

AAA3 Vantage PREMIUM (HMO-POS) 2012 Summary of Benefits



130 DeSiard Street, Suite 300
Monroe, LA 71201
(318) 361-0900
(888) 823-1910
www.vhp-medicare.com

SECTION I: INTRODUCTION TO SUMMARY OF BENEFITS
for AAA3 VANTAGE PREMIUM (HMO-POS)
JANUARY 1, 2012 – DECEMBER 31, 2012
North Louisiana, Central Louisiana

Thank you for your interest in **AAA3 Vantage PREMIUM (HMO-POS)**. Our plan is offered by VANTAGE HEALTH PLAN, INC. (Vantage), a Medicare Advantage Health Maintenance Organization (HMO), with a point-of-service option (POS). This Summary of Benefits tells you some features of our plan. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call **Vantage** 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 **AAA3 Vantage PREMIUM (HMO-POS)**. You may have other options, too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call **Vantage** 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 **AAA3 Vantage PREMIUM (HMO-POS)** 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 AAA3 VANTAGE PREMIUM (HMO-POS) AVAILABLE?

The service area for this plan includes: Bienville, Bossier, Caddo, Caldwell, Cameron, Catahoula, Claiborne, Concordia, East Carroll, Franklin, Grant, Jackson, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Rapides, Red River, Richland, Sabine, Tensas, Union, Webster, West Carroll, and Winn Parishes, LA. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN AAA3 VANTAGE PREMIUM (HMO-POS)?

You can join **AAA3 Vantage PREMIUM (HMO-POS)** if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in **AAA3 Vantage PREMIUM (HMO-POS)** unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

AAA3 Vantage PREMIUM (HMO-POS) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory. For an updated list, visit us at www.vhp-medicare.com. Our Member Services number is listed at the end of this introduction.

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

Generally, you are restricted to a doctor who is part of your network. However, we will cover your care from any provider for emergency or urgently needed care. Also, our point of service benefit allows you to get care from providers not in your network under certain conditions. For more information, please call the Member Services number listed at the end of this introduction.

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

AAA3 Vantage PREMIUM (HMO-POS) 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.catalystrx.com. Our Member Services number is listed at the end of this introduction.

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

AAA3 Vantage PREMIUM (HMO-POS) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

AAA3 Vantage PREMIUM (HMO-POS) 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.vhp-medicare.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?

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 '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?

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 **AAA3 Vantage PREMIUM (HMO-POS)**, 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 **AAA3 Vantage PREMIUM (HMO-POS)**, 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 **Vantage** 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 **Vantage** for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs 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 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 Member Services number is listed below.

Please call Vantage Health Plan, Inc. for more information about AAA3 Vantage PREMIUM (HMO-POS).

Visit us at www.vhp-medicare.com or, call us:

Member Services Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. – 8:00 p.m. Central.

Current and Prospective members should call toll-free (888) 823-1910 ext. 1 for questions related to the Medicare Advantage Program. (TTY (866) 524-5144)

Current and Prospective Members should call locally (318) 361-0900 ext 1 for questions related to the Medicare Advantage Program. (TTY (318) 361-2131)

Current and Prospective Members should call toll-free (888) 823-1910 ext 1 for questions related to the Medicare Part D Prescription Drug Program (TTY (866) 524-5144).

Current and Prospective Members should call locally (318) 361-0900 ext 1 for questions related to the Medicare Part D Prescription Drug Program. (TTY (318) 361-2131)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or visit www.medicare.gov on the web.

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 Member Services at the phone number listed above.

