

**Introduction to the Summary of Benefits Report for  
ADVANTAGE Special Needs Plan (HMO SNP) [Contract H8822]  
January 1, 2012 - December 31, 2012  
HAMILTON, HANCOCK, JOHNSON, MARION, MORGAN**

Thank you for your interest in ADVANTAGE Special Needs Plan (HMO SNP). Our plan is offered by ADVANTAGE HEALTH SOLUTIONS, INC., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan (SNP). 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 ADVANTAGE Special Needs Plan (HMO SNP) 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 ADVANTAGE Special Needs Plan (HMO SNP) 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 ADVANTAGE Special Needs Plan (HMO SNP). 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 ADVANTAGE Special Needs Plan (HMO SNP) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD 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 ADVANTAGE Special Needs Plan (HMO SNP) 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 ADVANTAGE Special Needs Plan (HMO SNP) AVAILABLE?

The service area for this plan includes: Hamilton, Hancock, Johnson, Marion, Morgan Counties, IN. You must live in one of these areas to join the plan.

#### WHO IS ELIGIBLE TO JOIN ADVANTAGE Special Needs Plan (HMO SNP)?

You can join ADVANTAGE Special Needs Plan (HMO SNP) 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 generally are not eligible to enroll in ADVANTAGE Special Needs Plan (HMO SNP) unless they are members of our organization and have been since their dialysis began.

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

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

#### CAN I CHOOSE MY DOCTORS?

ADVANTAGE Special Needs Plan (HMO SNP) 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. For an updated list, visit us at [www.advantageplan.com](http://www.advantageplan.com). Our customer service number is listed at the end of this introduction.

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

If you choose to go to a doctor outside of our network, you must pay for these services yourself except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services

#### WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

ADVANTAGE Special Needs Plan (HMO SNP) 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.advantageplan.com](http://www.advantageplan.com). Our customer service number is listed at the end of this introduction.

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

ADVANTAGE Special Needs Plan (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

#### WHAT IS A PRESCRIPTION DRUG FORMULARY?

ADVANTAGE Special Needs Plan (HMO SNP) 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 website at [www.advantageplan.com](http://www.advantageplan.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 MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

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You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see [www.medicare.gov](http://www.medicare.gov) 'Programs for People with Limited Income and Resources' in the publication Medicare You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

## WHAT ARE MY PROTECTIONS IN THIS PLAN?

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All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, 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 ADVANTAGE Special Needs Plan (HMO SNP), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of ADVANTAGE Special Needs Plan (HMO SNP), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you

have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

#### WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we 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 ADVANTAGE Special Needs Plan (HMO SNP) 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 ADVANTAGE Special Needs Plan (HMO SNP) 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 Alfa 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 administered through DME.

#### WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on [www.medicare.gov](http://www.medicare.gov) and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call ADVANTAGE Health Solutions, Inc. for more information about ADVANTAGE Special Needs Plan (HMO SNP).

Visit us at [www.advantageplan.com](http://www.advantageplan.com) or, call us:

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,  
8:00 a.m. - 8:00 p.m. Eastern

Current members should call toll-free (800)-523-7533 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-743-3333)

Prospective members should call toll-free (800)-201-8342 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-743-3333)

Current members should call locally (317)-573-7950 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-743-3333)

Prospective members should call locally (800)-201-8342 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-743-3333)

Current members should call toll-free (877)-684-0014 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-763-9630)

Prospective members should call toll-free (800)-201-8342 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800)-743-3333)

Current members should call locally (877)-684-0014 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (866)-763-9630)

Prospective members should call locally (800)-201-8342 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800)-743-3333)

For more information about Medicare,  
please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.  
Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

If you have any questions about this plan's benefits or costs, please contact ADVANTAGE Health Solutions.

| Benefit | Original Medicare | ADVANTAGE Special Needs Plan<br>(HMO SNP) |
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**IMPORTANT INFORMATION**

**1 - Premium and Other Important Information**

The Medicare cost-sharing amount may vary based on your level of Medicaid eligibility.

In 2011 the monthly Part B Premium was \$0 or \$96.40 and may change for 2012 and the annual Part B deductible amount was \$0 or \$162 and may change for 2012.\*

**General**

\* Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for Original Medicare services.

\*\* Please consult with your plan about cost-sharing when receiving services from out-of-network providers.

\$0-\$35.90 monthly plan premium in addition to your monthly Medicare Part B premium.\*

This plan does not allow providers to balance bill (charging more than your cost-share amount).

In 2011 the monthly Part B Premium was \$0 or \$96.40 and may change for 2012 and the annual Part B deductible amount was \$0 or \$162 and may change for 2012.\* Contact the plan for services that apply.

**In-Network**

In 2011 the monthly Part B Premium was \$0 or \$96.40 and may change for 2012 and the annual Part B deductible amount was \$0 or \$162 and may change for 2012.\* Contact the plan for services that apply.

\$6700 out-of-pocket limit for Medicare-covered services.\*

**Out-of-Network**

In 2011 the monthly Part B Premium was \$0 or \$96.40 and may change for 2012 and the annual Part B deductible

