

2023 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Capital Blue Cross | WellSpan Health Value (PPO)
Capital Blue Cross | WellSpan Health Advantage (PPO)
Capital Blue Cross | WellSpan Health AdvantagePlus
(PPO)

January 1, 2023 - December 31, 2023

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1

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, visit our website at CapitalBlueMedicare.com. You may also call us and ask us to mail you an Evidence of Coverage.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Capital Blue Cross | WellSpan Health Value (PPO), Capital Blue Cross | WellSpan Health Advantage (PPO) and Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what Capital Blue Cross | WellSpan Health Value (PPO), Capital Blue Cross | WellSpan Health Advantage (PPO) and Capital Blue Cross | WellSpan Health AdvantagePlus (PPO) covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <u>Medicare.gov</u>.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at Medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About Capital Blue Cross | WellSpan Health Value (PPO), Capital Blue Cross | WellSpan Health Advantage (PPO) and Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
- Monthly Premium, Deductible, and limits on how much you pay for covered services
- Covered medical and hospital benefits
- Prescription drug benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-866-987-4213 (TTY: 711).

Hours of operation and contact information

- From October 1 to March 31 we're open 8:00 AM to 8:00 PM ET, 7 days a week.
- From April 1 to September 30, we're open 8:00 AM to 8:00 PM ET, Monday through Friday.
- If you are a member of this plan, call us at 1-866-987-4213, TTY: 711.
- If you are not a member of this plan, call us at 1-800-990-4201, TTY: 711.
- Our website: CapitalBlueMedicare.com.

Who can join?

To join Capital Blue Cross | WellSpan Health Value (PPO), Capital Blue Cross | WellSpan Health Advantage (PPO) and Capital Blue Cross | WellSpan Health AdvantagePlus (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service area for Capital Blue Cross | WellSpan Health Value (PPO) includes the following counties in Pennsylvania: Adams, Cumberland, Franklin, Fulton, Lancaster, Lebanon, and York.

The service area for **Capital Blue Cross | WellSpan Health Advantage (PPO)** includes the following counties in Pennsylvania: Adams, Cumberland, Franklin, Fulton, Lancaster, Lebanon, and York.

The service area for **Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)** includes the following counties in Pennsylvania: Adams, Cumberland, Franklin, Fulton, Lancaster, Lebanon, and York.

However, you may use network providers across our 21- county Medicare Advantage service area to obtain medical care.

Which doctors, hospitals, and pharmacies can I use?

Capital Blue Cross | WellSpan Health Value (PPO), Capital Blue Cross | WellSpan Health Advantage (PPO) and Capital Blue Cross | WellSpan Health AdvantagePlus (PPO) have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. With our PPO plans, you can also use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider/pharmacy directory at our website (<u>CapitalBlueMedicare.com</u>). Or, call us and we will send you a copy of the provider/pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

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

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, CapitalBlueMedicare.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Capital Blue Cross.

SECTION II - SUMMARY OF BENEFITS

Capital Blue Cross | WellSpan Health Value (PPO)

WellSpan Health Advantage (PPO)

Capital Blue Cross | Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Monthly Plan Premium	You do not pay a separate monthly plan premium for Capital Blue Cross WellSpan Health Value (PPO). You must continue to pay your Medicare Part B premium.	You do not pay a separate monthly plan premium for Capital Blue Cross WellSpan Health Advantage (PPO). You must continue to pay your Medicare Part B premium.	\$19 per month. In addition, you must keep paying your Medicare Part B premiums.
Medicare Part B Premium Reduction	You receive a \$25 Part B premium reduction each month.	Not Applicable	Not Applicable

Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.	
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • \$8,000 for services you receive from innetwork providers. • \$8,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Your yearly limit(s) in this plan: • \$6,600 for services you receive from innetwork providers. • \$6,600 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Your yearly limit(s) in this plan: • \$5,900 for services you receive from innetwork providers. • \$5,900 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	
COVERED MEDICAL AND HOSPITAL BENEFITS				
Inpatient Hospital	\$375 Copay per stay May require prior authorization.	\$300 Copay per stay May require prior authorization.	\$275 Copay per stay May require prior authorization.	
	Out-of-Network: \$375 Copay per stay.	Out-of-Network: \$300 Copay per stay.	Out-of-Network: \$275 Copay per stay.	