If you have any questions about this plan's benefits or costs, please contact Vantage Health Plan, Inc. for details.

| SECTION II - SUMMARY OF BENEFITS | | |
|--|---|---|
| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
| IMPORTANT INFORMATION | | |
| 1 - Premium and Other Important Information | <p>In 2011, the monthly Part B Premium was \$96.40 and may change for 2012 and the annual Part B deductible amount was \$162 and may change for 2012.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY user should call 1-800-325-0778.</p> | <p>\$99 monthly plan premium in addition to your monthly Medicare Part B Premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network \$3,800 out-of-pocket limit for Medicare-covered services.</p> |
| 2. Doctor and Hospital Choice (For more information, see Emergency Care #15 and Urgently Needed Care #16) | You may go to any doctor, specialist or hospital that accepts Medicare. | In-Network Referral required for network specialists (for certain benefits). |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|--|--|---|
| SUMMARY OF BENEFITS | | |
| <p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p> | <p>In 2011, the amounts for each benefit period were: Days 1 - 60: \$1132 deductible Days 61 - 90: \$283 per day Days 91 - 150: \$566 per lifetime reserve day</p> <p>These amounts may change for 2012.</p> <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>In-Network Plan covers 90 days each benefit period.</p> <p>\$200 copay for each Medicare-covered hospital stay.</p> <p>Plan covers 60 lifetime reserve days. \$0 copay per lifetime reserve day.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|--|--|---|
| <p>4 - Inpatient Mental Health Care</p> | <p>In 2011, the amounts for each benefit period were: Days 1 - 60: \$1132 deductible Days 61 - 90: \$283 per day 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>In-Network 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>\$200 copay for each Medicare-covered hospital stay.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> |
| <p>5 - Skilled Nursing Facility (SNF) (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: Days 1-20: \$0 for per day Days 21-100: \$141.50 for 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</p> | <p>Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period.</p> <p>3-day prior hospital stay is required.</p> <p>For Medicare-covered SNF stays: Days 1 - 20: \$50 copay per day Days 21 - 100: \$125 copay per day</p> |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|---|---|---|
| 5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility) <i>(cont)</i> | 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. | |
| 6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.) | \$0 copay | Authorization rules may apply. In-Network \$0 copay for each Medicare-covered home health visit. |
| 7 – Hospice | You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice. | You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice. |
| OUTPATIENT CARE | | |
| 8 - Doctor Office Visits | 20% coinsurance | Authorization rules may apply. In-Network \$5 copay or 0% to 20% of the cost for each medical home-primary care doctor visit for Medicare-covered benefits. \$65 copay for each in-area, network urgent care Medicare-covered visit. \$25 copay or 0% to 20% of the cost for each specialist visit for Medicare-covered benefits. |
| 9 - Chiropractic Services | Supplemental routine care not covered. 20% coinsurance for manual manipulation of the spine to correct | Authorization rules may apply. In-Network \$20 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|---|--|--|
| 9 - Chiropractic Services <i>(cont)</i> | subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. | displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. |
| 10 - Podiatry Services | Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. | Authorization rules may apply. In-Network \$25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care. |
| 11 - Outpatient Mental Health Care | 40% coinsurance for most outpatient mental health services Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. “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. | Authorization rules may apply. In-Network 40% of the cost for each Medicare-covered individual therapy visit. 40% of the cost for each Medicare-covered group therapy visit. \$25 copay for each Medicare-covered individual therapy visit with a psychiatrist. \$25 copay for each Medicare-covered group therapy visit with a psychiatrist. 40% of the cost for Medicare-covered partial hospitalization program services. |
| 12 - Outpatient Substance Abuse Care | 20% coinsurance | Authorization rules may apply. In-Network 40% of the cost for Medicare-covered individual visits. 40% of the cost for Medicare-covered group visits. |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|--|--|--|
| 13 – Outpatient Services/ Surgery | <p>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>20% coinsurance for ambulatory surgical center facility services.</p> | <p>Authorization rules may apply.</p> <p>In-Network \$200 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$65 to \$200 copay for each Medicare-covered outpatient hospital facility visit.</p> |
| 14 – Ambulance Services (medically necessary ambulance services) | <p>20% coinsurance</p> | <p>Authorization rules may apply.</p> <p>In-Network \$150 copay for Medicare-covered ambulance benefits.</p> |
