

# HEALTH PLANS COMPARISON CHART MEDICARE-ELIGIBLE RETIREES – PLAN YEAR 2021

This chart provides a general comparison of benefits offered through Medicare and individual Group Benefits Program (GBP) plans, effective January 1, 2021. View [Medicare.gov](https://www.medicare.gov) and each plans' Evidence of Coverage for more details. Rates and benefits are subject to change.

Plan	Original Medicare	HealthSelect <sup>SM</sup> MA PPO In-Network and Out-of-Network	HealthSelect <sup>SM</sup> Secondary In-Network and Out-of-Network	Community First Health Plans HMO In-Network	Scott and White Care Plans HMO In-Network
<b>Overview</b>	Medicare covers hospital stays (Part A) and certain doctors' services, supplies, preventive services and more (Part B). You can also purchase Part D prescription drug coverage. Providers who accept Medicare submit claims for you.	This plan is a Medicare Advantage plan, also known as Medicare Part C. It includes benefits in Medicare Parts A and B plus extra programs. It also includes prescription drug coverage through HealthSelect <sup>SM</sup> Medicare Rx. You must continue to pay your Part B premium. This plan has a provider network, but you can see any provider who accepts Medicare. In-network providers will submit claims for you.	HealthSelect Secondary pays secondary to Medicare, but is not a Medicare Advantage plan. The plan has a provider network, but you can see any provider who accepts Medicare. In-network providers will submit claims for you. This plan has higher dependent and tiered premiums, and higher out-of-pocket costs than the Medicare Advantage plan.	CFHP HMO pays secondary to Medicare. The plan has a provider network, and you must see in-network providers for the service to be covered (except for emergencies and urgent situations).	SWCP HMO pays secondary to Medicare. This plan has a network, and you must see a network provider for the service to be covered (except for emergencies and urgent care situations).
<b>Annual deductible</b>	Part A: \$1,408 Part B: \$198 You must meet your annual deductible before Medicare pays for covered services.	None	\$200 per individual \$600 per family You must meet <b>both</b> your Medicare and your HealthSelect Secondary deductible(s) before this plan pays for covered services. The two deductibles run concurrently.	None You must meet Medicare deductible(s) before plan pays for covered services.	None You must meet Medicare deductible(s) before plan pays for covered services.
<b>Out-of-network coverage?</b>	N/A; the benefits below apply to services from any provider who accepts Medicare	Services are covered at the same benefit levels long as the provider accepts Medicare. See below for details.	Yes Most services are covered at the same benefit levels as long as the provider accepts Medicare and this plan. See below for details.	No, except for emergency and urgent care services, services provided by out-of-network, facility-based providers in a network facility, and out-of-network services that are authorized in advance by the plan.	No, except for emergency and urgent care services, services provided by out-of-network, facility-based providers in a network facility, and out-of-network services that are authorized in advance by the plan.
<b>Balance billing?</b> (when an out-of-network provider charges you the difference between their billed charges and amount your plan allows)	No. Balance billing will not apply as long as provider accepts Medicare.	No	Yes. Balance billing may apply to certain out-of-network services. When a service is not covered by Medicare or your Medicare benefits are exhausted, you could be balance-billed for non-emergency services from a non-network provider.	N/A. Out-of-network benefits are not covered unless authorized in advance or in an emergency; balance billing would not apply.	N/A. Out-of-network benefits are not covered unless authorized in advance or in an emergency; balance billing would not apply.
<b>Total in-network out-of-pocket maximum</b> (including deductibles, coinsurance and copays)	None	\$1,000 per person Resets on Jan. 1	\$6,750 per person <sup>1</sup> \$13,500 per family Resets on Jan. 1	\$6,750 per person <sup>1</sup> \$13,500 per family Resets on Sept. 1	\$6,750 per person <sup>1</sup> \$13,500 per family Resets on Sept. 1
<b>Out-of-pocket coinsurance maximum</b>	None	None	\$3,000 per person Resets on Jan. 1	\$2,000 per person Resets on Sept. 1	\$2,000 per person Resets on Sept. 1
<b>Inpatient copay maximum</b>	None	None	None	<ul style="list-style-type: none"> <li>• \$750 copay max, up to 5 days per hospital stay</li> <li>• \$2,250 copay max per plan year per person</li> </ul>	<ul style="list-style-type: none"> <li>• \$750 copay max, up to 5 days per hospital stay</li> <li>• \$2,250 copay max per plan year per person</li> </ul>
<b>Primary care provider (PCP) required?</b>	No	No, but recommended	No	Yes	No
<b>Referrals required?</b>	No	No	No	No	No