Outpatient Surgery: \$0 - \$350 Copay.

- \$0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient surgical services.

May require prior authorization.

Outpatient

Hospital

(Surgery)

Out-of-Network:

Outpatient Surgery: \$0 - \$350 Copay.

- \$0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient surgical services.

In-Network:

Outpatient Surgery: \$0 - \$315 Copay.

- \$0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient surgical services.

May require prior authorization.

Out-of-Network:

Outpatient Surgery: \$0 - \$315 Copay.

- \$0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient surgical services.

In-Network:

Outpatient Surgery: \$0 - \$275 Copay.

- \$0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient surgical services.

May require prior authorization.

Out-of-Network:

Outpatient Surgery: \$0 - \$275 Copay.

- \$0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient surgical services.

Ambulatory Surgical Center: \$0 - \$350 Copay.

- \$0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient ambulatory surgical center services.

Ambulatory Surgical Center

May require prior authorization.

Out-of-Network:

Ambulatory Surgical Center: \$0 - \$350 Copay.

- \$0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient

In-Network:

Ambulatory Surgical Center: \$0 - \$300 Copay.

- \$0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient ambulatory surgical center services.

May require prior authorization.

Out-of-Network:

Ambulatory Surgical Center: \$0 - \$300 Copay.

- \$0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient ambulatory surgical center services.

In-Network:

Ambulatory Surgical Center: \$0 - \$225 Copay.

- \$0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient ambulatory surgical center services.

May require prior authorization.

Out-of-Network:

Ambulatory Surgical Center: \$0 - \$225 Copay.

- \$0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services.
- Higher cost sharing: for all other outpatient ambulatory surgical center services.

	ambulatory surgical center services.		
	<u>In-Network:</u>	In-Network:	In-Network:
Doctor's Office	Primary care physician visit: \$10 Copay.	Primary care physician visit: \$0 Copay.	Primary care physician visit: \$0 Copay.
	Specialist visit: \$45 Copay.	Specialist visit: \$40 Copay.	Specialist visit: \$25 Copay.
Visits	Out-of-Network:	Out-of-Network:	Out-of-Network:
	Primary care physician visit: \$10 Copay.	Primary care physician visit: \$5 Copay.	Primary care physician visit: \$5 Copay.
	Specialist visit: \$45 Copay.	Specialist visit: \$40 Copay.	Specialist visit: \$25 Copay.
	In-Network:	In-Network:	In-Network:
Preventive Care (e.g., flu vaccine, diabetic screenings)	\$0 Copay for all preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.	\$0 Copay for all preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.	\$0 Copay for all preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.
	Out-of-Network:	Out-of-Network:	Out-of-Network:
	20% Coinsurance for all preventive services.	20% Coinsurance for all preventive services.	20% Coinsurance for all preventive services.
Emergency Care	In-Network and Out-of-Network: \$95 Copay per visit.	In-Network and Out-of-Network: \$95 Copay per visit.	In-Network and Out-of-Network: \$100 Copay per visit.
Urgently Needed Services	In-Network and Out-of-Network: \$60 Copay per visit.	In-Network and Out-of-Network: \$50 Copay per visit.	In-Network and Out-of-Network: \$50 Copay per visit.

Diagnostic tests and procedures: \$0 - \$35 Copay.

- \$0 for routine/monitoring diagnostic tests such as EKG, EEG, ECG, and stress tests.
- Higher cost sharing for all other nonroutine diagnostic tests.

Lab services: \$0 - \$35 Copay.

