

2009 SUMMARY OF BENEFITS

ADVANTRAONE

H5517



SECTION 1 – INTRODUCTION TO SUMMARY OF BENEFITS

AdvantraOne

January 1, 2009 – December 31, 2009

Thank you for your interest in AdvantraOne. Our plan is offered by COVENTRY HEALTH AND LIFE INS. COMPANY/Advantra, a Medicare Advantage Preferred Provider Organization (PPO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria.

You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Please call AdvantraOne to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call AdvantraOne 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 AdvantraOne. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

. Please call AdvantraOne at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare AdvantraOne 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 ADVANTRAONE AVAILABLE?

The service area for this plan includes: Boone, Brooke, Clay, Hancock, Kanawha, Marshall, Mineral, Ohio, and Putnam, Tyler, Wetzel Counties, WV. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN ADVANTRAONE?

You can join AdvantraOne if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area.

You must also receive assistance from the state to join this plan.

Please call plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

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

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WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

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

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

AdvantraOne 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?

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

WHAT IS A PRESCRIPTION DRUG FORMULARY?

AdvantraOne 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.chcadvantra.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 AdvantraOne, 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 AdvantraOne, 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

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to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Advantra Platinum or Advantra Silver for more details.

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

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Advantra Platinum or Advantra Silver for more details.

Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.

Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

Injectable Drugs: Most injectable drugs administered incident to a physician's service.

Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.

Some Oral Cancer Drugs: If the same drug is available in injectable form.

Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen. Inhalation and infusion drugs provided through DME.

AdvantraOne is a product of Coventry Health and Life Ins. Company, A PPO with a Medicare Advantage Prescription Drug Contract, administered by Carelink Health Plans

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Please call Advantra for more information about this plan.

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

Customer Service Hours:

Members

November 15, 2008 – March 1, 2009,

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

Eastern Time

March 2, 2009 – November 14, 2009

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

Toll-free: 1-877-843-1938

TTY/TDD 1-800-207-1262 for the hearing impaired

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: 1-888-271-7647

TTY/TDD: 1-888-788-4010 for the hearing impaired

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Medicare Prescription Drug (Part D)

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

Current Members should call toll-free 1-866-291-5518

TTY/TDD 1-800-716-3231

Prospective Members should call toll-free 1-888-271-7647

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 Advantra for details.

Benefit	Original Medicare	AdvantraOne
<p>IMPORTANT INFORMATION :</p> <p>1 - Premium and Other Important Information</p> <p><i>See page 26 for additional information</i></p>	<p>The Medicare cost sharing amount may vary based on your level of Medicaid eligibility.</p> <p>In 2009 the monthly Part B Premium is \$0 or \$96.40 and the yearly Part B deductible amount is \$0 or \$135.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>General \$29.20 monthly plan premium in addition to your monthly Medicare Part B premium.*</p> <p>*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.</p> <p>In-Network: In 2009 the yearly Part B deductible amount is \$0 or \$135.* Contact the plan for services that apply.</p> <p>Out-of-Network: In 2009 the yearly Part B deductible amount is \$0 or \$135.* Contact the plan for services that</p>
<p>2 - Doctor and Hospital Choice</p> <p>(For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network: No referral required for network doctors, specialists, and hospitals.</p>
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<p>INPATIENT CARE</p>		
<p>3 - Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p> <p><i>See page 26 for additional information</i></p>	<p>In 2009 the amounts for each benefit period, \$0 or Days 1 - 60: \$1068 deductible* Days 61 - 90: \$267 per day* Days 91 - 150: \$534 per lifetime reserve day*</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once.</p>	<p>In 2009 the amounts for each benefit period, \$0 or Days 1 - 60: \$1068 deductible* Days 61 - 90: \$267 per day* Days 91 - 150: \$534 per lifetime reserve day*</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>Plan covers 90 days each benefit</p>

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<p>3 - Inpatient Hospital Care (continued)</p> <p><i>See page 26 for additional information</i></p>	<p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>	<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-network: 20% of the cost for each hospital stay.</p>
<p>4 - Inpatient Mental Health Care</p> <p><i>See page 26 for additional information</i></p>	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p>	<p>In-Network: Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care")</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 be admitted to the hospital.</p> <p>Out-of-Network:</p>
		<p>20% of the cost for each hospital stay.</p>

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<p>5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 – 20: \$0 per day* Days 21 – 100: \$0 or \$133.50 per day*</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. There is no limit to the number of benefit periods you can have.</p>	<p>General: Authorization is required.</p> <p>In-Network: In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 – 20: \$0 per day* Days 21 – 100: \$0 or \$133.50 per day*</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>Plan covers up to 100 days each benefit period</p> <p>3-day prior hospital stay is required.</p>
<p>6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>General: Authorization rules may apply.</p> <p>In-Network: \$0 copay for Medicare- covered home health visits.</p> <p>Out-of-Network: 20% for home health visits.</p>
<p>7 - Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.</p>	<p>In-Network: You must get care from a Medicare-certified hospice.</p>