| 15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care) | <p>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 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>\$65 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 72 hours for the same condition, you pay \$0 for the emergency room visit.</p> |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|--|--|---|
| 16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.) | 20% coinsurance, or a set copay. NOT covered outside the U.S. except under limited circumstances. | \$65 copay for Medicare-covered urgently-needed-care visits. |
| 17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy) | 20% coinsurance | Authorization rules may apply. In-Network There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits. 20% of the cost for Medicare-covered Occupational Therapy visits. 20% of the cost for Medicare-covered Physical and/or Speech and Language Therapy visits. |
| OUTPATIENT MEDICAL SERVICES AND SUPPLIES | | |
| 18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.) | 20% coinsurance | Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items. |
| 19 – Prosthetic Devices (includes braces, artificial limbs and eyes, etc.) | 20% coinsurance | Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items. |
| 20 - Diabetes Programs and Supplies | 20% coinsurance for diabetes self-management training. 20% coinsurance for diabetes supplies. 20% coinsurance for diabetic therapeutic shoes or inserts. | Authorization rules may apply. In-Network \$0 copay for Diabetes self-management training. 20% of the cost for Diabetes monitoring supplies. 20% of the cost for Therapeutic shoes or inserts. |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|--|--|--|
| 20 - Diabetes Programs and Supplies <i>(cont)</i> | | If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of \$5 to \$25 may apply. |
| 21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services | <p>20% coinsurance for diagnostic tests and x-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>Lab services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine supplemental screening tests, like checking your cholesterol.</p> | <p>Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered lab services.</p> <p>\$0 to \$200 copay for Medicare-covered diagnostic procedures and tests.</p> <p>\$0 copay for Medicare-covered X-rays.</p> <p>\$100 to \$200 copay for Medicare-covered diagnostic radiology services (not including X-rays).</p> <p>5% 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 \$5 to \$25 may apply.</p> <p>If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$5 to \$25 may apply.</p> |
| 22 – Cardiac and Pulmonary Rehabilitation Services | <p>20% coinsurance for Cardiac Rehabilitation services.</p> <p>20% coinsurance for Pulmonary Rehabilitation services.</p> | <p>Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered Cardiac Rehabilitation services.</p> |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|---|---|--|
| 22 – Cardiac and Pulmonary Rehabilitation Services <i>(cont)</i> | 20% coinsurance for Intensive Cardiac Rehabilitation services. This applies to program services provided in a doctor’s office. Specified cost sharing for program services provided by hospital outpatient departments. | 20% of the cost for Medicare-covered Intensive Cardiac Rehabilitation services. 20% of the cost for Medicare-covered Pulmonary Rehabilitation services. |
| PREVENTIVE SERVICES | | |
| 23 - Preventive Services and Wellness/Education Programs | No coinsurance, copayment or deductible for the following: <ul style="list-style-type: none"> – Abdominal Aortic Aneurysm Screening – Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. – Cardiovascular Screening – Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine for people with Medicare who are at risk – HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the | \$0 copay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> – Abdominal Aortic Aneurysm Screening – Bone Mass Measurement – Cardiovascular Screening – Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine – HIV Screening – Breast Cancer Screening (Mammogram) – Medical Nutrition Therapy Services – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine – Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) – Smoking Cessation (Counseling to stop smoking) – Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|--|--|--|
| <p>23 - Preventive Services and Wellness/Education Programs <i>(cont)</i></p> | <p>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.</p> <ul style="list-style-type: none"> - 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. - 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. | <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>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> - Written health education materials, including newsletters |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|--|---|--------------------------------|
| <p>23 - Preventive Services and Wellness/Education Programs <i>(cont)</i></p> | <ul style="list-style-type: none"> - Personalized Prevention Plan Services (Annual Wellness Visits)Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. - Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - 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. - Welcome to Medicare Physical Exam (initial preventive physical exam). When you join Medicare Part B, then 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. | |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|---|--|--|
| 24 – Kidney Disease and Conditions | <p>20% coinsurance for renal dialysis.</p> <p>20% coinsurance for kidney disease education services.</p> | <p>Authorization rules may apply.</p> <p>In-Network 20% of the cost for renal dialysis.</p> <p>20% of the cost for kidney disease education services.</p> |