| <b>Benefit</b>   | <b>Original Medicare</b>   | <b>ADVANTAGE Special Needs Plan<br/>(HMO SNP)</b>   |
|--|--|---|
|  |  | <p>amount was \$0 or \$162 and may change for 2012.* Contact the plan for services that apply.</p> <p>\$3300 out-of-pocket limit for Medicare-covered services.**</p> <p><b>In and Out-of-Network</b></p> <p>In 2011 the monthly Part B Premium was \$0 or \$96.40 and may change for 2012 and the annual Part B deductible amount was \$0 or \$162 and may change for 2012.* Contact the plan for services that apply.</p> <p>\$10,000 out-of-pocket limit for Medicare-covered services.*</p> |
| <p><b>2 - Doctor and Hospital Choice</b></p> <p>(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)</p> | <p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>   | <p><b>In-Network</b></p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p>  |
| <p><b>SUMMARY OF BENEFITS<br/>INPATIENT CARE</b></p>   |  |   |
| <p><b>3 - Inpatient Hospital Care</b></p> <p>(includes Substance Abuse and Rehabilitation Services)</p>                              | <p>In 2011 the amounts for each benefit period were:</p> <p>\$0 or</p> <p>Days 1 - 60: \$1132 deductible.*</p> <p>Days 61 - 90: \$283 per day.*</p> <p>Days 91 - 150: \$566 per lifetime reserve day.*</p> <p>These amounts may change for 2012.</p> | <p><b>In-Network</b></p> <p>Plan covers 90 days each benefit period.</p> <p>In 2012 the amounts for each benefit period are:</p> <p>\$0 or:</p> <p>Days 1 - 60: \$1132 deductible.*</p> <p>Days 61 - 90: \$283 per day.*</p> <p>Days 91 - 150: \$566 per lifetime reserve</p>   |

| <b>Benefit</b>                                 | <b>Original Medicare</b>   | <b>ADVANTAGE Special Needs Plan<br/>(HMO SNP)</b>  |
|--|--|--|
|  | <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</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. 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>day.*</p> <p>These amounts may change for 2012.</p> <p>You will not be charged additional cost-sharing for professional services.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>  |
| <p><b>4 - Inpatient Mental Health Care</b></p> | <p>In 2011 the amounts for each benefit period were:</p> <p>\$0 or:</p> <p>Days 1 - 60: \$1132 deductible.*</p> <p>Days 61 - 90: \$283 per day.*</p> <p>Days 91 - 150: \$566 per lifetime reserve day.*</p> <p>These amounts may change for 2012.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> | <p><b>In-Network</b></p> <p>In 2012 the amounts for each benefit period are:</p> <p>\$0 or</p> <p>Days 1 - 60: \$1132 deductible.*</p> <p>Days 61 - 90: \$283 per day.*</p> <p>Days 91 - 150: \$566 per lifetime reserve day.*</p> <p>These amounts may change for 2012.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> |

| <b>Benefit</b>   | <b>Original Medicare</b>  | <b>ADVANTAGE Special Needs Plan (HMO SNP)</b>   |
|--|---|---|
| <p><b>5 - Skilled Nursing Facility (SNF)</b><br/><br/>(in a Medicare-certified skilled nursing facility)</p>   | <p>In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p>Days 1 - 20: \$0 per day.*</p> <p>Days 21 - 100: \$0 or \$141.50 per day.*</p> <p>These amounts may change for 2012.</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><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>Plan covers up to 100 days each benefit period.<br/>3-day prior hospital stay is required.</p> <p>In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <p>\$0 or</p> <p>Days 1 - 20: \$0 per day.*</p> <p>Days 21 - 100: \$0 or \$141.50 per day.*</p> <p>These amounts may change for 2012.</p> <p>You will not be charged additional cost-sharing for professional services.</p> |
| <p><b>6 - Home Health Care</b><br/><br/>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p> | <p>\$0 copay.</p>   | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>\$0 copay for Medicare-covered home health visits.*</p>   |
| <p><b>7 - Hospice</b></p>  | <p>You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>   | <p><b>General</b><br/>You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>   |
| <b>OUTPATIENT CARE</b>   |   |   |
| <p><b>8 - Doctor Office Visits</b></p>   | <p>0% or 20% coinsurance.</p>   | <p><b>In-Network</b><br/>0% or 20% of the cost for each primary care doctor visit for Medicare-covered</p>  |

| Benefit                                   | Original Medicare   | ADVANTAGE Special Needs Plan (HMO SNP)   |
|---|---|--|
|   |   | <p>benefits.*</p> <p>0% or 20% of the cost for each in-area, network urgent care Medicare-covered visit.*</p> <p>0% or 20% of the cost for each specialist visit for Medicare-covered benefits.*</p>   |
| <b>9 - Chiropractic Services</b>          | <p>Supplemental 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><b>In-Network</b></p> <p>0% or 20% of the cost for each Medicare-covered visit.*</p> <p>Medicare-covered chiropractic visits are 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>   |
| <b>10 - Podiatry Services</b>             | <p>Supplemental 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><b>In-Network</b></p> <p>0% or 20% of the cost for each Medicare-covered visit.*</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>   |
| <b>11 - Outpatient Mental Health Care</b> | <p>0% or 40% coinsurance for most outpatient mental health services.</p> <p>0% or 40% coinsurance of the Medicare-approved amount for each service you get from a qualified professional as part of a Partial Hospitalization Program.</p> <p>"Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.</p> | <p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>0% or 40% of the cost for each Medicare-covered individual therapy visit.*</p> <p>0% or 40% of the cost for each Medicare-covered group therapy visit.*</p> <p>0% or 20% of the cost for each Medicare-covered individual therapy visit with a psychiatrist.*</p> <p>0% or 20% of the cost for each Medicare-covered group therapy visit with a psychiatrist.*</p> |

| Benefit   | Original Medicare  | ADVANTAGE Special Needs Plan (HMO SNP)   |
|---|--|--|
|   |  | 0% or 20% of the cost for Medicare-covered partial hospitalization program services.*  |
| <b>12 - Outpatient Substance Abuse Care</b>   | 0% or 20% coinsurance  | <p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>0% or 20% of the cost for Medicare-covered individual therapy visits.*</p> <p>0% or 20% of the cost for Medicare-covered group visits.*</p>  |
| <b>13 - Outpatient Services/Surgery</b>   | <p>0% or 20% coinsurance for the doctor's services.</p> <p>Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>0% or 20% coinsurance for ambulatory surgical center facility services.</p>  | <p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>0% or 20% of the cost for each Medicare-covered ambulatory surgical center visit.*</p> <p>0% or 20% of the cost for each Medicare-covered outpatient hospital facility visit.*</p>   |
| <b>14 - Ambulance Services</b><br><br>(medically necessary ambulance services)  | 0% or 20% coinsurance.   | <p><b>In-Network</b></p> <p>0% or 20% of the cost for Medicare-covered ambulance benefits.*</p>  |
| <b>15 - Emergency Care</b><br><br>(You may go to any emergency room if you reasonably believe you need emergency care.) | <p>0% or 20% coinsurance for the doctor's services.</p> <p>Specified copayment for outpatient hospital facility emergency services.</p> <p>Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.</p> <p>You don't have to pay the emergency</p> | <p><b>General</b></p> <p>0% or 20% of the cost (up to \$65) for Medicare-covered emergency room visits.*</p> <p>Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay</p> |