 \$0 for routine/monitoring lab tests, such as A1C test, complete blood counts and lipid panels.

Diagnostic

Services /

Labs/ Imaging

 Higher cost sharing for all other nonroutine lab services.

Diagnostic Radiology Services (such as MRI, CAT Scan): \$285 Copay.

X-rays: \$35 Copay.

Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.

May require prior authorization.

In-Network:

Diagnostic tests and procedures: \$0 - \$25 Copay.

- \$0 for routine/monitoring diagnostic tests such as EKG, EEG, ECG, and stress tests.
- Higher cost sharing for all other nonroutine diagnostic tests.

Lab services: \$0 - \$25 Copay.

- \$0 for routine/monitoring lab tests, such as A1C test, complete blood counts and lipid panels.
- Higher cost sharing for all other nonroutine lab services.

Diagnostic Radiology Services (such as MRI, CAT Scan): \$225 Copay.

X-rays: \$20 Copay.

Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.

May require prior authorization.

In-Network:

Diagnostic tests and procedures: \$0 - \$20 Copay.

- \$0 for routine/monitoring diagnostic tests such as EKG, EEG, ECG, and stress tests.
- Higher cost sharing for all other nonroutine diagnostic tests.

Lab services: \$0 - \$20 Copay.

- \$0 for routine/monitoring lab tests, such as A1C test, complete blood counts and lipid panels.
- Higher cost sharing for all other nonroutine lab services.

Diagnostic Radiology Services (such as MRI, CAT Scan): \$180 Copay.

X-rays: \$20 Copay.

Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.

May require prior authorization.

	Out-of-Network:	Out-of-Network:	Out-of-Network:
procedures: 20% Coinsurance. Lab services: 20 Coinsurance. Diagnostic Radio Services (such a CAT Scan): 20%	Diagnostic tests and procedures: 20% Coinsurance.	Diagnostic tests and procedures: 20% Coinsurance.	Diagnostic tests and procedures: 20% Coinsurance.
	Lab services: 20% Coinsurance.	Lab services: 20% Coinsurance.	Lab services: 20% Coinsurance.
	Diagnostic Radiology Services (such as MRI, CAT Scan): 20% Coinsurance.	Diagnostic Radiology Services (such as MRI, CAT Scan): 20% Coinsurance.	Diagnostic Radiology Services (such as MRI, CAT Scan): 20% Coinsurance.
	X-rays: 20% Coinsurance.	X-rays: 20% Coinsurance.	X-rays: 20% Coinsurance.
	Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.	Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.	Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.
	In-Network:	<u>In-Network:</u>	In-Network:
Hearing Services	Medicare covered Hearing Exam: \$45 Copay.	Medicare covered Hearing Exam: \$40 Copay.	Medicare covered Hearing Exam: \$25 Copay.
	Routine hearing exam: \$0 Copay. 1 visit every year (combined in and out of network).	Routine hearing exam: \$0 Copay. 1 visit every year (combined in and out of network).	Routine hearing exam: \$0 Copay. 1 visit every year (combined in and out of network).
Services	Out-of-Network:	Out-of-Network:	Out-of-Network:
Services	Out-of-Network: Medicare covered Hearing Exam: \$45 Copay.	Out-of-Network: Medicare covered Hearing Exam: \$40 Copay.	Out-of-Network: Medicare covered Hearing Exam: \$25 Copay.

Medicare covered dental exam: \$45 Copay.

Preventive dental services: \$10 Copay.

- Oral exam.
- Cleaning.
- Fluoride treatment.
- Dental bitewing X-rays.

2 visits every year (combined in and out of network).

Dental Services

Out-of-Network:

Medicare covered dental exam: \$45 Copay.

Preventive dental services: 50% Coinsurance.

- Oral exam.
- Cleaning.
- Fluoride treatment.
- Dental bitewing X-rays.

2 visits every year (combined in and out of network).

In-Network:

Medicare covered dental exam: \$40 Copay.

