, Inc., a Medicare Advantage Health Maintenance Organization (HMO) and Coventry Health and Life Insurance Company, a Medicare Advantage Preferred Provider Organization. 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 Advantra 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 Advantra. 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 Advantra 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 Advantra 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 ADVANTRA 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: Black Hawk, Bremer, Buchanan, Butler, Cedar, Dallas, Delaware, Fayette, Grundy, Jasper, Johnson, Jones, Linn, Madison, Marion, Monroe, Muscatine, Plymouth, Polk, Scott, Warren, Washington, Winneshiek, Woodbury,

Wright Counties, IA. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN ADVANTRA?

You can join Advantra 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 Advantra unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

For Advantra Silver and Advantra Gold: 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. Our customer service number is listed at the end of this introduction.

For Advantra Platinum PPO and Advantra Platinum Plus PPO: has 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.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?

For Advantra Silver and Advantra Gold: If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Advantra nor the Original Medicare Plan will pay for these services.

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For Advantra Platinum PPO and Advantra Platinum Plus PPO: 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?

Advantra 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?

Advantra 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.ia.chcadvantra.com. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Advantra 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.

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 Advantra, 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 Advantra, 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

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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 Advantra 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 Advantra 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.

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Please call Coventry Health Care for more information about Advantra.

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

Customer Service Hours:

Members

November 15, 2008 - March 1, 2009

Monday – Friday, 8:00 a.m. – 8:00 p.m. Central Time, and Saturday, 9:00 a.m. – 3:00 p.m. Central Time

March 2, 2009 – November 14, 2009

Monday – Friday, 8:00 a.m. – 6:00 p.m. Central Time

Toll-free: 1-866-901-4692

TTY/TDD: 1-877-231-0573

Prospective Members

October 1, 2008 – March 15, 2009

8:00 a.m. – 11:00 p.m. local time, seven (7) days a week

March 16 – September 30, 2009

8:00 a.m. – 5:00 p.m. Monday – Friday

Toll-free: 1-866-983-7845

TTY/TDD: 1-888-788-4010

Medicare Prescription Drug (Part D)

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

Current Members should call toll-free 1-866-294-1211

TTY/TDD 1-800-716-3231

Prospective Members should call toll-free 1-866-983-7845

TTY/TDD 1-888-788-4010

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 Coventry Health Care of Iowa for details.

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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 \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$1,700 in-network out-of-pocket limit. Not all plan services are covered under the out-of-pocket limit. Contact plan for a listing of non-covered services.</p>	<p>General \$65 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$1,000 yearly deductible.</p> <p>Contact the plan for services that apply.</p>	<p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$2,000 in-network out-of-pocket limit.</p> <p>Not all plan services are covered under the out-of-pocket limit. Contact plan for a detailed list of non-covered services.</p> <p>Out-of-Network \$5,000 out-of-network out-of-pocket limit.</p> <p>Not all plan services are covered under the out-of-pocket limit.</p>	<p>General \$49 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$2,000 in-network out-of-pocket limit.</p> <p>Not all plan services are covered under the out-of-pocket limit. Contact plan for a detailed list of non-covered services.</p> <p>Out-of-Network \$5,000 out-of-network out-of-pocket limit.</p> <p>Not all plan services are covered under the out-of-pocket limit.</p>

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Advantira
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1 - Premium and Other Important Information				Contact plan for a detailed list of non-covered services.	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.	In-Network 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.	In-Network You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.	In-Network No referral required for network doctors, specialists, and hospitals. You may have to pay a separate copay for certain doctor office visits.	In-Network No referral required for network doctors, specialists, and hospitals.

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INPATIENT CARE					
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2008 the amounts for each benefit period were: Days 1 - 60: \$1024 deductible Days 61 - 90: \$256 per day Days 91 - 150: \$512 per lifetime reserve day. These amounts will change for 2009. 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	In-Network For Medicare-covered hospital stays: Days 1 – 9: \$150 copay per day Days 10 – 90: \$0 per day \$0 copay for additional hospital days 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.	In-Network \$0 copay 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.	In-Network \$600 copay for each medicare-covered hospital stay \$0 copay for additional hospital days 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.	In-Network \$250 copay for each Medicare-covered hospital stay \$0 copay for additional hospital Days 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.
				Out-of-Network For hospital stays: Days 1 and beyond: 20% of the cost per day	Out-of-Network For hospital stays: Days 1 and beyond: 10% of the cost per day

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3 - Inpatient Hospital Care	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>In-Network For hospital stays: Days 1 – 9: \$150 copay per day Days 10 – 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>In-Network \$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network \$600 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 For hospital stays: Days 1 and beyond: 20% of the cost per day</p>	<p>In-Network \$250 copay for each Medicare-covered hospital stay.</p> <p>\$0 copay for additional hospital days</p> <p>Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days.</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 For hospital stays: Days 1 and beyond: 10% of the cost per day</p>