| 25 – Outpatient Prescription Drugs Drugs covered under Medicare Part B | | <p>0% to 20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>5% of the cost for Part B-covered chemotherapy drugs.</p> |
| Drugs covered under Medicare Part D | <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>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.vhp-medicare.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long-term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers. <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 both you and a Part D plan.</p> |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|---|-------------------|--|
| Drugs covered under Medicare Part D (Prescription Drug Benefit) (cont) | | <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 AAA3 Vantage PREMIUM (HMO-POS) 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>If you request a formulary exception for a drug and AAA3 Vantage PREMIUM (HMO-POS) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.</p> |
| Deductible | | In-Network \$0 deductible |
| Initial Coverage | | You pay the following until total yearly drugs costs reach \$2,930: |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|-----------------------------------|--------------------------|---|
| Retail Pharmacy | | |
| Tier 1: Generic Drugs | | - \$0 copay for a one-month (31-day) supply of drugs in this tier - \$0 copay for a three-month (90-day) supply of drugs in this tier |
| Tier 2: Preferred Brand Drugs | | - \$35 copay for a one-month (31-day) supply of drugs in this tier - \$105 copay for a three-month (90-day) supply of drugs in this tier |
| Tier 3: Non-Preferred Brand Drugs | | - \$75 copay for a one-month (31-day) supply of drugs in this tier - \$225 copay for a three-month (90-day) supply of drugs in this tier |
| Tier 4: Specialty Tier Drugs | | - 33% coinsurance for a one-month (31-day) supply of drugs in this tier |
| Long-Term Care Pharmacy | | |
| Tier 1: Generic Drugs | | - \$0 copay for a one-month (31-day) supply of drugs in this tier |
| Tier 2: Preferred Brand Drugs | | - \$35 copay for a one-month (31-day) supply of drugs in this tier |
| Tier 3: Non-Preferred Brand Drugs | | - \$75 copay for a one-month (31-day) supply of drugs in this tier |
| Tier 4: Specialty Tier Drugs | | - 33% coinsurance for a one-month (31-day) supply of drugs in this tier |
| Mail Order | | |
| Tier 1: Generic Drugs | | - \$0 copay for a three-month (90-day) supply of drugs in this tier |
| Tier 2: Preferred Brand Drugs | | - \$105 copay for a three-month (90-day) supply of drugs in this tier |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|--|-------------------|---|
| Tier 3: Non-Preferred Brand Drugs | | - \$225 copay for a three-month (90-day) supply of drugs in this tier |
| Tier 4: Specialty Tier Drugs | | - 33% coinsurance for a one-month (31-day) supply of drugs in this tier |
| Additional Coverage Gap | | The plan covers many formulary generics (65%-99% of formulary generic drugs) through the coverage gap. You pay the following: |
| Retail Pharmacy Tier 1: Generic Drugs | | - \$0 copay for a one-month (31-day) supply of all drugs covered in this tier - \$0 copay for a three-month (90-day) supply of all drugs covered in this tier |
| Long-Term Care Pharmacy Tier 1: Generic Drugs | | - \$0 copay for a one-month (31-day) supply of all drugs covered in this tier |
| Mail Order Tier 1: Generic Drugs | | - \$0 copay for a three-month (90-day) supply of all drugs covered in this tier |
| | | After your total yearly drug costs reach \$2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand-name drugs and generally pay no more than 86% of the plan's costs for generic drugs that may be included in Tiers 2, 3, or 4 until your yearly out-of-pocket drug costs reach \$4,700. |
| Catastrophic Coverage | | After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of: <ul style="list-style-type: none"> • 5% coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. |
| Out-of-Network | | Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|---|-------------------|---|
| Out-of-Network <i>(cont)</i> | | 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 AAA3 Vantage PREMIUM (HMO-POS). |
| Out-of-Network Initial Coverage | | You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930: |
| Tier 1: Generic Drugs | | - \$0 copay for a one-month (31-day) supply of drugs in this tier |
| Tier 2: Preferred Brand Drugs | | - \$35 copay for a one-month (31-day) supply of drugs in this tier |
| Tier 3: Non-Preferred Brand Drugs | | - \$75 copay for a one-month (31-day) supply of drugs in this tier |
| Tier 4: Specialty Tier Drugs | | - 33% coinsurance for a one-month (31-day) supply of drugs in this tier |
| | | You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. |
| Additional Out-of-Network Coverage Gap | | You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: |
| Tier 1: Generic Drugs | | - \$0 copay for a one-month (31-day) supply of all drugs covered in this tier |
| Tier 2: Preferred Brand Drugs | | <p>You will be reimbursed up 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,700.</p> <p>You will be reimbursed up to the coverage gap discount amount for brand-name drugs purchased out-of-network until total yearly drug costs reach \$4,700.</p> |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|---|-------------------|---|
| Tier 3: Non-Preferred Brand Drugs | | <p>You will be reimbursed up 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,700.</p> <p>You will be reimbursed up to the coverage gap discount amount for brand-name drugs purchased out-of-network until total yearly drug costs reach \$4,700.</p> |