| <b>Benefit</b>   | <b>Original Medicare</b>  | <b>ADVANTAGE Special Needs Plan<br/>(HMO SNP)</b>   |
|--|---|---|
|  | <p>room copay if you are admitted to the hospital as an inpatient 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>\$0 for the emergency room visit.</p>  |
| <p><b>16 - Urgently Needed Care</b></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><b>General</b></p> <p>0% or 20% of the cost for Medicare-covered urgently-needed-care visits.*</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the urgently-needed-care visit.</p>  |
| <p><b>17 - Outpatient Rehabilitation Services</b></p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p> | <p>0% or 20% coinsurance.</p>   | <p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits.</p> <p>0% or 20% of the cost for Medicare-covered Occupational Therapy visits.*</p> <p>0% or 20% of the cost for Medicare-covered Physical and/or Speech and Language Therapy visits.*</p> |
| <b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>  |   |   |
| <p><b>18 - Durable Medical Equipment</b></p> <p>(includes wheelchairs, oxygen, etc.)</p>   | <p>0% or 20% coinsurance.</p>   | <p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>0% or 20% of the cost for Medicare-covered items.*</p>  |

| <b>Benefit</b>   | <b>Original Medicare</b>   | <b>ADVANTAGE Special Needs Plan<br/>(HMO SNP)</b>  |
|--|--|--|
| <p><b>19 - Prosthetic Devices</b><br/>(includes braces, artificial limbs and eyes, etc.)</p> | <p>0% or 20% coinsurance</p>   | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>0% or 20% of the cost for Medicare-covered items.*</p>   |
| <p><b>20 - Diabetes Programs and Supplies</b></p>  | <p>0% or 20% coinsurance for diabetes self-management training.</p> <p>0% or 20% coinsurance for diabetes supplies.</p> <p>0% or 20% coinsurance for diabetic therapeutic shoes or inserts.</p>  | <p><b>In-Network</b><br/>0% or 20% of the cost for diabetes self-management training.*</p> <p>0% or 0% to 20% of the cost for diabetes monitoring supplies.*</p> <p>0% or 20% of the cost for therapeutic shoes or inserts*</p>  |
| <p><b>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b></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 supplemental routine screening tests, like checking your cholesterol.</p> | <p><b>General</b><br/>Authorization rules may apply.</p> <p><b>In-Network</b><br/>0% or 20% of the cost for Medicare-covered lab services.*</p> <p>0% or 20% of the cost for Medicare-covered diagnostic procedures and tests.*</p> <p>0% or 20% of the cost for Medicare-covered X-rays.*</p> <p>0% or 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays).*</p> <p>0% or 20% of the cost for Medicare-covered therapeutic radiology services.*</p> <p>If the doctor provides you services in addition to outpatient diagnostic procedures, tests and lab services, separate cost-sharing of 0% or 20% of</p> |

| Benefit  | Original Medicare  | ADVANTAGE Special Needs Plan (HMO SNP)   |
|--|--|--|
|  |  | <p>the cost may apply.*</p> <p>If the doctor provides you services in addition to outpatient diagnostic and therapeutic radiology services, separate cost-sharing of 0% or 20% of the cost may apply.*</p>   |
| <p><b>22 - Cardiac and Pulmonary Rehabilitation Services</b></p>       | <p>0% or 20% coinsurance for Cardiac Rehabilitation services.</p> <p>0% or 20% coinsurance for Pulmonary Rehabilitation services.</p> <p>0% or 20% coinsurance for Intensive Cardiac Rehabilitation services.</p> <p>This applies to program services provided in a doctor's office. Specified cost-sharing for program services provided by hospital outpatient departments.</p>  | <p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>0% or 20% of the cost for Medicare-covered Cardiac Rehabilitation Services.*</p> <p>0% or 20% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services.*</p> <p>0% or 20% of the cost for Medicare-covered Pulmonary Rehabilitation Services.*</p>   |
| <p><b>PREVENTIVE SERVICES</b></p>                                      |  |  |
| <p><b>23 - Preventive Services and Wellness/Education Programs</b></p> | <p>No coinsurance, copayment or deductible for the following:</p> <ul style="list-style-type: none"> <li>- Abdominal Aortic Aneurysm Screening.</li> <li>- Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</li> <li>- Cardiovascular Screening.</li> <li>- Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk.</li> <li>- Colorectal Cancer Screening.</li> <li>- Diabetes Screening.</li> <li>- Influenza Vaccine.</li> <li>- Hepatitis B Vaccine for people with Medicare who are at risk.</li> </ul> | <p><b>General</b></p> <p>\$0 copay for all preventive services covered under Original Medicare at zero cost-sharing:</p> <ul style="list-style-type: none"> <li>- Abdominal Aortic Aneurysm screening.</li> <li>- Bone Mass Measurement.</li> <li>- Cardiovascular Screening.</li> <li>- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam).</li> <li>- Colorectal Cancer Screening.</li> <li>- Diabetes Screening.</li> <li>- Influenza Vaccine.</li> <li>- Hepatitis B Vaccine.</li> <li>- HIV Screening.</li> <li>- Breast Cancer Screening (Mammogram).</li> </ul> |

