

COMPARISON OF COVENTRY ADVANTRA HEALTH INSURANCE PLANS EFFECTIVE MAY 1, 2013 - PUBLISHED BY THE RETIREMENT DIVISION

<u>HEALTH INSURANCE COMPANY:</u>	<u>COVENTRY ADVANTRA HMO PLAN 2</u>	<u>COVENTRY ADVANTRA HMO PLAN 3</u>
	In-Network	Out-of-Network
		No coverage out-of-network.
HOSPITAL(S)	112 Area Hospitals	112 Area Hospitals
Primary Care Physician Choices	2,139	2,139
Specialist Choices	6,752	6,752
Deductible	None	None
Coinsurance %	100% of Medicare allowed amounts	100% of Medicare allowed amounts
Out-of-Pocket Maximum	\$2,000 for in-network medical benefits (prescription drugs excluded)	\$3,400 for in-network medical benefits (prescription drugs excluded).
Lifetime Maximum Benefit	No Limit	No Limit
HOSPITAL COVERAGE		
Inpatient Room	\$150/day Co-Pay for days 1-5 per admission; additional days covered at 100%. Unlimited number of days.	\$200/day Co-Pay for days 1-7 per admission; additional days covered at 100%. Unlimited number of days.
Maternity	\$150/day Co-Pay for days 1-5 per admission; additional days covered at 100%. Unlimited number of days.	\$200/day Co-Pay for days 1-7 per admission; additional days covered at 100%. Unlimited number of days.
Mental Health (Inpatient)	\$150/day Co-Pay for days 1-5 per admission; additional days covered at 100%. Unlimited number of days.	\$200/day Co-Pay for days 1-7 per admission; additional days covered at 100%. Unlimited number of days.
Substance Abuse (Inpatient)	\$150/day Co-Pay for days 1-5 per admission; additional days covered at 100%. Unlimited number of days.	\$200/day Co-Pay for days 1-7 per admission; additional days covered at 100%. Unlimited number of days.
Out-Patient X-Ray & Laboratory	100% clinical/diagnostic lab services and Medicare-covered x-ray visit	100% clinical/diagnostic lab services and regular x-ray
Out-Patient Surgery	\$100 Co-Pay	\$225 Co-Pay
Emergency Room	\$50 Co-Pay for Medicare covered visit. (Waived if admitted to same hospital within 72 hours)	\$65 Co-Pay for Medicare covered visit. (Waived if admitted within 72 hours)
DOCTOR/PCP COVERAGE		
Annual Wellness Visits & Immunizations	\$0 Co-Pay PCP for one routine physical per year. 100% immunizations.	\$0 Co-Pay PCP for one routine physical per year. 100% immunizations.
Office (Illness/Injury)	\$10 Co-Pay PCP, \$20 Co-Pay Specialist	\$5 Co-Pay PCP, \$30 Co-Pay Specialist
Lab Tests & X-Rays	100% routine lab and x-ray \$0 Co-Pay for CAT scan, PET scan and MRI 0% Coinsurance for each Medicare covered radiation therapy service	100% routine lab and x-ray \$150 Co-Pay for CAT scan 20% coinsurance for PET scans, MRI, MRA and therapeutic radiology
Allergy Treatment	\$10 Co-Pay PCP, \$20 Co-Pay Specialist	\$5 Co-Pay PCP, \$30 Co-Pay Specialist
Allergy Testing	\$10 Co-Pay PCP, \$20 Co-Pay Specialist	\$5 Co-Pay PCP, \$30 Co-Pay Specialist
Mental Health (Outpatient)	\$20 Co-Pay individual visit, \$10 Co-Pay group session.	\$30 Co-Pay individual visit
Substance Abuse (Outpatient)	\$20 Co-Pay individual visit, \$10 Co-Pay group session.	\$30 Co-Pay individual visit
Out of Hospital Prescriptions	Up to 30 day supply at Participating Pharmacy. \$10 Preferred Generic; \$30 Preferred Brand Name; \$55 Non-Preferred Generics & Non-Preferred Brand Name; Pharmacy & Mail Order 90 day supply \$20/\$60/\$110. Co-Pay plus the difference in cost between the Brand Name and the Generic when the Brand Name is purchased.	Up to 30 day supply at Participating Pharmacy. \$6 Preferred Generic; \$45 Preferred Brand Name; \$80 Non-Preferred Generics & Non-Preferred Brand Name; Pharmacy & Mail Order 90 day supply \$18/\$135/\$240. Co-Pay plus the difference in cost between the Brand Name and the Generic when the Brand Name is purchased. After total plan costs for Preferred Brand and Non-Preferred Generics & Brand paid by both you and your plan reach \$2,970, you have Preferred Generic drug coverage only until your plan year out of pocket costs reach \$4,750. After the \$2,970 limit is met you can use your Advantra ID card for a discount. After your plan year out-of-pocket drug costs reach \$4,750, you pay the greater of: \$2.65 for generic or brand name drugs treated as generic and \$6.60 for all other drugs, or 5% coinsurance, whichever is highest. (Preferred Generics do not count toward the \$2,970 or \$4,750 limits.) Co-Pay plus the difference in cost between the Brand Name and the Generic when the Brand Name is purchased.
Routine Eye Exam	\$10 PCP Co-Pay or \$20 Specialist Co-Pay for one routine visit per calendar year. \$20 Co-Pay for each Medicare approved diagnostic exam. \$100 credit toward lenses and frames every 24 months or \$70 credit toward contact lenses every 24 months.	\$5 Co-Pay for one routine eye exam. \$30 Co-Pay for all other Medicare covered exams. \$0 CoPay for glaucoma screenings. \$125 coverage limit for non-Medicare covered eyewear per year.
Routine Hearing Exam	\$10 Co-Pay, one visit per calendar year.	\$5 Co-Pay, one visit per calendar year.
Dental	Not Covered.	Not covered
SilverSneakers Fitness Benefit	Designated Health Club Membership/Fitness Classes	Designated Health Club Membership/Fitness Classes
Dependent Coverage	End of the calendar year in which eligible child reaches age 26 regardless of student status if covered on a City non-Medicare plan.	End of the calendar year in which eligible child reaches age 26 regardless of student status if covered on a City non-Medicare plan.

THIS IS A GENERAL SUMMARY OF BENEFITS FOR REFERENCE ONLY. THE EVIDENCE OF COVERAGE FROM COVENTRY HEALTH CARE IS THE BINDING CONTRACT. CONTACT COVENTRY AT 1-800-727-9712 FOR MORE INFORMATION.