| Tier 4: Specialty Tier Drugs | | <p>You will be reimbursed up 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach \$4,700.</p> <p>You will be reimbursed up to the coverage gap discount amount for brand-name drugs purchased out-of-network until total yearly drug costs reach \$4,700.</p> |
| | | <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> |
| Out-of-Network Catastrophic Coverage | | <p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> • 5 % coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|------------------------------|---|--|
| 26 - Dental Services | Preventive dental services (such as cleaning) not covered. | <p>Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered dental benefits.</p> <p>20% of the cost for an office visit that includes:</p> <ul style="list-style-type: none"> • Up to 1 oral exam every six months • Up to 1 cleaning every six months • Up to 1 dental x-ray every year <p>\$100 plan coverage limit for preventive dental benefits (oral exam and cleaning) every six months.</p> <p>\$50 plan coverage limit every year for one dental x-ray.</p> |
| 27 - Hearing Services | <p>Supplemental routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams</p> | <p>Authorization rules may apply.</p> <p>In-Network In general, supplemental routine hearing exams and hearing aids not covered.</p> <p>20% of the cost for Medicare-covered diagnostic hearing exams</p> |
| 28 - Vision Services | <p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye</p> <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>In-Network 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>\$0 to \$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$25 copay for up to 1 supplemental routine eye exam every year.</p> <p>20% of the cost for up to 1 pair of glasses every year.</p> |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|------------------------------------|---|---|
| 28 - Vision Services (cont) | Annual glaucoma screenings covered for people at risk. | 20% of the cost for up to 12 pairs of contacts every year \$100 plan coverage limit for eye wear every year. |
| Over-the Counter items | Not covered. | The plan does not cover Over-the-Counter items. |
| Transportation (Routine) | Not covered. | In-Network This plan does not cover supplemental routine transportation. |
| Acupuncture | Not covered. | In-Network This plan does not cover Acupuncture. |
| Point of Service | You may go to any doctor, specialist or hospital that accepts Medicare. | Authorization rules may apply. Out-of-Network Point of Service coverage is available for the following benefits: <ul style="list-style-type: none"> - Inpatient Hospital Acute - Inpatient Hospital Psychiatric - Skilled Nursing Facility (SNF) - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Home Health Services - Medical Home-Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Mental Health Specialty Services - Podiatry Services - Other Health Care Professional - Psychiatric Services - Physical Therapy and Speech-Language Pathology Services |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|---------------------------------------|-------------------|--|
| Point of Service <i>(cont)</i> | | <ul style="list-style-type: none"> - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Substance Abuse - Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies - Diabetic Supplies and Services - Medicare-covered Preventive Services - Supplemental Education/Wellness Programs - Kidney Disease Education Services - Diabetes Self-Management Training - Preventive Dental - Eye Exams - Eye Wear - Hearing Exams <p>\$5,000 plan coverage limit every year for the following POS Benefits:</p> <ul style="list-style-type: none"> - Inpatient Hospital Acute - Inpatient Hospital Psychiatric - Skilled Nursing Facility (SNF) - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Home Health Services - Medical Home-Primary Care Physician Services |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|--------------------------------|-------------------|--|
| Point of Service <i>(cont)</i> | | <ul style="list-style-type: none"> - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Mental Health Specialty Services - Podiatry Services - Other Health Care Professional - Psychiatric Services - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Substance Abuse - Outpatient Blood Services - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies - Diabetic Supplies and Services - Medicare-covered Preventive Services - Supplemental Education/Wellness Programs - Kidney Disease Education Services - Diabetes Self-Management Training - Preventive Dental - Eye Exams - Eye Wear - Hearing Exams |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|--|-------------------|---|
| <p>Point of Service <i>(cont)</i></p> | | <p>\$200 copay and 20% of the cost per hospital stay.</p> <p>\$200 copay and 20% of the cost per Inpatient Psychiatric Hospital stay.</p> <p>20% of the cost for each SNF stay For each SNF stay: Days 1-20: \$50 copay per SNF day Days 21-100: \$125 copay per SNF day</p> <p>25% to 60% of the cost for</p> <ul style="list-style-type: none"> - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Occupational Therapy Services - Mental Health Specialty Services - Physical Therapy and Speech-Language Pathology Services - Therapeutic Radiological Services - Outpatient Substance Abuse - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies - Diabetic Supplies and Services - Kidney Disease Education Services - Preventive Dental - Eye Wear - Hearing Exams |