## Medical Benefits – Member’s Share of Cost

Plan	Original Medicare (Medicare benefits are subject to change)	HealthSelect MA PPO In-Network and Out-of-Network	Medicare Primary, HealthSelect Secondary In-Network and Out-of-Network	Medicare Primary, Community First Health Plans HMO Secondary In-Network	Medicare Primary, Scott and White Health Plan HMO Secondary In-Network
<b>How this plan works</b>	Once you meet your deductible(s), you are responsible for the share of cost listed below.	There are no required deductibles for the medical plan (prescription drug coverage is separated and has a deductible). You are responsible for the share of cost listed below.	The plan pays secondary to Medicare and your share of costs is usually \$0 after Medicare pays. If Medicare does not cover a service, this plan pays primary. Once you meet your annual deductibles, you are responsible for the share of cost listed below.	The plan pays secondary to Medicare and your share of costs is usually \$0 after Medicare pays. When Medicare does not cover a service, your share is the copay and/or coinsurance listed below.	The plan pays secondary to Medicare and your share of costs is usually \$0 after Medicare pays. When Medicare does not cover a service, your share is the copay and/or coinsurance listed below.
<b>Allergy treatment</b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>Ambulance services</b> (for emergencies)	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>Bariatric surgery</b>	Covered for certain conditions related to morbid obesity. Bariatric surgery that meets requirements is covered at the same cost as an inpatient hospital or outpatient hospital visit depending on where the surgery is performed.	Covered for certain conditions related to morbid obesity. No cost to participant(s) when coverage requirements are met.	Not covered	Not covered	Not covered
<b>Chiropractic care</b>	20% for Medicare-covered chiropractic services	No cost to participants. Chiropractic services not covered by Medicare are limited to 30 visits per plan year.	\$0 copay / 30% coinsurance	\$0 copay / \$40 copay plus 20%; \$75 limit per visit Limited to 30 visits per plan year.	Without office visit: \$0 copay/ 20% coinsurance. With office visit: \$40 copay/ 20% coinsurance. Limited to 35 visits per calendar year
<b>Diabetes equipment<sup>2</sup></b>	20% after the annual Part B deductible is met	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>Diabetes supplies</b>	Covered under Medicare Part D. Coinsurance or copay applies, depending on Part D plan benefits.	No cost to participant(s) for certain brands of blood glucose monitors and test strips. Some supplies may be covered under the pharmacy plan benefits.	\$0 copay / 30% coinsurance Some supplies may be covered under the pharmacy plan benefits at \$0 cost to you.	\$0 copay / 20% coinsurance for in-network supplies only, no out-of-network coverage. Covered under the pharmacy plan.	\$0 copay / 20% coinsurance for in-network supplies only, no out-of-network coverage. Covered under the pharmacy plan.
<b>Diagnostic X-rays and lab tests<sup>6</sup></b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>Diagnostic mammography</b>	20% coinsurance	No cost to participant(s)	\$0 copay In-network diagnostic mammography is covered at no cost to participant(s)	\$0 copay In-network diagnostic mammography is covered at no cost to participant(s)	\$0 copay In-network diagnostic mammography is covered at no cost to participant(s)
<b>Durable medical equipment<sup>2</sup></b>	20% coinsurance	No cost to participant(s) for Medicare-covered equipment	\$0 copay / 30% coinsurance	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>Facility-based providers</b> (radiologists, pathologists and labs, anesthesiologists, emergency room physicians etc.)	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance

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<b>Facility emergency care and hospital-affiliated freestanding emergency departments</b> (not freestanding emergency room facilities)	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / \$150 plus 20% coinsurance (if admitted, copay applies to hospital copay)	\$0 copay / \$150 plus 20% coinsurance (if admitted, copay applies to hospital copay)
<b>Freestanding emergency room facility (FSER)<sup>6</sup></b>	Not covered	Not covered	\$0 copay / 30% coinsurance	\$150 copay plus 20% coinsurance for in-network and out-of-network	\$150 copay plus 20% coinsurance for in-network and out-of-network
<b>Habilitation and rehabilitation services - outpatient therapy</b> (including physical therapy, occupational therapy and speech therapy)	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / 20% coinsurance without office visit, \$40 plus 20% coinsurance with office visit	\$0 copay / 20% coinsurance without office visit, \$40 plus 20% coinsurance with office visit
<b>Hearing aids</b> (for covered participants over age 18)	Not covered	Up to \$2,000 for combined ears every three years	\$0 copay Up to \$1,000 per ear for any consecutive 36-month period and \$1 per battery. Annual HealthSelect Secondary deductible does not apply.	Up to \$1,000 per ear every three years. No out-of-network benefits available. Repairs not covered.	Up to \$1,000 per ear every three years. No out-of-network benefits available. Repairs not covered.
<b>High-tech radiology</b> (CT scan, MRI and nuclear medicine) <sup>2</sup>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / \$100 copay plus 20% coinsurance	\$0 copay / \$100 copay plus 20% coinsurance
<b>Home health care<sup>2</sup></b>	No cost to participant(s)	No cost to participant(s)	\$0 copay / 30% coinsurance for home infusion therapy. Plan pays 100% for all other home health care services. Maximum of 100 visits per calendar year when non-network providers are used.	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>Hospice care<sup>2</sup></b>	Covered services from Medicare-certified hospice program: <ul style="list-style-type: none"> <li>• Hospice services and Part A and Part B services related to terminal prognosis</li> <li>• 5% coinsurance for Medicare-approved inpatient respite care</li> <li>• \$5 copay for pain management drugs</li> </ul>	Services through a Medicare-certified hospice program are covered by Medicare, not HealthSelect MA PPO. See Medicare benefits to the left for details.	\$0 copay / 30% coinsurance Annual HealthSelect deductible does not apply.	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>Hospital – inpatient stay</b> (semi-private room and day's board, and intensive care unit) <sup>2</sup>	\$0 after the following amounts for each benefit period <sup>3</sup> : <ul style="list-style-type: none"> <li>• 1-60 days: \$1,408 deductible</li> <li>• 61-90 days: \$352 copay per day</li> <li>• 91-150 days: \$704 copay per lifetime reserve day</li> </ul>	No cost to participant(s)	\$0 copay <sup>5</sup> / 30% coinsurance	\$0 copay <sup>5</sup> If provider doesn't accept Part A, then coverage is \$150 copay per day up to \$750 per admission and \$2,250 per calendar year. 20% coinsurance after copay	\$0 copay <sup>5</sup> If provider doesn't accept Part A, then coverage is \$150 copay per day up to \$750 per admission and \$2,250 per calendar year. 20% coinsurance after copay
<b>Medications and injections administered by a provider</b> (see below for outpatient medications and injections) <sup>2</sup>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance Preventive vaccines are covered at 100%	\$0 copay / Covered at benefits throughout chart dependent upon place of service in which they are administered. Preventive vaccines covered at 100%	\$0 copay / Covered at benefits throughout chart dependent upon place of service in which they are administered. Preventive vaccines covered at 100%