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<p>5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>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.</p> <p>100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: Days 1 – 6: \$0 copay per day Days 7 – 22: \$75 copay per day Days 23 – 100: \$0 copay per day</p> <p>Plan covers up to 100 days each benefit period No prior hospital stay is required.</p>	<p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: \$0 copay for SNF services</p> <p>Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p>	<p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: Days 1 – 6: \$0 copay per day Days 7 – 26: \$75 copay per day Days 27 – 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>Out-of-Network For each SNF stay: 20% of the cost per SNF day.</p>	<p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: Days 1 – 15: \$0 copay per day Days 16-36: \$100 per day Days 37 – 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>Out-of-Network For each SNF stay: 10% of the cost per SNF day.</p>

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6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits.	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 10% for home health visits.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.
OUTPATIENT CARE					
8 - Doctor Office Visits	20% coinsurance	General See "Physical Exams," for more information. Authorization rules may apply.	General See "Physical Exams," for more information. Authorization rules may apply.	General See "Physical Exams," for more information.	General See "Physical Exams," for more information.

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8 - Doctor Office Visits		<p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$50 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>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits</p> <p>\$0 copay for the cost of each in-area, network urgent care Medicare-covered visit*</p> <p>\$0 copay for each specialist doctor visit for Medicare-covered benefits.</p>	<p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$50 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.</p> <p>20% for each specialist visit.</p>	<p>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits</p> <p>\$50 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$0 copay for each specialist doctor visit for Medicare-covered benefits.</p> <p>Out-of-Network 10% for each primary care doctor visit.</p> <p>10% for each specialist visit.</p>

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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.	In-Network \$20 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.	In-Network \$0 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.	General Authorization rules may apply. In-Network \$20 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. Out-of-Network 20% of the cost for chiropractic benefits.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. Out-of-Network 10% of the cost for chiropractic benefits.
10 - Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	In-Network \$10 to \$30 copay for each Medicare-covered visit.	In-Network \$0 copay for Medicare-covered podiatry benefits.	General Authorization rules may apply. In-Network \$10 to \$30 copay for each Medicare-covered visit.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered podiatry benefits.

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10 - Podiatry Services		Medicare-covered podiatry benefits are for medically-necessary foot care.	Medicare-covered podiatry benefits are for medically-necessary foot care.	Medicare-covered podiatry benefits are for medically-necessary foot care. Out-of-Network 20% of the cost for podiatry benefits.	Medicare-covered podiatry benefits are for medically-necessary foot care. Out-of-Network 10% of the cost for podiatry benefits.
11 - Outpatient Mental Health Care	50% coinsurance for most outpatient mental health services.	General Authorization rules may apply. In-Network \$30 copay for each Medicare-covered individual therapy visit. \$10 copay for each Medicare-covered group therapy visit.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered Mental Health visits.	General Authorization rules may apply. In-Network \$30 copay for each Medicare-covered individual therapy visit. \$10 copay for each Medicare-covered group therapy visit. Out-of-Network 20% of the cost for Mental Health benefits. 20% of the cost for Mental Health benefits with a psychiatrist.	General Authorization rules may apply. In-Network \$10 copay for each Medicare-covered individual or group therapy visit. Out-of-Network 10% of the cost for Mental Health benefits. 10% of the cost for Mental Health benefits with a psychiatrist.

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12 - Outpatient Substance Abuse Care	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual visits. \$10 copay for Medicare-covered group visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual visits. \$10 copay for Medicare-covered 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 \$10 copay for Medicare-covered individual or group visits.</p> <p>Out-of-Network 10% of the cost for outpatient substance abuse benefits.</p>
13 - Outpatient Services/Surgery	<p>20% coinsurance for the doctor</p> <p>20% of outpatient facility charges</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$50 copay for each Medicare-covered ambulatory surgical center visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay for each Medicare-covered ambulatory surgical center visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay for each Medicare-covered ambulatory surgical center visit.</p>

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13 - Outpatient Services/Surgery		\$50 copay or 20% of the cost for each Medicare-covered outpatient hospital facility visit.	\$0 copay for each Medicare-covered outpatient hospital facility visit.	\$100 copay or 20% of the cost for each Medicare-covered outpatient hospital facility visit. Out-of-Network 20% of the cost for ambulatory surgical center benefits. 20% of the cost for outpatient hospital facility benefits.	\$100 copay or 10% of the cost for each Medicare-covered outpatient hospital facility visit. Out-of-Network 10% of the cost for ambulatory surgical center benefits. 10% of the cost for outpatient hospital facility benefits.
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	General Authorization rules may apply. In-Network \$115 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network \$150 copay for Medicare-covered ambulance benefits. Out-of-Network \$150 copay for ambulance benefits.	General Authorization rules may apply. In-Network \$150 copay for Medicare-covered ambulance benefits. Out-of-Network \$150 copay for ambulance benefits.