| Benefit Category | Original Medicare | AAA3 Vantage PREMIUM (HMO-POS) |
|---------------------------------------|-------------------|---|
| Point of Service <i>(cont)</i> | | <p>\$5 to \$200 copay and 20% of the cost for</p> <ul style="list-style-type: none"> - Medical Home-Primary Care Physician Services - Chiropractic Services - Physician Specialist Services - Podiatry Services - Other Health Care Professional - Psychiatric Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Ambulance Services - Eye Exams <p>0% to 20% of the cost for</p> <ul style="list-style-type: none"> - Home Health Services - Outpatient Blood Services - Medicare-covered Preventive Services - Supplemental Education/Wellness Programs - Diabetes Self-Management Training <p>20% of the cost for</p> <ul style="list-style-type: none"> - Outpatient X-Rays |



130 DeSiard Street, Suite 300
Monroe, LA 71201
(318) 361-0900
(888) 823-1910
TTY: (318) 361-2131
TTY: (866) 524-5144
www.vhp-medicare.com

Vantage Health Plan is a health plan with a Medicare contract. You may be eligible to enroll in a Vantage Medicare Advantage plan if you reside in our service area and are currently entitled to Medicare Part A and enrolled in Medicare B. The benefit information provided herein is a brief summary, but not a comprehensive description of available benefits. For more information, contact the plan. Benefits may change on January 1, 2013. You must continue to pay your Medicare Part B premium even if the Medicare Advantage plan premium is \$0. Limitations, copayments/co-insurance, and restrictions may apply. You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for extra help, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week; TTY users should call 1-877-486-2048. You may also call the Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday; TTY users should call 1-800-325-0778. You may also call your State Medicaid Office. Members may enroll in the plan only during specific times of the year. Members must use network pharmacies to access their prescription drug benefit, except under non-routine circumstances. Prescription drug quantity limitations and restrictions may apply. Routine services provided by out-of-network providers may cost more than services provided by in-network providers, unless the services are related to urgent care or an emergency.