Plan	Original Medicare (Medicare benefits are subject to change)	HealthSelect MA PPO In-Network and Out-of-Network	Medicare Primary, HealthSelect Secondary In-Network and Out-of-Network	Medicare Primary, Community First Health Plans HMO Secondary In-Network	Medicare Primary, Scott and White Health Plan HMO Secondary In-Network
<b>Office surgery and diagnostic procedures</b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>PCP office visit</b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / \$25 copay	\$0 copay / \$25 copay
<b>Preventive Services</b> (physical, screening mammogram, well woman exam, prostate cancer screening, etc.)	No cost to participant(s) if covered by Medicare*; limited to one screening per type per plan year. Does not cover lab tests.	No cost to participant(s) if covered by Medicare*	No cost to participant(s)*	No cost to participant(s)*	No cost to participant(s)*
<b>Private duty nursing<sup>2</sup></b>	Not covered	30% coinsurance, up to maximum benefit of \$8,000 per plan year	30% coinsurance; Unlimited hours	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>Retail health/ convenience care clinic</b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	Not covered	\$0 copay / \$25 or \$40 copay <sup>4</sup>
<b>Routine eye exam</b>	Not covered	No cost to participant(s) for refraction exam; limited to one exam every 12 months	30% coinsurance; limited to one exam per calendar year	\$40 copay; limited to one exam per plan year	\$40 copay; limited to one exam per plan year
<b>Routine hearing test</b>	Not covered	No cost to participant(s); limited to one test per plan year	30% coinsurance	Without office visit: 20% coinsurance With office visit: \$40 plus 20% coinsurance	Without office visit: 20% coinsurance With office visit: \$40 plus 20% coinsurance
<b>Skilled nursing facility (SNF)/inpatient rehabilitation facility services<sup>2</sup></b>	Days 1-20: \$0 (3-day hospital stay required) Days 21-100: \$176 coinsurance per day per benefit period <sup>3</sup>	No cost to participant(s) per 100-day benefit period <sup>3</sup> Includes unlimited 100-day benefit periods. If services extend beyond 100 days, participants must pay out-of-pocket.	No cost to participant(s) Annual HealthSelect deductible does not apply	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>Specialist physician office visit</b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / \$40 copay	\$0 copay / \$40 copay
<b>Surgery (outpatient) other than in physician's office<sup>2</sup></b>	20% coinsurance; specified copay for outpatient hospital facility charges	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / \$100 copay plus 20% coinsurance	\$0 copay / \$100 copay plus 20% coinsurance
<b>Telemedicine visit<sup>6,7</sup></b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	<ul style="list-style-type: none"> <li>PCP: \$0 copay/\$25 copay</li> <li>Specialist: \$0 copay/\$40 copay</li> <li>Other outpatient telemedicine: \$0 copay/20% coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>PCP: \$0 copay/\$25 copay</li> <li>Specialist: \$0 copay/\$40 copay</li> <li>Other outpatient telemedicine: \$0 copay/20% coinsurance</li> </ul>
<b>Therapeutic treatments - outpatient</b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / 20% coinsurance	\$0 copay / 20% coinsurance
<b>Urgent care clinic<sup>6</sup></b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / \$50 copay plus 20% coinsurance	\$0 copay / \$50 copay plus 20% coinsurance
<b>Virtual visits/e-visits (medical)<sup>6,7</sup></b>	Not covered	Amwell or Doctor on Demand covered at no cost to participant(s). Other providers not covered.	Doctor on Demand or MDLive covered at no cost to participant(s). Other providers not covered.	Not offered	Covered at 100% with SWCP provider through online portal or app.

# Mental Health Benefits – Member’s Share of Costs

(Benefits apply to all covered mental health and behavioral health services, including serious mental illness treatment, substance abuse treatment, autism spectrum disorder services, etc.)