Preventive dental services: \$10 Copay.

- Oral exam.
- Cleaning.
- Fluoride treatment.
- Dental bitewing X-rays.

2 visits every year (combined in and out of network).

Out-of-Network:

Medicare covered dental exam: \$40 Copay.

Preventive dental services: 50% Coinsurance.

- Oral exam.
- Cleaning.
- Fluoride treatment.
- Dental bitewing X-rays.

2 visits every year (combined in and out of network).

In-Network:

Medicare covered dental exam: \$25 Copay.

Preventive dental services: \$10 Copay.

- Oral exam.
- Cleaning.
- Fluoride treatment.
- Dental bitewing X-rays.

2 visits every year (combined in and out of network).

Out-of-Network:

Medicare covered dental exam: \$25 Copay.

Preventive dental services: 50% Coinsurance.

- Oral exam.
- Cleaning.
- Fluoride treatment.
- Dental bitewing X-rays.

2 visits every year (combined in and out of network).

Medicare covered vision exam: \$45 Copay.

 \$0 Copay applies to glaucoma screening exam or diabetic retinal eye exam.

Routine eye exam: \$10 Copay.

1 visit every year (combined in and out of network).

Medicare covered eyeglasses or contact lenses after cataract surgery: \$0 Copay.

Vision Services

Our plan pays up to \$100 every year for eyewear or contacts (combined in and out of network).

Out-of-Network:

Medicare covered vision exam: \$45 Copay, including diabetic retinal exam.

 20% Coinsurance for glaucoma screening exam.

Routine eye exam: 50% Coinsurance.

1 visit every year (combined in and out of network).

Medicare covered eyeglasses or contact

In-Network:

Medicare covered vision exam: \$40 Copay.

 \$0 Copay applies to glaucoma screening exam or diabetic retinal eye exam.

Routine eye exam: \$0 Copay.

1 visit every year (combined in and out of network).

Medicare covered eyeglasses or contact lenses after cataract surgery: \$0 Copay.

Our plan pays up to \$150 every year for eyewear or contacts (combined in and out of network).

Out-of-Network:

Medicare covered vision exam: \$40 Copay, including diabetic retinal exam.

 20% Coinsurance for glaucoma screening exam.

Routine eye: 50% Coinsurance.

1 visit every year (combined in and out of network).

Medicare covered eyeglasses or contact lenses after cataract

In-Network:

Medicare covered vision exam: \$25 Copay.

 \$0 Copay applies to glaucoma screening exam or diabetic retinal eye exam.

Routine eye exam: \$0 Copay.

1 visit every year (combined in and out of network).

Medicare covered eyeglasses or contact lenses after cataract surgery: \$0 Copay.

Our plan pays up to \$225 every year for eyewear or contacts (combined in and out of network).

Out-of-Network:

Medicare covered vision exam: \$25 Copay, including diabetic retinal exam.

 20% Coinsurance for glaucoma screening exam.

Routine eye exam: 50% Coinsurance.

1 visit every year (combined in and out of network).

Medicare covered eyeglasses or contact lenses after cataract

	lenses after cataract surgery: 20% Coinsurance. Our plan pays up to \$100 every year for eyewear or contacts (combined in and out of network).	surgery: 20% Coinsurance. Our plan pays up to \$150 every year for eyewear or contacts (combined in and out of network).	surgery: 20% Coinsurance. Our plan pays up to \$225 every year for eyewear or contacts (combined in and out of network).
	In-Network:	In-Network:	In-Network:
Mental Health	Outpatient group therapy visit: \$40 Copay.	Outpatient group therapy visit: \$40 Copay.	Outpatient group therapy visit: \$25 Copay.
	Individual therapy visit: \$40 Copay.	Individual therapy visit: \$40 Copay.	Individual therapy visit: \$25 Copay.
	Inpatient Mental Health Care: \$375 Copay per stay.	Inpatient Mental Health Care: \$300 Copay per stay.	Inpatient Mental Health Care: \$275 Copay per stay.
Care	Out-of-Network:	Out-of-Network:	Out-of-Network:
	Outpatient group therapy visit: \$40 Copay.	Outpatient group therapy visit: \$40 Copay.	Outpatient group therapy visit: \$25 Copay.
	Individual therapy visit: \$40 Copay.	Individual therapy visit: \$40 Copay.	Individual therapy visit: \$25 Copay.
	Inpatient Mental Health Care: \$375 Copay per stay.	Inpatient Mental Health Care: \$300 Copay per stay.	Inpatient Mental Health Care: \$275 Copay per stay.