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<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</p> <p>20% of facility charge, or a set copay per emergency room visit</p> <p>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.</p> <p>Out-of-Network Worldwide coverage.</p> <p>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.</p> <p>See page 55 for additional information about Emergency Care Services.</p>	<p>In-Network \$0 copay for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p> <p>See page 55 for additional information about Emergency Care Services.</p>	<p>In-Network \$50 copay for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p> <p>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</p> <p>See page 55 for additional information about Emergency Care Services.</p>	<p>In-Network \$50 copay for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p> <p>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</p> <p>See page 55 for additional information about Emergency Care Services.</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</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$50 copay for Medicare-covered urgently needed care visits.</p>	<p>General \$0 copay for Medicare-covered urgent-care visits.</p>	<p>General \$50 copay for Medicare-covered urgently needed care visits.</p>	<p>General \$50 copay for Medicare-covered urgently needed care visits.</p>

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16 - Urgently Needed Care		See page 55 for additional information about Urgent Care Services.	See page 55 for additional information about Urgent Care Services.	See page 55 for additional information about Urgent Care Services.	See page 55 for additional information about Urgent Care Services.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p>Out-of-Network 20% of the cost for Occupational Therapy benefits.</p> <p>20% of the cost for</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$10 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p>Out-of-Network 10% of the cost for Occupational Therapy benefits.</p> <p>10% of the cost for</p>

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17 - Outpatient Rehabilitation Services				Physical and/or Speech/Language Therapy visits.	Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES					
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 30% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items.	General Authorization rules may apply. In-Network 30% of the cost for Medicare-covered items. Out-of-Network 30% of the cost for durable medical equipment.	General Authorization rules may apply. In-Network 10% of the cost for Medicare-covered items. Out-of-Network 10% of the cost for durable medical equipment.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 30% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items.	General Authorization rules may apply. In-Network 30% of the cost for Medicare-covered items. Out-of-Network 30% of the cost for prosthetic devices.	General Authorization rules may apply. In-Network 10% of the cost for Medicare-covered items. Out-of-Network 10% of the cost for prosthetic devices.

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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.</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 Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>0% to 10% of the cost for Diabetes supplies.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>0% to 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>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>0% to 10% of the cost for Diabetes supplies.</p> <p>Out-of-Network 10% of the cost for Diabetes self-monitoring training</p> <p>10% of the cost for Nutrition Therapy for Diabetes.</p> <p>10% of the cost for Diabetes supplies.</p>

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21 - Diagnostic Tests, X-Rays, and Lab Services	<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 0% of the cost for Medicare-covered lab services.</p> <p>20% of the cost for Medicare-covered diagnostic procedures and tests.</p> <p>0% of the cost for Medicare-covered X-rays.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> • lab services • diagnostic procedures and Tests • X-rays • diagnostic radiology services (not including X-rays) • therapeutic radiology services 	<p>General Authorization rules may apply.</p> <p>In-Network 0% of the cost for Medicare-covered lab services.</p> <p>0% of the cost for Medicare-covered diagnostic procedures and tests.</p> <p>0% of the cost for Medicare-covered X-rays.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% of the cost for Medicare-covered lab services.</p> <p>10% of the cost for Medicare-covered diagnostic procedures and tests.</p> <p>0% of the cost for Medicare-covered X-rays.</p> <p>10% of the cost for Medicare-covered diagnostic radiology services.</p> <p>10% of the cost for Medicare-covered therapeutic radiology services.</p>

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21 - Diagnostic Tests, X-Rays, and Lab Services				<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>Out-of-Network 10% of the cost for diagnostic procedures, tests, and lab services.</p> <p>10% of the cost for therapeutic radiology services</p> <p>10% of the cost for outpatient x-rays.</p> <p>10% of the cost for diagnostic radiology services</p>

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PREVENTIVE CARE					
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.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered bone mass measurement	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered bone mass measurement.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered bone mass measurement Out-of-Network 20% of the cost for Medicare-covered bone mass measurement.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered bone mass measurement Out-of-Network 10% of the cost for Medicare-covered bone mass measurement.
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	In-Network \$0 copay for Medicare-covered colorectal screenings.	In-Network \$0 copay for Medicare-covered colorectal screenings.	In-Network \$0 copay for Medicare-covered colorectal screenings. Out-of-Network 20% of the cost for colorectal screenings.	In-Network \$0 copay for Medicare-covered colorectal screenings. Out-of-Network 10% of the cost for colorectal screenings.