Plan	Original Medicare	HealthSelect MA PPO In-Network and Out-of-Network	HealthSelect Secondary In-Network and Out-of-Network	Community First Health Plans HMO In-Network	Scott and White Care Plans HMO In-Network
<b>Administrator and network</b>	N/A	Optum Behavioral Health Network	BCBSTX	CFHP	SWCP
<b>Inpatient hospital mental health stay<sup>2</sup></b>	\$0 after the following amounts for each benefit period <sup>3</sup> : <ul style="list-style-type: none"> <li>Days 1-60: \$1,408 deductible</li> <li>Days 61-90: \$352 copay per day</li> <li>Days 91-150: \$704 copy per lifetime reserve day</li> </ul>	No cost to participant(s). Limited to 190 days in a psychiatric hospital over lifetime	\$0 copay <sup>5</sup> / 30% coinsurance	<ul style="list-style-type: none"> <li>\$0 copay<sup>5</sup></li> <li>If provider doesn't accept Medicare Part A, then \$150 copay per day up to \$750 per admission and \$2,250 per calendar year</li> <li>20% coinsurance after copay</li> </ul>	<ul style="list-style-type: none"> <li>\$0 copay<sup>5</sup></li> <li>If provider doesn't accept Medicare Part A, then \$150 copay per day up to \$750 per admission and \$2,250 per calendar year</li> <li>20% coinsurance after copay</li> </ul>
<b>Mental health telemedicine<sup>7</sup></b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	<ul style="list-style-type: none"> <li>Physician office: \$0 copay/\$25 copay</li> <li>Other outpatient telemedicine: \$0 copay/20% coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>Physician office: \$0 copay/\$25 copay</li> <li>Other outpatient telemedicine: \$0 copay/20% coinsurance</li> </ul>
<b>Outpatient facility care</b> (partial hospitalization/ day treatment and extensive outpatient treatment) <sup>2</sup>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / \$25 copay	\$0 copay / \$25 copay
<b>Outpatient physician or mental health provider office visit</b>	20% coinsurance	No cost to participant(s)	\$0 copay / 30% coinsurance	\$0 copay / \$25 copay	\$0 copay / \$25 copay
<b>Virtual visits/ e-visits</b> (mental health) <sup>7</sup>	Not covered	Amwell or Doctor on Demand covered at no cost to participant(s). Other providers not covered.	Doctor on Demand or MDLive covered at no cost to participant(s). Other providers not covered.	Not covered	Not covered

# Prescription Drug Benefits – Member’s Share of Cost

NOTE: Pharmacy Benefit Managers (PBMs) have different formularies and covered drugs, based on the determinations of their own pharmacy and therapeutics committees and individual formulary strategies. Drugs covered under the HealthSelect plan may not be the same drugs covered under CFHP or SWHP.