	In-Network:	In-Network:	In-Network:
Skilled Nursing Facility (SNF)	Days 1-20: \$0 Copay per day.	Days 1-20: \$0 Copay per day.	Days 1-20: \$0 Copay per day.
	Days 21-100: \$196 Copay per day.	Days 21-100: \$196 Copay per day.	Days 21-100: \$196 Copay per day.
	May require prior authorization.	May require prior authorization.	May require prior authorization.
	Out-of-Network:	Out-of-Network:	Out-of-Network:
	Days 1-20: \$0 Copay per day.	Days 1-20: \$0 Copay per day.	Days 1-20: \$0 Copay per day.
	Days 21-100: \$196 Copay per day.	Days 21-100: \$196 Copay per day.	Days 21-100: \$196 Copay per day.
	In-Network:	In-Network:	In-Network:
	Occupational therapy visit: \$40 Copay.	Occupational therapy visit: \$30 Copay.	Occupational therapy visit: \$25 Copay.
	Physical therapy and speech and language therapy visit: \$40 Copay.	Physical therapy and speech and language therapy visit: \$30 Copay.	Physical therapy and speech and language therapy visit: \$25 Copay.
Outpatient Rehabilitation	May require prior authorization.	May require prior authorization.	May require prior authorization.
	Out-of-Network:	Out-of-Network:	Out-of-Network:
	Occupational therapy visit: \$40 Copay.	Occupational therapy visit: \$30 Copay.	Occupational therapy visit: \$25 Copay.
	Physical therapy and speech and language therapy visit: \$40 Copay.	Physical therapy and speech and language therapy visit: \$30 Copay.	Physical therapy and speech and language therapy visit: \$25 Copay.

	In-Network:	In-Network:	In-Network:
Ambulance	Ground Ambulance: \$350 Copay.	Ground Ambulance: \$275 Copay.	Ground Ambulance: \$250 Copay.
	Air Ambulance: \$350 Copay.	Air Ambulance: \$275 Copay.	Air Ambulance: \$250 Copay.
	May require prior authorization.	May require prior authorization.	May require prior authorization.
	Out-of-Network:	Out-of-Network:	Out-of-Network:
	Ground Ambulance: \$350 Copay.	Ground Ambulance: \$275 Copay.	Ground Ambulance: \$250 Copay.
	Air Ambulance: \$350 Copay.	Air Ambulance: \$275 Copay.	Air Ambulance: \$250 Copay.
	In-Network:	In-Network:	In-Network:
	Not Covered.	\$0 Copay.	\$0 Copay.
	Out-of-Network: Not Covered.	16 One-way trips every year to Plan-approved Health-related Location.	48 One-way trips every year to Plan-approved Health-related Location.
Transportation		Requires prior authorization.	Requires prior authorization.
		Must use our vendor.	Must use our vendor.
		Out-of-Network:	Out-of-Network:
		\$0 Copay.	\$0 Copay.
		16 One-way trips every year to Plan-approved Health-related Location.	48 One-way trips every year to Plan-approved Health-related Location.