| Benefit | Original Medicare   | ADVANTAGE Special Needs Plan<br>(HMO SNP)   |
|---------|---|---|
|         | <ul style="list-style-type: none"> <li>- HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor’s visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</li> <li>- Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39.</li> <li>- Medical Nutrition Therapy Services 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 and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</li> <li>- Personalized Prevention Plan Services (Annual Wellness Visits).</li> <li>- Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</li> <li>- Prostate Cancer Screening Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.</li> <li>- Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</li> <li>- Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then</li> </ul> | <ul style="list-style-type: none"> <li>- Medical Nutrition Therapy Services.</li> <li>- Personalized Prevention Plan Services (Annual Wellness Visits).</li> <li>- Pneumococcal Vaccine.</li> <li>- Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only).</li> <li>- Smoking Cessation (Counseling to stop smoking).</li> <li>- Welcome to Medicare Physical Exam (Initial Preventive Physical Exam).</li> </ul> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p><b>In-Network</b></p> <p>This plan does not cover supplemental education/wellness programs.</p> |

| <b>Benefit</b>                                   | <b>Original Medicare</b>   | <b>ADVANTAGE Special Needs Plan (HMO SNP)</b>   |
|--|--|---|
|  | <p>you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.</p>   |   |
| <p><b>24 - Kidney Disease and Conditions</b></p> | <p>0% or 20% coinsurance for renal dialysis.</p> <p>0% or 20% coinsurance for kidney disease education services.</p>   | <p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>0% or 20% of the cost for renal dialysis.*</p> <p>\$0 copay for kidney disease education services.*</p>   |
| <p><b>25 - Outpatient Prescription Drugs</b></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><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b></p> <p>\$0 annual deductible for Part B-covered drugs.*</p> <p>0% or 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.*</p> <p><b>Drugs covered under Medicare Part D</b></p> <p><b>General</b></p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.advantageplan.com">www.advantageplan.com</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who:</p> <ul style="list-style-type: none"> <li>-have limited incomes,</li> <li>-live in long term care facilities, or</li> <li>-have access to Indian/Tribal/Urban (Indian Health Service) providers.</li> </ul> |

| Benefit | Original Medicare | ADVANTAGE Special Needs Plan (HMO SNP)   |
|---------|-------------------|--|
|         |                   | <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by 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 ADVANTAGE Special Needs Plan (HMO SNP) for certain drugs.</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 that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p><b>In-Network</b></p> <p>You pay a \$0 annual deductible.</p> |

| <b>Benefit</b> | <b>Original Medicare</b> | <b>ADVANTAGE Special Needs Plan<br/>(HMO SNP)</b>   |
|----------------|--------------------------|---|
|                |                          | <p><b>Initial Coverage</b></p> <p>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"> <li>- A \$0 copay or</li> <li>- A \$1.10 copay or</li> <li>- A \$2.60 copay.</li> </ul> <p>For all other drugs, either:</p> <ul style="list-style-type: none"> <li>- A \$0 copay or</li> <li>- A \$3.30 copay or</li> <li>- A \$6.50 copay.</li> </ul> <p><b>Retail Pharmacy</b></p> <p>You can get drugs the following way(s):</p> <ul style="list-style-type: none"> <li>- one-month (30-day) supply</li> <li>- three-month (90-day) supply</li> </ul> <p>Not all drugs are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Long Term Care Pharmacy</b></p> <p>You can get drugs the following way(s):</p> <ul style="list-style-type: none"> <li>- one-month (31-day) supply.</li> </ul> <p><b>Mail Order</b></p> <p>You can get drugs the following way(s):</p> <ul style="list-style-type: none"> <li>- one-month (30-day) supply.</li> </ul> |

| <b>Benefit</b> | <b>Original Medicare</b> | <b>ADVANTAGE Special Needs Plan (HMO SNP)</b>  |
|----------------|--------------------------|--|
|                |                          | <p>- three-month (90-day) supply.</p> <p>Not all drugs are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you pay a \$0 copay.</p> <p><b>Out-of-Network</b></p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to 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 ADVANTAGE Special Needs Plan (HMO SNP).</p> <p>You can get drugs the following way:</p> <p>- one-month (30-day) supply.</p> <p><b>Out-of-Network Initial Coverage</b></p> <p>Depending on your income and institutional status, you will be reimbursed by ADVANTAGE Special Needs Plan (HMO SNP) up to the plan's cost of the drug minus the following:</p> <p>For generic drugs purchased out-of-network (including brand drugs treated as generic), either:</p> <p>- A \$0 copay or</p> <p>- A \$1.10 copay or</p> |

| <b>Benefit</b>               | <b>Original Medicare</b>   | <b>ADVANTAGE Special Needs Plan (HMO SNP)</b>   |
|------------------------------|--|---|
|                              |  | <p>- A \$2.60 copay.</p> <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> <li>- A \$0 copay or</li> <li>- A \$3.30 copay or</li> <li>- A \$6.50 copay.</li> </ul> <p><b>Out-of-Network Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed in full for drugs purchased out-of-network.</p> |
| <b>26 - Dental Services</b>  | Preventive dental services (such as cleaning) not covered.   | <p><b>In-Network</b></p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>- up to 1 oral exam every year.</li> <li>- up to 1 cleaning every year.</li> <li>- up to 1 fluoride treatment every year.</li> <li>- up to 1 dental x-ray every year.</li> </ul> <p>0% or 20% of the cost for Medicare-covered dental benefits.*</p>                     |
| <b>27 - Hearing Services</b> | <p>Supplemental routine hearing exams and hearing aids not covered.</p> <p>0% or 20% coinsurance for diagnostic hearing exams.</p> | <p><b>In-Network</b></p> <p>In general, supplemental routine hearing exams and hearing aids not covered.</p> <ul style="list-style-type: none"> <li>- 0% or 20% of the cost for Medicare-covered diagnostic hearing exams*</li> </ul>   |
| <b>28 - Vision Services</b>  | 0% or 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.   | <p><b>In-Network</b></p> <p>\$0 copay for</p>   |