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Outpatient care		
8 - Doctor Office Visits	0% or 20% coinsurance	<p>In-Network:</p> <p>0% to 20% of the cost for each primary care doctor visit for Medicare-covered benefits.* \$0 copay for each in-area, network urgent care Medicare-covered visit*</p> <p>Out-of-Network:</p> <p>20% for each primary care doctor visit. 20% for each specialist visit.</p>
9 - Chiropractic Services	<p>Routine care not covered.</p> <p>0% or 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>In-Network:</p> <p>0% to 20% of the cost for Medicare- covered visits.*</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p> <p>Out-of-Network:</p> <p>20% of the cost for chiropractic benefits.</p>
10 - Podiatry Services	<p>Routine care not covered.</p> <p>0% or 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network:</p> <p>0% to 20% of the cost for each Medicare- covered visit.*</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network:</p> <p>20% of the cost for podiatry benefits.</p>

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<p>11 - Outpatient Mental Health Care <i>See page 26 for additional information 11</i></p>	<p>0% or 50% coinsurance for most outpatient mental health services.</p>	<p>General: Authorization rules may apply.</p> <p>In-Network: 0% or 50% of the cost for each Medicare- covered individual or group therapy visit.*</p> <p>Out-of-Network: 50% of the cost for Mental Health benefits.</p> <p>50% of the cost for Mental Health benefits with a psychiatrist</p>
<p>12- Outpatient Substance Abuse Care <i>See page 26 for additional information</i></p>	<p>0% or 20% coinsurance</p>	<p>General: Authorization rules may apply.</p> <p>In-Network: 0% or 20% of the cost for Medicare covered individual or group therapy visits.*</p> <p>Out-of-Network: 20% of the cost for out patient substance abuse benefits.</p>
<p>13- Outpatient Services/ Surgery <i>See page 26 for additional information</i></p>	<p>0% or 20% coinsurance for the doctor</p> <p>0% or 20% of outpatient facility charges</p>	<p>General: Authorization rules may apply</p> <p>In-Network: 0% to 20% of the cost for each Medicare-Covered ambulatory surgical center visit.*</p> <p>0% to 20% of the cost for each Medicare covered outpatient hospital facility visit.*</p> <p>Out-of-Network: 20% of the cost for ambulatory surgical center benefits 20% of the cost for outpatient hospital facility benefits</p>

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<p>14 - Ambulance Services</p> <p>(medically necessary ambulance services)</p>	<p>0% or 20% coinsurance</p>	<p>General: Authorization rules may apply.</p> <p>In-Network: 0% to 20% of the cost for Medicare-covered ambulance benefits.*</p> <p>Out-of-Network: 20% of the cost for ambulance benefits.</p>
<p>15 - Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p> <p><i>See page 26 for additional information</i></p>	<p>0% or 20% coinsurance for the doctor</p> <p>0% or 20% of facility charge</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.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>In-Network: 0% to 20% of the cost (up to \$50) for Medicare-covered emergency room visits.*</p> <p>This amount applies toward you in-network plan deductible.</p> <p>This amount applies toward your out-of-network plan deductible.</p> <p>Out-of-Network: Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.</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>16 - Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>0% or 20% coinsurance</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General: 0% to 20% of the cost for Medicare-covered urgently needed care visits.*</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.</p>

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<p>17 - Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>0% or 20% coinsurance</p>	<p>General:</p> <p>Authorization rules may apply.</p> <p>In-Network:</p> <p>0% to 20% of the cost for Medicare-covered Occupational Therapy visits.*</p> <p>0% to 20% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p>Out-of-Network:</p> <p>20% of the cost for Occupational Therapy benefits.</p> <p>20% of the cost for Physical and/or Speech/ Language Therapy visits.</p>
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
<p>18 - Durable Medical Equipment</p> <p>(includes wheelchairs, oxygen, etc.)</p> <p><i>See page 26 for additional information</i></p>	<p>0% or 20% coinsurance</p>	<p>General:</p> <p>Authorization rules may apply.</p> <p>In-Network:</p> <p>0% to 20% of the cost for Medicare-covered items.*</p> <p>Out-of-Network:</p> <p>20% of the cost for durable medical equipment.</p>
<p>19 - Prosthetic Devices</p> <p>(includes braces, artificial limbs and eyes, etc.)</p>	<p>0% or 20% coinsurance</p>	<p>General:</p> <p>Authorization rules may apply.</p> <p>In-Network:</p> <p>0% to 20% of the cost for Medicare-covered items.*</p> <p>Out-of-Network:</p> <p>20% of the cost for prosthetic devices.</p>