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<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</p> <p>\$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>In-Network</p> <p>\$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>In-Network</p> <p>\$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>In-Network</p> <p>\$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 10% of the cost for immunizations.</p>
<p>25 - Mammograms (Annual Screening)</p> <p>(for women with Medicare age 40 and older)</p>	<p>20% coinsurance</p> <p>No referral needed.</p> <p>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</p> <p>\$0 copay for Medicare-covered screening mammograms.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered screening mammograms.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered screening mammograms.</p> <p>Out-of-Network 20% of the cost for screening mammograms.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered screening mammograms.</p> <p>Out-of-Network 10% of the cost for screening mammograms.</p>

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<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 and - up to 1 additional pap smear(s) and pelvic exam(s) every Year</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams and - up to 1 additional pap smear (s) and pelvic exam(s) every year</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams and -up to 1 additional pap smear(s) and pelvic exam(s) every year Out-of-Network 0% of the cost for pap smears and pelvic exams.</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams and -up to 1 additional pap smear(s) and pelvic exam(s) every year Out-of-Network 10% 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.</p>	<p>In-Network \$0 copay for Medicare-covered 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>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening. Out-of-Network 10% of the cost for prostate cancer screening.</p>

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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>In-Network 20% of the cost for renal Dialysis</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease</p>	<p>In-Network \$0 copay for renal dialysis</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease</p>	<p>In-Network 20% of the cost 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>In-Network 10% of the cost for renal Dialysis</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease</p> <p>Out-of-Network 10% of the cost for renal dialysis.</p> <p>10% of the cost for Nutrition Therapy for End-Stage Renal Disease.</p>

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29 - Prescription Drugs	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>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.advantraplans.com on the web.</p>	<p>Drugs covered under Medicare Part B General 0% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>0% 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.advantraplans.com on the web.</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.advantraplans.com on the web.</p>	<p>Drugs covered under Medicare Part B General 10% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>10% 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.advantraplans.com on the web.</p>

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29 - Prescription Drugs		<p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, <p>or</p> <ul style="list-style-type: none"> • have access to Indian/Tribal/Urban (Indian Health Service). <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>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, <p>or</p> <ul style="list-style-type: none"> • have access to Indian/Tribal/Urban (Indian Health Service). <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>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, <p>or</p> <ul style="list-style-type: none"> • have access to Indian/Tribal/Urban (Indian Health Service). <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>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, <p>or</p> <ul style="list-style-type: none"> • have access to Indian/Tribal/Urban (Indian Health Service). <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>

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29 - Prescription Drugs		<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 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>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 Advantra Gold 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>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 Advantra Platinum PPO 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>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 Advantra Platinum Plus PPO 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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29 - Prescription Drugs		<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</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</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</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</p>

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Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<p>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</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of drugs in this tier • \$0 copay for a three-month (90-day) supply of drugs in this tier 	<p>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</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of drugs in this tier • \$0 copay for a three-month (90-day) supply of drugs in this tier 	<p>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</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of drugs in this tier • \$0 copay for a three-month (90-day) supply of drugs in this tier 	<p>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</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of drugs in this tier • \$0 copay for a three-month (90-day) supply of drugs in this tier

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Advantra
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Section 2 – Summary of Benefits					
Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (30-day) supply of drugs in this tier \$48 copay for a three-month (90-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (30-day) supply of drugs in this tier \$210 copay for a three-month (90-day) supply of drugs in this tier 	<p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (30-day) supply of drugs in this tier \$48 copay for a three-month (90-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (30-day) supply of drugs in this tier \$210 copay for a three-month (90-day) supply of drugs in this tier 	<p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (30-day) supply of drugs in this tier \$48 copay for a three-month (90-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (30-day) supply of drugs in this tier \$210 copay for a three-month (90-day) supply of drugs in this tier 	<p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (30-day) supply of drugs in this tier \$48 copay for a three-month (90-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (30-day) supply of drugs in this tier \$210 copay for a three-month (90-day) supply of drugs in this tier

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Advantra
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Section 2 – Summary of Benefits					
Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (30-day) supply of drugs in this tier <p>Long Term Care Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a one-month (31-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (31-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (31-day) supply of drugs in this tier 	<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (30-day) supply of drugs in this tier <p>Long Term Care Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a one-month (31-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (31-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (31-day) supply of drugs in this tier 	<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (30-day) supply of drugs in this tier <p>Long Term Care Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a one-month (31-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (31-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (31-day) supply of drugs in this tier 	<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (30-day) supply of drugs in this tier <p>Long Term Care Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a one-month (31-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (31-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (31-day) supply of drugs in this tier

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Section 2 – Summary of Benefits					
Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a three-month (90-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$48 copay for a three-month (90-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$210 copay for a three-month (90-day) supply of drugs in this tier 	<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a three-month (90-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$48 copay for a three-month (90-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$210 copay for a three-month (90-day) supply of drugs in this tier 	<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a three-month (90-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$48 copay for a three-month (90-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$210 copay for a three-month (90-day) supply of drugs in this tier 	<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a three-month (90-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$48 copay for a three-month (90-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$210 copay for a three-month (90-day) supply of drugs in this tier