| <b>Benefit</b>                         | <b>Original Medicare</b>   | <b>ADVANTAGE Special Needs Plan<br/>(HMO SNP)</b>   |
|--|--|---|
|  | <p>Supplemental 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> | <ul style="list-style-type: none"> <li>- one pair of eyeglasses or contact lenses after cataract surgery.*</li> <li>- glasses</li> <li>- contacts</li> <li>- 0% or 20% of the cost for exams to diagnose and treat diseases and conditions of the eye.*</li> <li>- 0% of the cost for up to 1 supplemental routine eye exam(s) every year</li> </ul> <p>\$150 plan coverage limit for eye wear every two years.</p> |
| <b>Over-the-Counter Items</b>          | Not covered.   | <p><b>General</b></p> <p>The plan does not cover Over-the-Counter items.</p>  |
| <b>Transportation</b><br><br>(Routine) | Not covered.   | <p><b>General</b></p> <p>Authorization rules may apply.</p> <p><b>In-Network</b></p> <p>\$0 copay for up to 13 round trip(s) to plan-approved location every year.</p>  |
| <b>Acupuncture</b>                     | Not covered.   | <p><b>In-Network</b></p> <p>This plan does not cover Acupuncture.</p>   |

| <b>SECTION 3</b>  |  |
|---|--|
| <b>Category</b>   | <b>Notes Text</b>  |
|   | <b>ADVANTAGE Special Needs Plans (HMO SNP)</b>   |
| <i>See page 9 for information about Doctor Office Visits</i>                        | A primary doctor is a general practitioner, internal medicine doctor, family practice doctor, pediatrician or gynecologist.  |
| <i>See page 12 for information about Outpatient Rehabilitation Services</i>         | Medicare defined coverage limits apply.  |
| <i>See page 12 for information about Durable Medical Equipment</i>                  | Prior Authorization required for DME greater than \$500.   |
| <i>See page 13 for information about Prosthetic Devices</i>                         | Prior Authorization required for Prosthetics and Medical Supplies greater than \$500.  |
| <i>See page 13 for information about Diagnostic Tests, X-Rays, and Lab Services</i> | Authorization for Chemotherapy and Radiation Therapy only.   |
| <i>See page 21 for Transportation</i>   | Member must receive Authorization from ADVANTAGE Member Services.<br><br>Transportation coverage is provided by contracted medical transport company only. No other transportation type covered. |
| <i>See page 22 for Meal Benefit</i>   | 10 Meal limit per inpatient stay.<br>Authorization rules may apply.  |

## Section IV

The kind of Medicaid benefits you receive are determined by the State of Indiana and may vary based upon your income and resources. Also, your Medicaid benefits can change throughout the year. With the assistance of Medicaid, some dual eligibles do not have to pay for certain Medicare costs. The Medicaid benefit categories and type of assistance served by our plan are listed below:

1. **Qualified Medicare Beneficiary (QMB) -only coverage:**
  - The member's benefits are limited to payment of the member's Medicare Part A and Part B premiums as well as deductibles and coinsurance for Medicare-covered services only. Claims for services not covered by Medicare are denied as Medicaid non-covered services.
2. **Qualified Medicare Beneficiary (QMB)-plus coverage without spend-down:**
  - The member's benefits include payment of the member's Medicare premiums, deductibles, and coinsurance on Medicare-covered services in addition to Traditional Medicaid benefits throughout each month of eligibility. For these members, Medicaid claims for services not covered by Medicare will be submitted as regular Medicaid claims.
3. **Qualified Medicare Beneficiary (QMB)-plus coverage with spend-down:**
  - The member's benefits include payment of the member's Medicare premiums, deductibles, and coinsurance for Medicare-covered services in addition to Traditional Medicaid benefits after the member's monthly spend-down liability is met. After the spend-down liability is met, the member becomes eligible for the full benefits covered by the Traditional Medicaid program excluding prescription drug coverage. Claims may process toward the member's spend-down amount; however, until the spend-down liability is satisfied, the member's benefits are limited to payment of Medicare deductibles and coinsurance for Medicare-covered services.
4. **Specified Low Income Medicare Beneficiary (SLMB) -only coverage:**
  - The member's benefits are limited to payment of the member's Medicare Part B premium only.
5. **Specified Low Income Medicare Beneficiary (SLMB)-plus coverage without spend-down:**
  - The member's benefits include payment of the member's Medicare Part B premium in addition to Traditional Medicaid benefits throughout each month of eligibility.
6. **Specified Low Income Medicare Beneficiary (SLMB)-plus coverage with spend-down:**
  - The member's benefits include payment of the member's Medicare Part B premium in addition to Traditional Medicaid benefits after his or her monthly spend-down liability is met. After the spend-down liability is met, the member becomes eligible for the full benefits covered by the Traditional Medicaid program excluding prescription drug. Claims may process toward the member's spend-down amount; however, until the spend-down liability is satisfied, the member's benefits are limited to payment of the Medicare Part B premium.
7. **Qualifying Individual (QI) coverage:**
  - The member's benefit is payment of the member's Medicare Part B premium.
8. **Qualifying Disabled Working Individual (QDWI) coverage:**
  - The member's benefit is payment of the member's Medicare Part A premium.
9. **Full Benefit Dual Eligible (FBDE)**
  - Eligible for the full benefits covered by the Traditional Medicaid program

The chart below provides a summary of the different Medicaid benefit categories and the coverage they offer.

