Summary of Benefits

Advantra Gold (PPO)

H1608, Plan 025

This is a summary of services covered by Advantra Gold (PPO)
January 1, 2017 - December 31, 2017

Advantra Gold (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. The plan's "Evidence of Coverage" provides a complete list of services we cover. The "Evidence of Coverage" is available on our website or you may call us to request a copy.

To join Advantra Gold (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in North Carolina: Alexander, Caldwell, Catawba, Durham, Gaston, Guilford, Randolph and Wake.

Y0001_2017_H1608_025_SB Accepted 9/2016

Premiums and Benefits	Advantra Gold (PPO)	What You Should Know
Monthly Plan Premium	$44	You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$5,500 for in-network services annually $10,000 for in and out-of-network services combined.	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage	In-network: $265 per day, days 1-6; $0 per day, days 7-90 You pay $0 per day for days 91 and beyond. Our plan covers an unlimited number of days for an inpatient hospital stay. Out-of-network: 25% per stay	Prior authorization may be required. This benefit will begin on day one each time you are admitted to a specific facility type. A transfer within or to a facility, including Inpatient Rehabilitation, Long Term Acute Care, Inpatient Acute or Psychiatric facility is considered a new admission. You pay your cost share per admission.
Doctor Visits		
• Primary Care Physician (PCP)	In-network: $7 copay per visit Out-of-network: $35 copay	
• Specialists	In-network: $40 copay per visit Out-of-network: $55 copay	
Preventive Care	In-network: $0 copay Out-of-network: $0 copay	Any additional preventive services approved by

Premiums and Benefits	Advantra Gold (PPO)	What You Should Know
		Medicare during the contract year will be covered.
Emergency Care	$75 per visit $75 for emergency and urgent care outside of the United States	If you are admitted to the hospital, within 24 hours, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	$40 per urgent care facility visit $75 for emergency and urgent care outside of the United States	
Diagnostic Services/Labs/ Imaging		Prior authorization or physician's order may be required.
• Diagnostic radiology services (e.g., MRI)	In-network: 20% of the cost Out-of-network: 30% of the cost	
• Lab services	In-network: $20 copay Out-of-network: 30% of the cost	
• Diagnostic tests and procedures	In-network: 20% of the cost Out-of-network: 30% of the cost	
• Outpatient x-rays	In-network: 20% of the cost Out-of-network: 25% of the cost	
Hearing Services		
• Medicare-covered hearing exam	In-network: $40 copay Out-of-network: $40 copay	
• Routine hearing exam (one exam every year)	In-network: $0 copay Out-of-network: $0 copay	

Premiums and Benefits	Advantra Gold (PPO)	What You Should Know
• Hearing aids	Not Covered	
Dental Services		
	Our plan pays up to $250 for preventive dental services every year	Dental allowance: Any licensed dental provider may provide services. You pay for services, submit an itemized statement showing proof of payment and you will be reimbursed. Only select dental services are reimbursable. You are responsible for any amount over the dental coverage limit.
• Dental deductible	This plan does not have a deductible	
• Oral exam & cleaning (unlimited)	In-network: $0 copay for each covered service (See the Evidence of Coverage for details) Out-of-network: $0 copay for each covered service (See the Evidence of Coverage for details)	
• Fillings	Not Covered	
Vision Services		
• Medicare-covered eye exams	In-network: $0 copay for glaucoma screenings $0 copay for diabetic eye exams $40 copay for other exams to diagnose and treat diseases and conditions of the eye Out-of-network: $40 copay	

Premiums and Benefits	Advantra Gold (PPO)	What You Should Know
• Routine eye exam (one exam every year)	In-network: $0 copay Out-of-network: $0 copay	
• Contacts and Eyeglasses (frames and lenses)	Our plan pays up to $75 for contacts and eyeglasses every year (See the Evidence of Coverage for details)	Any licensed eyewear provider may provide services. You pay the provider for services, submit an itemized billing statement showing proof of payment to our plan and you will be reimbursed. You are responsible for any amount over the eyewear coverage limit.
• Eyeglasses or contact lenses after cataract surgery	In-network: $0 copay Out-of-network: $0 copay	
Mental Health Services		Prior authorization may be required.
• Inpatient visit	In-network: $318 per day, days 1-5; $0 per day, days 6-90 Out-of-network: 25% per stay	
• Outpatient group therapy visit	In-network: $40 copay Out-of-network: $55 copay	
• Outpatient individual therapy	In-network: $40 copay Out-of-network: $55 copay	
Skilled Nursing Facility (SNF)	In-network: $0 per day, days 1-20; $164 per day, days 21-100	Our plan covers up to 100 days in a SNF.