	In-Network:	In-Network:	In-Network:
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: 20% Coinsurance.	For Part B drugs such as chemotherapy drugs: 20% Coinsurance.	For Part B drugs such as chemotherapy drugs: 20% Coinsurance.
	Other Part B drugs: 20% Coinsurance.	Other Part B drugs: 20% Coinsurance.	Other Part B drugs: 20% Coinsurance.
	May require prior authorization.	May require prior authorization.	May require prior authorization.
	Out-of-Network:	Out-of-Network:	Out-of-Network:
	For Part B drugs such as chemotherapy drugs: 20% Coinsurance.	For Part B drugs such as chemotherapy drugs: 20% Coinsurance.	For Part B drugs such as chemotherapy drugs: 20% Coinsurance.
	Other Part B drugs: 20% Coinsurance.	Other Part B drugs: 20% Coinsurance.	Other Part B drugs: 20% Coinsurance.
PRESCRIPTION DRUG BENEFITS			
Deductible	Prescription Drug Deductible: Not Applicable.	Prescription Drug Deductible: Not Applicable.	Prescription Drug Deductible: Not Applicable.

You pay the following until your total yearly drug costs reach \$4,660. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

You won't pay more than \$25 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it is on.

your total yearly drug costs reach \$4,660. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

You won't pay more than \$10 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it is on.

You pay the following until You pay the following until your total yearly drug costs reach \$4,660. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

> Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

You won't pay more than \$5 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it is on.

Initial Coverage

Standard Retail Cost- Sharing		
Tier	One-month supply	
Tier 1		
(Preferred		
Generic)	\$12 copay	
Tier 2		
(Generic)	\$20 copay	
Tier 3		
(Preferred		
Brand)	\$47 copay	
Tier 4		
(Non-		
Preferred		
Drug)	\$100 copay	
Tier 5		
(Specialty	33%	
Tier)	coinsurance	

Standard R Cost-Shari	
	0

One-month supply
\$12 copay
\$20 copay
\$47 copay
\$100 copay
33%
coinsurance

Standard Retail Cost-Sharing

Tier	One-month supply
Tier 1	
(Preferred	
Generic)	\$10 copay
Tier 2	
(Generic)	\$20 copay
Tier 3	
(Preferred	
Brand)	\$47 copay
Tier 4	
(Non-	
Preferred	
Drug)	\$100 copay
Tier 5	
(Specialty	33%
Tier)	coinsurance

Part D Insulin Saver	\$25 copay	Part D Insulin Saver	\$10 copay	Part D Insulin Saver	\$5 copay
Tier	Two-month supply	Tier	Two-month supply	Tier	Two-month supply
Tier 1 (Preferred Generic)	\$24 copay	Tier 1 (Preferred Generic)	\$24 copay	Tier 1 (Preferred Generic)	\$20 copay
Tier 2 (Generic)	\$40 copay	Tier 2 (Generic)	\$40 copay	Tier 2 (Generic)	\$40 copay
Tier 3 (Preferred Brand)	\$94 copay	Tier 3 (Preferred Brand)	\$94 copay	Tier 3 (Preferred Brand)	\$94 copay
Tier 4 (Non- Preferred Drug)	\$200 copay	Tier 4 (Non- Preferred Drug)	\$200 copay	Tier 4 (Non- Preferred Drug)	\$200 copay
Tier 5 (Specialty Tier)	Not Applicable	Tier 5 (Specialty Tier)	Not Applicable	Tier 5 (Specialty Tier)	Not Applicable
Part D Insulin Saver	\$50 copay	Part D Insulin Saver	\$20 copay	Part D Insulin Saver	\$10 copay
Tier	Three- month supply	Tier	Three- month supply	Tier	Three- month supply
Tier 1 (Preferred Generic)	\$36 copay	Tier 1 (Preferred Generic)	\$36 copay	Tier 1 (Preferred Generic)	\$30 copay
Tier 2 (Generic)	\$60 copay	Tier 2 (Generic)	\$60 copay	Tier 2 (Generic)	\$60 copay
Tier 3 (Preferred Brand)	\$141 copay	Tier 3 (Preferred Brand)	\$141 copay	Tier 3 (Preferred Brand)	\$141 copay
Tier 4 (Non-	\$300 copay	Tier 4 (Non-	\$300 copay	Tier 4 (Non-	\$300 copay