| Medicaid Benefit Category |                           | Full Medicaid Medical Benefits    | Medicaid Pays for:      |                         |                               | Low Income Subsidy (LIS): also known as “Extra Help” for Part D benefits |
|---------------------------|---------------------------|-----------------------------------|-------------------------|-------------------------|-------------------------------|--|
|                           |                           |                                   | Medicare Part A Premium | Medicare Part B Premium | Medicare Medical Cost-sharing |  |
| <b>1</b>                  | QMB only                  |                                   | Covered                 | Covered                 | Covered                       | Automatically Qualify  |
| <b>2</b>                  | QMB + with no spend-down  | Covered                           | Covered                 | Covered                 | Covered                       | Automatically Qualify  |
| <b>3</b>                  | QMB + with spend-down     | Covered after reaching spend-down | Covered                 | Covered                 | Covered                       | Automatically Qualify  |
| <b>4</b>                  | SLMB only                 |                                   |                         | Covered                 |                               | Automatically Qualify  |
| <b>5</b>                  | SLMB + with no spend-down | Covered                           |                         | Covered                 |                               | Automatically Qualify  |
| <b>6</b>                  | SLMB + with spend-down    | Covered after reaching spend-down |                         | Covered                 |                               | Automatically Qualify  |
| <b>7</b>                  | QI                        |                                   |                         | Covered                 |                               | Automatically Qualify  |
| <b>8</b>                  | QDWI                      |                                   | Covered                 |                         |                               | Beneficiary will need to apply   |
| <b>9</b>                  | FBDE                      | Covered                           |                         |                         |                               | Automatically Qualify  |



**Summary of Benefits for Contract 2012,  
ADVANTAGE Special Needs Plan (HMO SNP)**

The services listed below are available only to those SNP members eligible under Medicaid for medical services. It is important to understand that Medicaid benefits can vary based on your income level and other standards. Also, your Medicaid benefits can change throughout the year. Depending on your current status, you may not qualify for all Medicaid benefits.

For information regarding Medicaid benefits, please contact your local Division of Family Resources Office.

**Hamilton County**

1105 S. 10th Street  
Noblesville, IN 46060  
Telephone: (317) 776-2603

**Hancock County**

1786 Melody Lane  
Greenfield, IN 46140  
Telephone: (317) 468-0810

**Johnson County**

1784 E Jefferson St  
Franklin, IN 46131-7277  
Telephone: (317) 738-0303

**Morgan County**

1326 S. Morton Ave.  
Martinsville, IN 46151  
Telephone: (765) 342-7101

**Marion County**

4720 Kingsway Drive, Ste.125  
Indianapolis, IN 46205  
Telephone: (317) 202-6400

3500 Lafayette Road Suite 200  
Indianapolis, IN 46222  
Telephone: (317) 329-1571

3524 North Meridian Street  
Indianapolis, IN 46208  
Telephone: (317) 931-2920

2855 North Keystone Avenue, Ste. 170  
Indianapolis, IN 46218  
Telephone: (317) 610-7240

3906 Madison Avenue  
Indianapolis, IN 46227.  
Telephone: (317) 233-9886

1213 N. Arlington Avenue  
Indianapolis, IN 46219  
Telephone: (317) 233-3328

| Benefit Category   | Medicaid (Standard Package A)  | ADVANTAGE Special Needs Plan (HMO SNP)   |
|--|--|--|
| <b>Case Management for Mentally Ill or Emotionally Disturbed</b>   | \$0 copay for Medicaid-covered services.   | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered.  |
| <b>Case Management for Pregnant Women</b><br><br>Prior Approval Always Required                              | \$0 copay for Medicaid-covered services.<br><br>Limited to one initial assessment, one reassessment per trimester, and one postpartum assessment.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered.  |
| <b>Chiropractors</b><br><br>Prior Approval Required Under Certain Circumstances                              | \$0 copay for Medicaid-covered services.<br><br>Limited to five visits and 50 therapeutic physical medicine treatments per member per year.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare covered.  |
| <b>Chronic Disease Management</b>  | \$0 copay for Medicaid-covered services.   | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered.  |
| <b>Dental Services</b>   | \$0 copay for Medicaid-covered services.<br><br>In accordance with federal law, all medically necessary dental services are provided for children under age 21 even if the service is not otherwise covered under Package A.<br><br>Benefit limit is \$1,000 per year for ages 21 years and older. | <b>In-Network</b><br><br>Includes preventive dental benefits described in Section 2.<br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Diabetes Self-Management Training Services</b><br><br>Prior Approval Required Under Certain Circumstances | \$0 copay for Medicaid-covered services.<br><br>Limited to eight units per member per year. Additional units may be prior authorized.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered.  |
| <b>Drugs – Prescribed (Legend) Drugs</b>   | \$3 copay for generic and brand (legend) drugs.  | <b>In-Network</b>  |

| Benefit Category  | Medicaid (Standard Package A)   | ADVANTAGE Special Needs Plan (HMO SNP)  |
|---|---|---|
|   |   | Provides coverage for Part D drugs as described in Section 2.   |
| <b>Drugs – Over-the-counter (Non-legend)</b>  | \$3 copay for over-the-counter (non-legend) drugs.  | Not covered   |
| <b>Early Intervention Services [Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)]</b> | \$0 copay for Medicaid-covered services.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered.   |
| <b>Emergency Services</b>   | \$0 copay for Medicaid-covered services.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered.   |
| <b>Eye Care, Eyeglasses, and Vision Services</b>  | <p>\$0 copay for Medicaid-covered services.</p> <p>Coverage for the initial vision care examination is limited to one examination per year for a member under 21 years of age and one examination every two years for a recipient 21 years of age or older unless more frequent care is medically necessary.</p> <p>Coverage for eyeglasses, including frames and lenses, are limited to a maximum of one pair per year for members under 21 years of age and one pair every five years for members 21 years and older. Exceptions are when a specified minimum prescription change makes additional coverage medically necessary or the member’s lenses and/or frames are lost, stolen, or broken beyond repair.</p> | <b>In-Network</b><br><br>Includes routine vision and coverage for eye wear or contacts as described in Section 2.<br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Federally Qualified Health Centers (FQHCs)</b>   | \$0 copay for Medicaid-covered services.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered.   |
| <b>Food Supplements, Nutritional Supplements, and</b>   | \$0 copay for Medicaid-covered services.<br><br>Coverage is available only when no other means  | <b>In-Network</b><br><br>\$0 copay for services that  |