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	Out-of-network: 25% per stay	Prior authorization may be required.
Rehabilitation Services		Prior authorization may be required.
• Occupational therapy visit	In-network: $40 copay Out-of-network: $55 copay	
• Physical therapy, speech therapy, and language therapy visit	In-network: $40 copay Out-of-network: $55 copay	
Ambulance (one-way trip)	In-network: $300 copay Out-of-network: $300 copay	Prior authorization is required for non-emergency transportation.
Transportation	Not Covered	
Foot Care (podiatry services)		
• Medicare-covered foot exams and treatment	In-network: $40 copay Out-of-network: $55 copay	
Medical Equipment/ Supplies		Prior authorization may be required.
• Durable medical equipment (wheelchair, oxygen, etc.)	In-network: 20% of the cost Out-of-network: 30% of the cost	
• Prosthetics (e.g., braces, artificial limbs)	In-network: 20% of the cost Out-of-network: 30% of the cost	

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• Diabetic supplies	In-network: 0% of the cost (preferred manufacturer) 20% of the cost (non-preferred manufacturer) Out-of-network: 20% of the cost	Preferred manufacturer: OneTouch/LifeScan. Prior authorization is required for blood glucose monitors in excess of one monitor per year and test strips in excess of 100 per 30 days, regardless of brand.
Wellness Program (e.g. fitness)	Free membership at participating SilverSneakers fitness facilities. Also access to online wellness related tools, planners, newsletters and classes.	
Medicare Part B Drugs	In-network: 20% of the cost for chemotherapy drugs 20% of the cost for other Part B drugs Out-of-network: 25% of the cost	Prior authorization may be required.
Other Information and Benefits		
Referrals	You don't need a referral from a PCP.	
Chiropractic Care	In-network: Medicare covered services: $20 copay Out-of-network: Medicare covered services: 25% of the cost	Medicare coverage is limited to manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). Prior Authorization may be required.
Dialysis	In-network: 20% of the cost Out-of-network: 25% of the cost	Prior authorization may be required.
Home Health Care	In-network: $0 copay Out-of-network: 25% of the cost	Prior authorization may be required.

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Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	Please see the Evidence of Coverage for more information about hospice care and coverage.
Outpatient Substance Abuse	In-network: Group therapy visit: $40 copay Individual therapy visit: $40 copay Out-of-network: 25% of the cost	Prior authorization may be required.
Outpatient Surgery	In-network: Freestanding ambulatory surgery center: $245 copay Outpatient hospital: $245 copay Out-of-network: Freestanding ambulatory surgery center: 25% of the cost Outpatient hospital: 25% of the cost	Prior authorization may be required.

Outpatient Prescription Drugs

Initial Coverage Limit (ICL) - total amount you and the plan pay for prescription drugs before you enter the coverage gap: $3,700

True Out-of-Pocket Threshold Amount (TrOOP) – total amount you pay before reaching the catastrophic coverage level: $4,950

Deductible: This plan does not have a pharmacy deductible.

Initial Coverage

Formulary: B3	Preferred Retail Rx 30-day supply	Preferred Retail and Preferred Mail Order 90-day supply	Standard Retail Rx 30-day supply	What You Should Know
Tier 1: Preferred Generic	$2	$0	$10	Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generic	$5	$15	$20	
Tier 3: Preferred Brand	$47	$141	$47	
Tier 4: Non-Preferred Drug	$100	$300	$100	
Tier 5: Specialty	33%	N/A	33%	

Members who get “Extra Help” are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

Additional Gap Coverage

Our plan offers some drug coverage in the Coverage Gap Stage.

Cost sharing for a 30-day supply at a network retail pharmacy that offers preferred cost sharing:

- Tier 1: $2
- Tier 2: $5

Cost sharing for a 30-day supply at a network retail pharmacy that offers standard cost sharing:

- Tier 1: $10
- Tier 2: $20

For all other formulary drugs, after you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap.

Catastrophic Coverage

After your total out-of-pocket costs reach $4,950, you pay the greater of:

- 5% of the cost of the drug
- $3.30 for a generic drug or a drug that is treated like a generic and $8.25 for all other drugs

Compare our plan to Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Contact us

For more information, please call us at the phone number below or visit us at http://www.coventry-medicare.com.

If you are not a member of this plan, call toll-free **1-855-338-9551** TTY users should call 711. From October 1 to February 14, you can call us 7 days a week from 8:00 am to 8:00 pm local time. From February 15 to September 30, you can call us Monday through Friday from 8:00 am to 8:00 pm local time.

Current members call the number on your ID card.