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Section 2 – Summary of Benefits					
Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<p>Coverage Gap The plan covers All Preferred Generics through the coverage gap.</p> <p>You pay the following: Retail Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> • -\$0 copay for a one-month (30-day) supply of all drugs covered in this tier • \$0 copay for a three-month (90-day) supply of all drugs covered in this tier <p>Long Term Care Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of all drugs 	<p>Coverage Gap The plan covers All Preferred Generics through the coverage gap.</p> <p>You pay the following: Retail Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of all drugs covered in this tier • \$0 copay for a three-month (90-day) supply of all drugs covered in this tier <p>Long Term Care Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month(31-day) supply of all drugs 	<p>Coverage Gap The plan covers All Preferred Generics through the coverage gap.</p> <p>You pay the following: Retail Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of all drugs covered in this tier • \$0 copay for a three-month (90-day) supply of all drugs covered in this tier <p>Long Term Care Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of all drugs 	<p>Coverage Gap The plan covers All Preferred Generics through the coverage gap.</p> <p>You pay the following: Retail Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (30-day) supply of all drugs covered in this tier • \$0 copay for a three-month (90-day) supply of all drugs covered in this tier <p>Long Term Care Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of all drugs

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Section 2 – Summary of Benefits					
Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<p>Mail Order Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a three-month (90-day) supply of all drugs covered in this tier <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:</p> <ul style="list-style-type: none"> A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> 5% coinsurance. 	<p>Mail Order Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a three-month (90-day) supply of all drugs covered in this tier <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:</p> <ul style="list-style-type: none"> A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> 5% coinsurance. 	<p>Mail Order Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a three-month (90-day) supply of all drugs covered in this tier <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:</p> <ul style="list-style-type: none"> A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> 5% coinsurance. 	<p>Mail Order Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a three-month (90-day) supply of all drugs covered in this tier <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:</p> <ul style="list-style-type: none"> A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> 5% coinsurance.

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Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<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 Advantra Silver.</p> <p>Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following</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 Advantra Gold.</p> <p>Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following</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 Advantra Platinum PPO.</p> <p>Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following</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 Advantra Platinum Plus PPO.</p> <p>Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following</p>

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Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<p>for drugs purchased out-of-network until total yearly drug costs reach \$2,700:</p> <p>Out-of-Network Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a one-month (30-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (30-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (30-day) supply of drugs in this tier 	<p>for drugs purchased out-of-network until total yearly drug costs reach \$2,700:</p> <p>Out-of-Network Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a one-month (30-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (30-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (30-day) supply of drugs in this tier 	<p>for drugs purchased out-of-network until total yearly drug costs reach \$2,700:</p> <p>Out-of-Network Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a one-month (30-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (30-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (30-day) supply of drugs in this tier 	<p>for drugs purchased out-of-network until total yearly drug costs reach \$2,700:</p> <p>Out-of-Network Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> \$0 copay for a one-month (30-day) supply of drugs in this tier. <p>Preferred Brand</p> <ul style="list-style-type: none"> \$24 copay for a one-month (30-day) supply of drugs in this tier <p>Non-Preferred Generic/Non-Preferred Brand</p> <ul style="list-style-type: none"> \$70 copay for a one-month (30-day) supply of drugs in this tier

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Section 2 – Summary of Benefits					
Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (30-day) supply of drugs in this tier <p>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</p> <ul style="list-style-type: none"> \$0 copay for a one-month (30-day) supply of all drugs covered in this tier 	<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (30-day) supply of drugs in this tier <p>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</p> <ul style="list-style-type: none"> \$0 copay for a one-month (30-day) supply of all drugs covered in this tier 	<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (30-day) supply of drugs in this tier <p>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</p> <ul style="list-style-type: none"> \$0 copay for a one-month (30-day) supply of all drugs covered in this tier 	<p>Specialty - Generic and Brand</p> <ul style="list-style-type: none"> 30% coinsurance for a one-month (30-day) supply of drugs in this tier <p>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</p> <ul style="list-style-type: none"> \$0 copay for a one-month (30-day) supply of all drugs covered in this tier

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Benefit	Original Medicare	Advantira Silver (H1609-001)	Advantira Gold (H1609-003)	Advantira Platinum PPO (H1608-001)	Advantira Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<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 Advantira Silver for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Advantira Silver so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>	<p>Preferred Brand 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 Advantira Gold for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Advantira Gold so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>	<p>Preferred Brand 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 Advantira Platinum PPO for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Advantira Platinum PPO so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>	<p>Preferred Brand 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 Advantira Platinum Plus PPO for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Advantira Platinum Plus PPO so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>

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Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<p>Non-Preferred Generic/Non-Preferred Brand</p> <p>After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by Advantra Silver for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to 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</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 Advantra Gold for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Advantra Gold so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>	<p>Non-Preferred Generic/Non-Preferred Brand</p> <p>After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by Advantra Platinum PPO for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Advantra Platinum PPO so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>	<p>Non-Preferred Generic/Non-Preferred Brand</p> <p>After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by Advantra Platinum Plus PPO for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Advantra Platinum Plus PPO so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>

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Section 2 – Summary of Benefits					
Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<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 Advantra Silver for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to 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>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 Advantra Gold for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Advantra Gold so we can add the amounts you spent out-of-network to your total out-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 Advantra Platinum PPO for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Advantra Platinum PPO so we can add the amounts you spent out-of-network to your total out-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 Advantra Platinum Plus PPO for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Advantra Platinum Plus PPO so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>

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Section 2 – Summary of Benefits					
Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
29 - Prescription Drugs		<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:</p> <ul style="list-style-type: none"> • A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> • - 5% coinsurance. 	<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:</p> <ul style="list-style-type: none"> • A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> • 5% coinsurance. 	<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:</p> <ul style="list-style-type: none"> • A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> • - 5% coinsurance. 	<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:</p> <ul style="list-style-type: none"> • A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> • - 5% coinsurance.