| <b>Benefit Category</b>  | <b>Medicaid (Standard Package A)</b>  | <b>ADVANTAGE Special Needs Plan (HMO SNP)</b>   |
|--|---|---|
| <b>Infant Formulas</b><br><br>Prior Approval Always Required                                     | of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.  | are both Medicaid- and Medicare-covered.  |
| <b>Hospital Services – Inpatient</b><br><br>Prior Approval Required Under Certain Circumstances  | \$0 copay for Medicaid-covered services.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Hospital Services – Outpatient</b><br><br>Prior Approval Required Under Certain Circumstances | \$0 copay for Medicaid-covered services.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Home Health Services</b><br><br>Prior Approval Always Required                                | \$0 copay for Medicaid-covered services.<br><br>Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals. | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Hospice Services</b><br><br>Prior Approval Always Required                                    | \$0 copay for Medicaid-covered services.<br><br>Coverage is available for two consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days.   | Covered by Original Medicare when care is received from Medicare-certified hospice provider.  |
| <b>Laboratory and Radiology Services</b>   | \$0 copay for Medicaid-covered services.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Long-Term Acute Care Hospitalization</b>  | \$0 copay for Medicaid-covered services.  | <b>In-Network</b>   |

| <b>Benefit Category</b>  | <b>Medicaid (Standard Package A)</b>   | <b>ADVANTAGE Special Needs Plan (HMO SNP)</b>  |
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| Prior Approval Always Required   |  | \$0 copay for services that are both Medicaid- and Medicare-covered.                                 |
| <p><b>Medical Supplies and Equipment (includes prosthetic devices, implants, hearing aids, dentures, and so forth)</b></p> <p>Prior Approval Always Required</p> | <p>\$0 copay for Medicaid-covered services.</p> <p>Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.</p> <p>Incontinence supplies are covered for members 3 years old or older.</p> <p>Incontinence, urological, and ostomy supplies are covered for one of three contracted vendors. A maximum allowable of \$1,950 per member per rolling calendar year for all incontinence supplies is assigned. Providers may only supply such services to an IHCP member in 30-day increments.</p> <p>Certain procedures are limited to 15 months of continuous rental.</p> | <p><b>In-Network</b></p> <p>\$0 copay for services that are both Medicaid- and Medicare-covered.</p> |
| <p><b>Mental Health Services – Outpatient</b></p> <p>Prior Approval Required Under Certain Circumstances</p>   | \$0 copay for Medicaid-covered services.   | <p><b>In-Network</b></p> <p>\$0 copay for services that are both Medicaid- and Medicare-covered.</p> |
| <p><b>MRO – Community Mental Health Centers</b></p> <p>Prior Approval Required Under Certain Circumstances</p>   | \$0 copay for Medicaid-covered services.   | <p><b>In-Network</b></p> <p>\$0 copay for services that are both Medicaid- and Medicare-covered.</p> |
| <p><b>Mental Health Services – Inpatient</b></p>   | <p>\$0 copay for Medicaid-covered services.</p> <p>Medicaid reimbursement is available for</p>   | <p><b>In-Network</b></p> <p>\$0 copay for services that</p>  |

| Benefit Category  | Medicaid (Standard Package A)  | ADVANTAGE Special Needs Plan (HMO SNP)  |
|---|--|---|
| Prior Approval Always Required  | inpatient psychiatric services provided to an individual between 22 and 65 years of age in a certified psychiatric hospital of 16 beds or less.  | are both Medicaid- and Medicare-covered.  |
| <b>Intermediate Care Facilities for the Mentally Retarded (ICF/MR) – Services</b><br><br>Prior Approval Always Required | \$0 copay for Medicaid-covered services.<br><br>60 days maximum, pending and prior to level of care determination. Medicaid coverage is available with preadmission diagnosis and evaluation. Includes room and board, mental health services, dental, therapy and habilitation services, durable medical equipment, medical supplies, pharmaceutical products, transportation, and optometric services. | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Nurse Midwife</b>  | \$0 copay for Medicaid-covered services.<br><br>Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Nurse Practitioners</b>  | \$0 copay for Medicaid-covered services.<br><br>Coverage is available for medically necessary services or preventative healthcare services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Nursing Facility Services (Long-term)</b><br><br>Prior Approval Always Required                                      | \$0 copay for Medicaid-covered services.<br><br>Coverage includes room and board; nursing care; medical supplies; durable medical equipment; and transportation for a maximum of 60 days and prior to level of care determination.   | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Nursing Facility Services (Short-term)</b><br><b>Intermediate Care Facilities for the Mentally Retarded</b>          | \$0 copay for Medicaid-covered services.<br><br>Nursing facility setting on a short-term basis, up to 60 calendar days.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |

| Benefit Category  | Medicaid (Standard Package A)   | ADVANTAGE Special Needs Plan (HMO SNP)  |
|---|---|---|
| <p><b>(ICF/MR) – Services</b></p> <p>Prior Approval Always Required</p>           | <p>Medicaid coverage is available with preadmission diagnosis and evaluation. Includes room and board, mental health services, dental, therapy and habilitation services, durable medical equipment, medical supplies, pharmaceutical products, transportation, and optometric services.</p>            |   |
| <p><b>Nursing Facility Services (Short-term)</b></p>                              | <p>\$0 copay for Medicaid-covered services.</p> <p>Nursing facility setting on a short-term basis, up to 60 calendar days.</p>  | <p><b>In-Network</b></p> <p>\$0 copay for services that are both Medicaid- and Medicare-covered.</p>                    |
| <p><b>Occupational Therapy</b></p> <p>Prior Approval Always Required</p>          | <p>\$0 copay for Medicaid-covered services.</p> <p>Any combination of therapies ordered cannot exceed 30 units in 30 calendar days without prior authorization.</p> <p>A limit of 25 therapy visits for each type of therapy per rolling 12-month period will apply to all members age 21 or older.</p> | <p><b>In-Network</b></p> <p>\$0 copay for services that are both Medicaid- and Medicare-covered.</p>                    |
| <p><b>Organ Transplants</b></p> <p>Prior Approval Always Required</p>             | <p>\$0 copay for Medicaid-covered services.</p> <p>Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike.</p>   | <p><b>In-Network</b></p> <p>\$0 copay for services that are both Medicaid- and Medicare-covered.</p>                    |
| <p><b>Orthodontics</b></p> <p>Prior Approval Always Required</p>                  | <p>\$0 copay for Medicaid-covered services.</p> <p>No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.</p>  | <p><b>In-Network</b></p> <p>\$0 copay for services that are both Medicaid- and Medicare-covered.</p>                    |
| <p><b>Out-of-state Medical Services</b></p> <p>Prior Approval Always Required</p> | <p>\$0 copay for Medicaid-covered services.</p> <p>Medicaid reimbursement is available for the following services provided outside Indiana: acute hospital care, physician services, dental</p>   | <p>Covers urgent care, emergency care, or out-of-area dialysis for treatment received from out-of-network providers</p> |

| <b>Benefit Category</b>   | <b>Medicaid (Standard Package A)</b>   | <b>ADVANTAGE Special Needs Plan (HMO SNP)</b>   |
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|   | services, pharmacy services, transportation services, therapy services, podiatry services, chiropractic services, and durable medical equipment and supplies. All out-of-state services are subject to the same limitations as in-state services.  | \$0 copay for services that are both Medicaid- and Medicare-covered.                          |
| <b>Physician Surgical and Medical Services</b><br><br>Prior Approval Required Under Certain Circumstances | \$0 copay for Medicaid-covered services.<br><br>Coverage includes reasonable services provided by an MD or DO for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within scope of practice. PMP office visits are limited to a maximum of four per month or 20 per year per member without prior authorization. | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Physical Therapy</b><br><br>Prior Approval Required Under Certain Circumstances                        | \$0 copay for Medicaid-covered services.<br><br>Any combination of therapies ordered cannot exceed 30 units in 30 calendar days without prior authorization.<br><br>A limit of 25 therapy visits for each type of therapy per rolling 12-month period will apply to all members age 21 or older.   | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Podiatric Services</b>   | \$0 copay for Medicaid-covered services.<br><br>Surgical procedures involving the foot, laboratory, X-ray services, and hospital stays are covered when medically necessary. No more than six routine foot care visits per year are covered.   | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Psychiatric Residential Treatment Facility (PRTF)</b><br><br>Prior Approval Always Required            | \$0 copay for Medicaid-covered services.   | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |

| <b>Benefit Category</b>   | <b>Medicaid (Standard Package A)</b>  | <b>ADVANTAGE Special Needs Plan (HMO SNP)</b>   |
|---|---|---|
| <b>Rehabilitation Unit Services – Inpatient</b><br><br>Prior Approval Always Required                                 | \$0 copay for Medicaid-covered services.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Respiratory Therapy</b><br><br>Prior Approval Required Under Certain Circumstances                                 | \$0 copay for Medicaid-covered services.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Rural Health Clinics (RHCs)</b>  | \$0 copay for Medicaid-covered services.<br><br>Coverage is available for services provided by a physician; nurse practitioner; or appropriately licensed, certified, or registered therapist employed by the rural health clinic.      | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Smoking Cessation Services</b>   | \$0 copay for Medicaid-covered services.<br><br>Reimbursement is available for one 12-week course of treatment per member per calendar year. One or more modalities may be included in any combination of treatment.                    | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Speech, Hearing and Language Disorders</b><br><br>Prior Approval Required Under Certain Circumstances              | \$0 copay for Medicaid-covered services.<br><br>A limit of 25 therapy visits for each type of therapy per rolling 12-month period will apply to all members age 21 or older.  | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Substance Abuse Services – Inpatient (Freestanding Psychiatric Facility)</b><br><br>Prior Approval Always Required | \$0 copay for Medicaid-covered services.<br><br>Medicaid reimbursement is available for inpatient psychiatric services provided to an individual between 22 and 65 years of age in a certified psychiatric hospital of 16 beds or less. | <b>In-Network</b><br><br>\$0 copay for services that are both Medicaid- and Medicare-covered. |
| <b>Substance Abuse</b>  | \$0 copay for Medicaid-covered services.  | <b>In-Network</b>   |

| <b>Benefit Category</b>   | <b>Medicaid (Standard Package A)</b>   | <b>ADVANTAGE Special Needs Plan (HMO SNP)</b>  |
|---|--|--|
| <p><b>Services – Outpatient</b></p> <p>Prior Approval Required Under Certain Circumstances</p>      | <p>Coverage includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as Health Services Providers in Psychology.</p>         | <p>\$0 copay for services that are both Medicaid- and Medicare-covered.</p>                          |
| <p><b>Transportation – Emergency</b></p> <p>Prior Approval Required Under Certain Circumstances</p> | <p>\$0 copay for Medicaid-covered services.</p> <p>Coverage has no limit or prior approval for emergency ambulance or trips to or from a hospital for inpatient admission or discharge, subject to the prudent layperson standard.</p> | <p><b>In-Network</b></p> <p>\$0 copay for services that are both Medicaid- and Medicare-covered.</p> |
| <p><b>Transportation – Nonemergent</b></p>  | <p>\$0.50- \$ 2.00 copay for Medicaid-covered services.</p> <p>Available for up to 20 one-way trips of less than 50 miles per year without prior authorization.</p>  | <p><b>In-Network</b></p> <p>Includes additional transportation benefits described in Section 2.</p>  |