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<p>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>0% or 20% coinsurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General: Authorization rules may apply.</p> <p>In-Network: 0% to 20% of the cost for Diabetes self-monitoring training.* 0% to 20% of the cost for Nutrition Therapy for Diabetes.* 0% to 20% of the cost for Diabetes supplies.*</p> <p>Out –of-Network: 20% of the cost for Diabetic self-monitoring training 20% of the cost for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies.</p>

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<p>21 - Diagnostic Tests, X-Rays, and Lab Services</p>	<p>0% or 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>0% to 20% of the cost for Medicare-covered diagnostic procedures and tests.*</p> <p>0% to 20% of the cost for Medicare-covered X-rays.*</p> <p>0% to 20% of the cost for Medicare-covered diagnostic radiology services.*</p> <p>0% to 20% of the cost for Medicare-covered therapeutic radiology services.*</p> <p>Out-of-Network: 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>20% of the cost for diagnostic procedures, test, and lab services.</p>

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PREVENTIVE CARE		
<p>22 - Bone Mass Measurement (for people with Medicare who are at risk)</p>	<p>0% or 20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>In-Network: 0% to 20% of the cost for Medicare-covered bone mass measurement.* Out-of-Network 20% of the cost for Medicare-covered bone mass measurement.</p>
<p>23 - Colorectal Screening Exams (for people with Medicare age 50 and older)</p>	<p>0% or 20% coinsurance Covered when you are high risk or when you are age 50 and older.</p>	<p>In-Network: 0% to 20% of the cost for Medicare-covered colorectal screenings.* Out-of-Network 20% of the cost for colorectal screenings</p>
<p>24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 copay for Flu and Pneumonia vaccines 0% or 20% coinsurance for Hepatitis B vaccine You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p>In-Network: \$0 copay for Flu and Pneumonia vaccines. No referral needed for Flu and pneumonia vaccines. 20% of the cost for Hepatitis B vaccine. Out-of-Network: 20% of the cost for immunizations.</p>
<p>25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p>	<p>0% or 20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p>In-Network: 0% or 20% of the cost Medicare-covered screening mammograms.* Out-of-Network: 20% 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</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>0% or 20% coinsurance for Pelvic Exams</p>	<p>In-Network: 0% of the cost for Medicare-covered pap smears.*</p> <p>0% or 20% of the cost for Medicare-covered pelvic exams.*</p> <p>Out-of-Network: 20% of the cost for pap smears and pelvic exams.</p>
<p>27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>0% or 20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 0% or 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>In-Network: 0% or 20% of the cost for Medicare-covered prostate cancer screening.*</p> <p>Out-of-Network: 20% of the cost for prostate cancer screening</p>
<p>28 - End-Stage Renal Disease</p>	<p>20% coinsurance for renal dialysis 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't 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% or 20% of the cost for renal dialysis*</p> <p>0% to 20% of the cost 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>

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<p>29 - Prescription Drugs</p> <p><i>See page 27 for additional information</i></p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General:</p> <p>\$0 yearly deductible for Part B covered drugs.*</p> <p>0% or 20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).*</p> <p>0% or 20% of the cost for Part B-covered chemotherapy drugs.</p> <p>Drugs covered under Medicare Part D</p> <p>General:</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.chcadvantra.com on the web.</p> <p>Different out-of-pocket costs may apply for people who:</p> <ul style="list-style-type: none"> – have limited incomes, – live in long term care facilities, or 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>

**SECTION 2–
SUMMARY OF BENEFITS**

AdvantraOne
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Benefit	Original Medicare	AdvantraOne
<p>29 - Prescription Drugs (continued)</p> <p><i>See page 27 for additional information</i></p>		<p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</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 AdvantraOne for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program.</p> <p>Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>In-Network: You pay a \$0 yearly deductible</p> <p>Some covered drugs don't count toward your out-of-pocket drug costs.</p> <p>Initial Coverage: Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> • A \$0 copay; or • A \$1.10 copay; or

**SECTION 2–
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Benefit	Original Medicare	AdvantraOne
<p>29 - Prescription Drugs (continued)</p> <p><i>See page 27 for additional information</i></p>		<ul style="list-style-type: none"> • A \$2.40 copay <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> • A \$0 copay; or • A \$3.20 copay, or • A \$6.00 copay <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed in full for drugs purchased out-of-network.</p>
<p>30 - Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>In-Network</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> - Up to 1 oral exam(s) every year – - Up to 1 cleaning(s) every year - Up to 1 dental x-ray(s) every year <p>0% to 20% of the cost for Medicare-covered dental benefits.*</p> <p>Out-of-Network</p> <p>20% of the cost for comprehensive dental benefits.</p> <p>In and Out-of-Network</p> <p>\$750 limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.</p>