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Section 2 – Summary of Benefits					
Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<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 fluoride treatment(s) every year • 50% of the cost for up to 1 dental x-ray visit(s) every year. • \$500 limit for preventive dental benefits every year. 	<p>In-Network 0% of the cost for Medicare-covered dental benefits.</p> <ul style="list-style-type: none"> • 0% of the cost for up to 2 oral exam(s) every year • 0% of the cost for up to 2 cleaning(s) every year • 0% of the cost for up to 1 fluoride treatment(s) every year • 0% of the cost for up to 1 dental x-ray visit(s) every year <p>Plan offers additional comprehensive dental benefits.</p> <ul style="list-style-type: none"> • \$1,000 limit for dental benefits every year 	<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 fluoride treatment(s) every year • 50% of the cost for up to 1 dental x-ray visit(s) every year 	<p>In-Network 0% of the cost for Medicare-covered dental benefits.</p> <ul style="list-style-type: none"> • 0% of the cost for up to 2 oral exam(s) every year • 0% of the cost for up to 2 cleaning(s) every year • 0% of the cost for up to 1 fluoride treatment(s) every year • 0% of the cost for up to 1 dental x-ray visit(s) every year

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30 - Dental Services		See page 51 for additional information about Dental Services.	See page 51 for additional information about Dental Services.	<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 51 for additional information about Dental Services.</p>	<p>Out-of-Network 0% to 50% of the cost for comprehensive dental benefits.</p> <p>In and Out-of-Network \$1,000 limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits.</p> <p>Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.</p> <p>See page 51 for additional information about Dental Services.</p>

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Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
31 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network Hearing aids not covered.</p> <ul style="list-style-type: none"> • \$10 to \$30 copay for Medicare-covered diagnostic hearing exams • \$10 to \$30 copay for up to 1 routine hearing test(s) every year. <p>See page 51 for additional information about Hearing Services.</p>	<p>In-Network \$0 copay for Medicare-covered diagnostic hearing exams</p> <ul style="list-style-type: none"> • up to 1 routine hearing test(s) every year • \$0 copay for hearing aids. <p>\$500 limit for hearing aids every year.</p> <p>See page 51 for additional information about Hearing Services.</p>	<p>In-Network Hearing aids not covered.</p> <ul style="list-style-type: none"> • \$10 to \$30 copay for Medicare-covered diagnostic hearing exams • \$10 to \$30 copay for up to 1 routine hearing test(s) every year <p>Out-of-Network 20% of the cost for hearing exams.</p> <p>See page 51 for additional information about Hearing Services.</p>	<p>In-Network \$0 copay for hearing aids.</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered diagnostic hearing exams • \$10 copay for up to 1 routine hearing test(s) every year <p>\$200 limit for hearing aids every year.</p> <p>Out-of-Network 10% of the cost for hearing exams.</p> <ul style="list-style-type: none"> • \$0 copay for hearing aids. <p>See page 51 for additional information about Hearing Services.</p>

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Section 2 – Summary of Benefits					
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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>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> one pair of eyeglasses or contact lenses after cataract surgery glasses contacts lenses frames <p>\$10 to \$30 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$10 to \$30 copay for up to 1 routine eye exam(s) every year</p> <p>\$100 limit for eyewear every year.</p> <p>Plan offers additional vision benefits.</p>	<p>In-Network \$0 copay for diagnosis and treatment for diseases and conditions of the eye - and up to 1 routine eye exam(s) every year</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> one pair of eyeglasses or contact lenses after cataract surgery glasses contacts lenses frames <p>\$200 limit for eye wear every year.</p> <p>Plan offers additional vision benefits.</p>	<p>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> one pair of eyeglasses or contact lenses after cataract surgery glasses contacts lenses frames <p>\$10 to \$30 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$10 to \$30 copay for up to 1 routine eye exam(s) every year</p> <p>\$100 limit for eyewear every year.</p> <p>Plan offers additional vision benefits.</p>	<p>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> one pair of eyeglasses or contact lenses after cataract surgery glasses contacts lenses frames <p>\$0 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$10 copay for up to 1 routine eye exam(s) every year</p> <p>\$100 limit for eyewear every year.</p> <p>Plan offers additional vision benefits.</p>