You can see our plan's provider directory at our website at http://www.coventry-medicare.com/findprovider.

Some of our network pharmacies have preferred cost sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website at http://www.coventry-medicare.com/findpharmacy.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at http://www.coventry-medicare.com/formulary.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

This document is available in other formats such as Braille, large print or audio.

Advantra Gold (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, you may pay more for these services. Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
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If you need these services, call the phone number listed in this material.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Aetna Medicare Grievance Department, P.O. Box 14067 Lexington, KY 40512. You can also file a grievance by phone by calling the phone number listed in this material. If you need help filing a grievance, call the phone number listed in this material. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also contact the Aetna Civil Rights Coordinator by phone at 1-855-348-1369, by email at MedicareCRCoordinator@aetna.com, or by writing to Aetna Medicare Grievance Department, ATTN: Civil Rights Coordinator, P.O. Box 14067, Lexington, KY 40512.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

ENGLISH:

ATTENTION: If you speak a language other than English, free language assistance services are available. Visit our website at www.aetnamedicare.com or call the phone number listed in this material.

ESPAÑOL (SPANISH):

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web en www.aetnamedicare.com o llame al número de teléfono que se indica en este material.

简体中文(CHINESE):

请注意：如果您说中文，您可以获得免费的语言援助服务。访问我们的网站 www.aetnamedicare.com 或致电本材料中列出的电话号码。

繁體中文 (CHINESE):

請注意：如果您說中文，您可以獲得免費的語言協助服務。請造訪我們的網站 www.aetnamedicare.com 或致電本材料中所列的電話號碼。

TAGALOG (TAGALOG - FILIPINO):

PAUNAWA: Kung nagsasalita ka ng Tagalog, may makukuhang libreng tulong na serbisyo para sa wika. Puntahan ang aming website sa www.aetnamedicare.com o tawagan ang numero ng telepono na nakalista sa materyales na ito.

FRANÇAIS (FRENCH):

ATTENTION : Si vous parlez le français, des services gratuits d'aide linguistique sont disponibles. Visitez notre site Web à l'adresse www.aetnamedicare.com ou appelez le numéro de téléphone indiqué dans ce document.

TIẾNG VIỆT (VIETNAMESE):

LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí. Xin truy cập trang web của chúng tôi tại www.aetnamedicare.com hoặc gọi số điện thoại ghi ở tài liệu này.

DEUTSCH (GERMAN):

ACHTUNG: Wenn Sie deutsch sprechen, steht ein kostenloser Dolmetscherservice zur Verfügung. Besuchen Sie unsere Website unter www.aetnamedicare.com oder rufen Sie unter der in diesem Dokument aufgeführten Telefonnummer an.

한국어 (KOREAN):

주의: 한국어를 하시는 분들을 위해 무료 통역 서비스가 제공됩니다. www.aetnamedicare.com 에서 웹사이트를 방문하거나 본 자료에 제공된 전화번호로 문의해 주시기 바랍니다.

РУССКИЙ (RUSSIAN):

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться нашими бесплатными услугами переводчиков. Посетите наш веб-сайт по адресу www.aetnamedicare.com или позвоните по телефону, указанному в этом документе.

العربية (ARABIC):

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية سوف تتوفر لك مجانًا. تفضل بزيارة الموقع www.aetnamedicare.com الإلكتروني الخاص بن أو اتصل برقم الهاتف الموضح في هذا المستند.

हिंदी (HINDI):

ध्यान दें: अगर आप बात करने में सक्षम हैं हिंदी, तो न शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। हमारी वेबसाइट www.aetnamedicare.com पर विजिट करें या इस सामग्री में सूचीबद्ध फोन नंबर पर कॉल करें।

ITALIANO (ITALIAN):

ATTENZIONE: Se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti. Visita il nostro sito web www.aetnamedicare.com o chiama il numero telefonico elencato di seguito.

PORTUGUÊS (PORTUGUESE):

ATENÇÃO: Se você fala português, serviços gratuitos de ajuda para esse idioma estão disponíveis. Visite nosso site www.aetnamedicare.com ou ligue para o número listado neste material.

KREYOL AYISYEN (FRENCH CREOLE):

ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd gratis nan lang ki disponib pou ou. Ale sou sitwèb nan www.aetnamedicare.com oswa rele nimewo telefòn ki endike nan dokiman sa a.

POLSKI (POLISH):

UWAGA! Osoby mówiące po polsku, mogą skorzystać z bezpłatnych usług pomocy językowej. Proszę wejść na naszą stronę internetową www.aetnamedicare.com lub zadzwonić pod numer telefonu podany w tym materiale.

日本語 (JAPANESE):

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