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Benefit	Original Medicare	AdvantraOne
31 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>0% or 20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network 0% copay for Medicare-covered diagnostic hearing exams</p> <p>\$0 copay for: - up to 1 routine hearing test(s) every - up to 1 fitting evaluation(s) for a hearing aid every year</p> <p>\$0 copay for up to 1 hearing aid(s) every three years.</p> <p>\$1,500 limit for hearing aids every three years.</p> <p>Out-of-Network</p> <p>\$0 copay for hearing exams. \$0 copay for hearing aids.</p>
32 - Vision Services	<p>0% or 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 diagnosis and treatment for diseases and conditions of the eye*</p> <p>\$0 copay for up to 1 routine eye exam(s) every year</p> <p>\$0 copay for: - one pair of eyeglasses or contact lenses after cataract surgery</p> <p>- up to 1 pair(s) of glasses contacts - up to 1 pair(s) of lenses - up to 1 frame(s)</p> <p>\$300 limit for eye wear every year.</p> <p>Out-of-Network</p> <p>\$0 copay for eye exams \$0 copay for eye wear</p>

**SECTION 3 –
PLAN SPECIFIC FEATURES**

AdvantraOne

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Premium and Other Important Information

All cost sharing with the AdvantraOne plan is based on your level of Medicaid eligibility. Unless otherwise noted, out-of-network services are not covered. No referral is required for network doctors, specialists, and hospitals.

3 - Inpatient Hospital Care

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

11 and 12 – Behavioral Health Services

Authorization is required through MHNNet Behavioral Health for inpatient psychiatric care, partial hospitalizations, mental health and psychiatric services. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. The same deductible and copay as inpatient hospital care applies to inpatient psychiatric hospitalization. You get up to 190 days in a psychiatric hospital in a lifetime. To receive benefits, participating providers must be used.

13 – Outpatient Services/Surgery

There is a 0% or 0% to 20% coinsurance for in-network Medicare-covered ambulatory surgical center visits and 0% or 0% to 20% coinsurance for in-network Medicare-covered outpatient hospital facility visit.

15 – Emergency Services

You pay 0% or 0% to 20% of the cost (up to \$50) for Medicare-covered emergency room visits. This amount applies to your in-network plan deductible. This amount applies to your out-of-network plan deductible. Emergency care is not covered outside of the U.S. except under limited circumstances. Contact the plan for details. If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the emergency room visit.

18 – Durable Medical Equipment (DME)

You pay 0% or 0% to 20% of the cost for each Medicare-covered item in-network in the AdvantraOne plan.

Health/Wellness - Advantra Forever Fit

Your AdvantraOne plan includes a health club membership at participating Advantra Forever Fit fitness centers. Membership at participating fit centers includes gyms, exercise facilities and fitness centers that provide access to conventional and state-of-the-art exercise equipment. Membership privileges include all amenities, programs and services that are associated with membership at each fitness center, including any exercise or recreation program or class that is included as part of the monthly fitness center membership. You pay 20% of the cost for these services out-of-network.

Over The Counter (OTC) Debit Card

In addition to your Medicare Part D prescription drug benefit; as a member of AdvantraOne you are entitled to up to \$35 monthly towards the price of over the counter medications. These include such items as aspirin, antacids, cough and cold medicines, etc. Simply show your OTC AdvantraOne debit card at time of purchase. Contact AdvantraOne customer service for additional information.

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Transportation

As a member of AdvantraOne, you have access to the equivalent of [15] roundtrip transportation services. The transportation benefit may reimburse you for such things as: a ride to the doctor's office, to the hospital for tests, to the pharmacy, etc. **This benefit requires prior authorization to be covered.** To be reimbursed, you need to complete a "Reimbursement for Transportation Services" form. Call customer service for more information or to request a reimbursement form.

Transplants

Inpatient hospital benefits apply to transplants.

Transplants Defined – Certain Medically Necessary transplants considered non-experimental by Medicare preauthorized by your Physician and approved through Advantra's Utilization management program.

Transplants currently considered non-experimental include:

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

Transplants are covered only when performed at an Advantra Contracted Provider Hospital that has been approved by Medicare for this procedure. Determinations of Medical Necessity shall take into account the proposed Medicare approved procedure's stability for the potential member recipient and availability of Medicare approved facilities for performing such procedures.

Outpatient Prescription Drug Coverage

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 STEP THERAPY PROGRAM

Advantra offers certain over-the-counter medications to you at no cost as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Some over-the-counter drugs do not count towards your out-of-pocket expenditure. You need to have a doctor's prescription in order to get

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these drugs at no cost. In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs.

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

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

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 AdvantraOne 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.