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Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
32 - Vision Services		See page 51 for additional information about Vision Services.	See page 51 for additional information about Vision Services.	<p>Out-of-Network 20% of the cost for eye exams.</p> <p>\$0 for eye wear.</p> <p>See page 51 for additional information about Vision Services.</p>	<p>Out-of-Network 10% of the cost for eye exams.</p> <p>\$0 for eye wear.</p> <p>See page 51 for additional information about Vision Services.</p>
33 - Physical Exams	<p>20% coinsurance for one exam within the first 6 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 6 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>In-Network \$10 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$10 copay for Medicare-covered benefits.</p> <p>See page 51 for additional information about Physical Exam Services.</p>	<p>In-Network \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>See page 51 for additional information about Physical Exam Services.</p>	<p>In-Network \$10 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$10 copay for Medicare-covered benefits.</p> <p>Out-of-Network 20% of the cost for routine exams.</p> <p>See page 51 for additional information about Physical Exam Services.</p>	<p>In-Network \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>Out-of-Network 10% of the cost for routine exams.</p> <p>See page 51 for additional information about Physical Exam Services.</p>

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Section 2 – Summary of Benefits					
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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.	<p>General Authorization rules may apply.</p> <p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Nutritional training • Health Club Membership/Fitness Classes 	<p>General Authorization rules may apply.</p> <p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Nutritional training • Health Club Membership/Fitness Classes 	<p>General Authorization rules may apply.</p> <p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Nutritional training • Health Club Membership/Fitness Classes <p>Out-of-Network 20% of the cost for Health and Wellness services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Nutritional training • Health Club Membership/Fitness Classes <p>Out-of-Network 10% of the cost for Health and Wellness services.</p>

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Benefit	Original Medicare	Advantra Silver (H1609-001)	Advantra Gold (H1609-003)	Advantra Platinum PPO (H1608-001)	Advantra Platinum Plus PPO (H1608-002)
Transportation (Routine)	Not covered.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.	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.	In-Network This plan does not cover Acupuncture.	In-Network This plan does not cover Acupuncture.

SECTION 3 – PLAN SPECIFIC FEATURES

Advantra

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ADDITIONAL PLAN BENEFITS

Taking care of ourselves is important. Preventive care not only includes our physical well being, it also includes annual vision and hearing exams as well as preventive trips to the dentist. At Coventry we include these services as additional plan benefits.

Health Club - Looking good, feeling fit, and having fun are important for Advantra members. That's why your Advantra plan includes a membership at any participating fitness center (gyms, exercise facilities and health clubs) – anywhere in the country. Use the facilities anytime during operating hours. Also included are all amenities, programs, and services that accompany the fitness center monthly membership (these vary by facility), such as conventional and state-of-the-art exercise equipment, steam and sauna rooms, exercise or recreation programs and trainers. All of these services are available to you for no copayment.

Hearing Services – Diagnostic hearing exams and Annual Routine Hearing Tests are offered to all Advantra members. Copayments for these services will vary depending on the plan you select.

Hearing Aids – To further help our members get the hearing services and products they need, a generous hearing aid benefit is included on the Advantra Gold and Advantra Platinum Plus PPO. Each year, Advantra Gold members will have a \$500 credit to apply towards the purchase of a hearing aid. Advantra Platinum Plus PPO members will have \$200 credit to apply toward the purchase of a hearing aid.

Dental Services – As a member of Advantra, you have the added benefit of a comprehensive dental program available on most plans. Both preventive and diagnostic dental procedures are available for coverage through a broad network of dental professionals. For Advantra Silver and Advantra Platinum PPO members, you will have coverage for both preventive and diagnostic services such as exams, cleanings, x-rays and fluoride treatments. As an Advantra Gold or Advantra Platinum Plus PPO member, your coverage is extended to include fillings and extractions.

Vision Services – Quality vision care is provided to you through a comprehensive network of optometrists and ophthalmologists. Please check your provider directory for participating providers. An annual routine eye-exam is offered to you each year (copayments for this service will vary depending on the plan you select). As an Advantra Silver, Platinum PPO or Platinum Plus PPO member you have a \$100 credit to apply towards glasses or contact lenses each year. As an Advantra Gold member, you have a \$200 credit. You can obtain your eyewear from a participating plan provider or you can purchase your glasses from the retailer of your choice and submit your receipt to our Claims Department for reimbursement.

Physical Exams - As an Advantra member you are entitled to one routine physical exam every year. This exam is inclusive of any laboratory tests, x-rays and additional items received during the routine exam. Your well being is important to us and we want to make sure we provide you with all the resources necessary to help you be healthy.

SECTION 3 – PLAN SPECIFIC FEATURES

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Prescription Drugs

In-Network Pharmacies

When you enroll in an Advantra 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 (OTC's) as Step Therapy

The Over-the-Counter medications we cover as part of Step Therapy are listed below. These over-the-counter medications will require a prescription from your doctor in order to have them filled at your pharmacy and covered under your pharmacy benefit. Quantity and days supply limits may apply to the medications on this list. To find the quantity and days supply limits, please refer to your Formulary. If you require another copy, please contact Customer Service at the phone numbers provided on the cover of this booklet. We provide a 31-day (one-month) supply for members in long-term care. Your copayment is \$0 for these covered over-the-counter drugs. If you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs.