Plan	Original Medicare	HealthSelect MA PPO In-Network and Out-of-Network	HealthSelect Secondary In-Network and Out-of-Network	Community First Health Plans HMO In-Network	Scott and White Care Plans HMO In-Network
<b>Pharmacy benefits manager (PBM)</b>	Must be enrolled in an eligible Medicare Part D plan. If you are not enrolled in a Part D plan, you do not have coverage for prescription drugs.	UnitedHealthcare (HealthSelect <sup>SM</sup> Medicare Rx Plan)	UnitedHealthcare (HealthSelect <sup>SM</sup> Medicare Rx Plan)	Navitus	OptumRx
<b>Out-of-network benefits?</b>	Depends on Part D plan and benefits	Yes	Yes	No	No
<b>Deductible</b>	Depends on Part D plan	\$50 per participant per calendar year	\$50 per participant per calendar year	\$50 per participant per plan year	\$50 per participant per plan year
<b>Tier 1 (mostly generic drugs)</b>	Depends on Part D plan	<ul style="list-style-type: none"> <li>\$10 copayment (non-maintenance)</li> <li>\$10 copayment (maintenance)</li> <li>\$30 copayment (90 days' supply mail order or extended day supply)</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copayment (non-maintenance)</li> <li>\$10 copayment (maintenance)</li> <li>\$30 copayment (90 days' supply mail order or extended day supply)</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copayment (non-maintenance)</li> <li>\$10 copayment (maintenance)</li> <li>\$30 copayment (90 days' supply mail order or extended day supply)</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copayment (non-maintenance)</li> <li>\$10 copayment (maintenance)</li> <li>\$30 copayment (90 days' supply mail order or extended day supply)</li> </ul>
<b>Tier 2 (mostly preferred brand name drugs)<sup>2</sup></b>	Depends on Part D plan	<ul style="list-style-type: none"> <li>\$35 copayment (nonmaintenance)</li> <li>\$45 copayment (maintenance)</li> <li>\$105 copayment (mail order or extended day supply)</li> </ul>	<ul style="list-style-type: none"> <li>\$35 copayment (nonmaintenance)</li> <li>\$45 copayment (maintenance)</li> <li>\$105 copayment (mail order or extended day supply)</li> </ul>	<ul style="list-style-type: none"> <li>\$35 copayment (nonmaintenance)</li> <li>\$45 copayment (maintenance)</li> <li>\$105 copayment (mail order or extended day supply)</li> </ul>	<ul style="list-style-type: none"> <li>\$35 copayment (nonmaintenance)</li> <li>\$45 copayment (maintenance)</li> <li>\$105 copayment (mail order or extended day supply)</li> </ul>
<b>Tier 3 (mostly non-preferred brand name drugs)<sup>2</sup></b>	Depends on Part D plan	<ul style="list-style-type: none"> <li>\$60 copayment (non-maintenance)</li> <li>\$75 copayment (maintenance)</li> <li>\$180 copayment (mail order or extended day supply)</li> </ul>	<ul style="list-style-type: none"> <li>\$60 copayment (non-maintenance)</li> <li>\$75 copayment (maintenance)</li> <li>\$180 copayment (mail order or extended day supply)</li> </ul>	<ul style="list-style-type: none"> <li>\$60 copayment (non-maintenance)</li> <li>\$75 copayment (maintenance)</li> <li>\$180 copayment (mail order or extended day supply)</li> </ul>	<ul style="list-style-type: none"> <li>\$60 copayment (non-maintenance)</li> <li>\$75 copayment (maintenance)</li> <li>\$180 copayment (mail order or extended day supply)</li> </ul>
<b>Specialty drugs<sup>2</sup></b>	Depends on Part D plan	Specialty drugs purchased through a pharmacy are covered at the applicable tier above.	Specialty drugs purchased through a pharmacy are covered as either Tier 2 (mostly preferred) or Tier 3 (mostly name brand) drugs. Otherwise they are covered as a medical benefit.	Specialty drugs purchased through a pharmacy are covered as either Tier 2 (mostly preferred) or Tier 3 (mostly name brand) drugs. Otherwise they are covered as a medical benefit.	Specialty drugs purchased through a pharmacy are covered as either Tier 2 (mostly preferred) or Tier 3 (mostly name brand) drugs. Otherwise they are covered as a medical benefit.
<b>Syringes for insulin administration</b>	Depends on Part D plan	No cost to participant(s)	No cost to participant(s)	<ul style="list-style-type: none"> <li>30 day supply: \$35 copay</li> <li>90 day supply: \$105 copay</li> </ul>	<ul style="list-style-type: none"> <li>30 day supply: \$35 copay</li> <li>90 day supply: \$105 copay</li> </ul>

\*Under the Affordable Care Act and CMS requirements, certain preventive health and women’s services are paid at 100% (at no cost to the participant) conditioned upon physician billing and diagnosis. In some cases, you may still be responsible for payment on some services. Some age requirements may apply.

<sup>1</sup> Includes medical and prescription drug copays, coinsurance and deductibles. Excludes non-network and non-covered services.

<sup>2</sup> Preauthorization may be required.

<sup>3</sup> A benefit period starts the day you go into the hospital. It ends after 60 days in a row without returning to hospital care. If you go into the hospital after one benefit period has ended, a new benefit period will begin. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you may have.

<sup>4</sup> Copayment amount depends on whether treatment is provided by a PCP or specialist.

<sup>5</sup> In the event that the provider/facility does not accept Medicare assignment (so the charges are not covered by Medicare and therefore not subject to COB); you may be responsible for copay(s) and/or a coinsurance. Please see your Evidence of Coverage or Master Benefit Plan Document (MBPD) for more information.

<sup>6</sup> Certain services related to COVID-19 testing may be covered by Medicare and your health plan at \$0 cost share during the Public Health Emergency. For information on what Medicare pays, visit <https://www.medicare.gov/medicare-coronavirus>. You may also contact your health plan by calling the number on the back of your medical ID card.

<sup>7</sup> Your health plan may have reduced your cost share for certain services (such as non-COVID-19 related telemedicine and virtual visits) that is not mandated by the Family First Coronavirus Response Act for a period of time due to the coronavirus pandemic. Contact your health plan for additional information by calling the number on the back of your medical ID card.