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	1mg/ml
Cetirizine HCL and Pseudoephedrine Hydrochloride	12 Hour Tablets	5mg/120mg
Prilosec OTC	Tablets	20 mg

Excluded Drugs –

Advantra covers some excluded 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

Advantra 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, effectiveness 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 Advantra Formulary. These additional requirements or limits may include:

- **Prior Authorization:** Advantra requires you or your physician to get prior authorization before you fill your prescriptions.
- **Quantity Limits:** For certain drugs, Advantra limits the amount of the drug that it will cover.
- **Step Therapy:** In some cases, Advantra 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:** Advantra allows these medications for an extended supply up to 90 days.

For More Information

If you have any questions, please contact us at 1-866-294-1211, TTY/TDD 1-800-716-3231, 24 hours a day; seven (7) days a week, including holidays, or visit our website at www.ia.chcadvantra.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.

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DOCTORS AND HOSPITAL CHOICE

Advantra Silver and Advantra Gold

In the Advantra Silver plan, you must choose a Primary Care Physician (PCP) who will coordinate your care with other Advantra participating providers. You must have a referral from your Primary Care Physician in order to see a specialist for covered services. However, you may self-refer for your Mammography Screening, Pap/Pelvic Exam, Colorectal Screening, Prostate Screening Exam, Bone Mass Measurement, Influenza Vaccine, and Pneumococcal Vaccine to any Advantra participating provider. You will not be subject to an additional copayment for the previously-referenced preventive services, however you may be subject to any applicable PCP or Specialist office visit copayments. You are encouraged to contact your PCP when medical care is needed.

In the Advantra Gold plan, you can go to any participating provider. You are not required to select a Primary Care Physician however, we still encourage you to establish a relationship with one. Advantra Gold members are not required to obtain a referral to see a Specialist; you may see any physician who participates with Advantra. If you obtain routine care from out-of-network providers, neither Medicare nor Advantra will be responsible for those costs.

Advantra Platinum and Advantra Platinum Plus PPO

Advantra PPO members do not have to select a Primary Care Physician (PCP). You can go to any doctor in-network or out-of-network. You may have to pay more for the services you receive outside of the network. Although you are not required to select or see a PCP, we still urge you to establish a relationship with one.

PRIOR AUTHORIZATION

Advantra Silver and Advantra Gold

In an effort to provide our members with the finest quality of care and to limit your financial responsibility, Coventry requires pre-authorization for specific medical services. Prior-authorizations are the responsibility of your Advantra participating provider and are subject to change by Coventry; however, you may verify that prior authorization has been obtained by contacting our Customer Service Department at the number listed at the end of Section 1.

Advantra Platinum and Advantra Platinum Plus

Out-of-Network Pre-Authorization is **YOUR** responsibility.

For any out of network services that require prior-authorization, it is YOUR responsibility to call for prior-authorization. You **MUST** call Coventry's Utilization Management Department at 1-800-470-6352 to request prior-authorization for those out-of-network services that require a prior-authorization. If you fail to obtain prior-authorization for out-of-network services, you may be responsible for charges incurred.

Prior authorization services from In-Network providers are the responsibility of your Advantra participating provider and are subject to change by Advantra; however, you may verify that prior authorization has been obtained by contracting our Customer Service Department at the numbers listed at the end of Section 1.

The following services will need Prior Authorization for **ALL Advantra Plans**:

SECTION 3 – PLAN SPECIFIC FEATURES

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Inpatient Hospital Services
Inpatient Mental Health
Skilled Nursing Facility
Home Health Care
Outpatient Mental Health/Substance Abuse
Outpatient Surgery/Services
Outpatient Rehabilitation
Durable Medical Equipment
Prosthetic Devices
Diabetes Self-Monitoring Training and Supplies
Some Diagnostic Tests
Some Prescription Drugs

WORLDWIDE EMERGENCY/URGENT BENEFIT

Under traditional Medicare, you are not always covered for medical emergencies or urgent care outside of the United States. As an 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 Coventry when you return from your trip.

TRANSPLANTS

Transplants are Medically Necessary, considered non-experimental by Medicare and approved through Coventry's Utilization Management Program.

Transplants currently considered non-experimental include:

- Bone marrow transplants
- Kidney transplants
- Pancreas transplants
- Liver transplants
- Heart transplants
- Lung transplants
- Heart/Lung transplants

Determinations of Medical Necessity shall take into account the proposed Medicare approved procedure's suitability for the potential Member recipient and availability of Medicare approved facilities for performing such procedures.



Advantra PPO is underwritten by Coventry Health and Life Insurance Company. Advantra PPO and Advantra are Medicare Advantage plans administered by Coventry Health Care of Iowa, Inc., through PPO and HMO Medicare Advantra prescription drug contracts.

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