Preferred		Preferred		Preferred	
Drug)		Drug)		Drug)	
Tier 5		Tier 5		Tier 5	
(Specialty	Not	(Specialty	Not	(Specialty	Not
Tier)	Applicable	Tier)	Applicable	Tier)	Applicable
Part D		Part D		Part D	
Insulin		Insulin		Insulin	
Saver	\$75 copay	Saver	\$30 copay	Saver	\$15 copay
Preferred R Sharing	etail Cost-	Preferred Retail Cost- Sharing		Preferred Retail Cost- Sharing	
Tier	One-month supply	Tier	One-month supply	Tier	One-mont
Tier 1		Tier 1		Tier 1	
(Preferred		(Preferred		(Preferred	
Generic)	\$0 Copay	Generic)	\$0 Copay	Generic)	\$0 Copay
Tier 2		Tier 2		Tier 2	
(Generic)	\$12 copay	(Generic)	\$10 copay	(Generic)	\$0 Copay
Tier 3		Tier 3		Tier 3	
(Preferred		(Preferred		(Preferred	
Brand)	\$40 copay	Brand)	\$40 copay	Brand)	\$40 copay
Tier 4		Tier 4		Tier 4	
(Non-		(Non-		(Non-	
Preferred		Preferred		Preferred	
Drug)	\$93 copay	Drug)	\$93 copay	Drug)	\$93 copay
Tier 5		Tier 5		Tier 5	
(Specialty	33%	(Specialty	33%	(Specialty	33%
Tier)	coinsurance	Tier)	coinsurance	Tier)	coinsuranc
Part D		Part D		Part D	
Insulin		Insulin		Insulin	
Saver	¢25 aanaa	Saver	¢10 a===:	Saver	ΦE
	\$25 copay		\$10 copay		\$5 copay
	,				1
	Two-month		Two-month		Two-mont
Tier	Two-month supply	Tier	Two-month supply	Tier	Two-mont supply
Tier 1		Tier		Tier 1	

Tier 2		Tier 2		Tier 2	
(Generic)	\$24 copay	(Generic)	\$20 copay	(Generic)	\$0 Copay
Tier 3		Tier 3		Tier 3	
(Preferred		(Preferred		(Preferred	
Brand)	\$80 copay	Brand)	\$80 copay	Brand)	\$80 copay
Tier 4		Tier 4		Tier 4	
(Non-		(Non-		(Non-	
Preferred		Preferred		Preferred	
Drug)	\$186 copay	Drug)	\$186 copay	Drug)	\$186 copay
Tier 5		Tier 5		Tier 5	
(Specialty	Not	(Specialty	Not	(Specialty	Not
Tier)	Applicable	Tier)	Applicable	Tier)	Applicable
Part D		Part D		Part D	
Insulin		Insulin		Insulin	
Saver	\$50 copay	Saver	\$20 copay	Saver	\$10 copay
	Three-		Three-		Three-
Tier	month	Tier	month	Tier	month
	supply		supply		supply
Tier 1		Tier 1		Tier 1	
(Preferred		(Preferred		(Preferred	
Generic)	\$0 Copay	Generic)	\$0 Copay	Generic)	\$0 Copay
Tier 2		Tier 2		Tier 2	
(Generic)	\$36 copay	(Generic)	\$30 copay	(Generic)	\$0 Copay
Tier 3		Tier 3		Tier 3	
(Preferred		(Preferred		(Preferred	
Brand)	\$120 copay	Brand)	\$120 copay	Brand)	\$120 copay
Tier 4		Tier 4		Tier 4	
(Non-		(Non-		(Non-	
	1		I II	Preferred	I
Preferred		Preferred		Fielelieu	
Preferred Drug)	\$279 copay	Preferred Drug)	\$279 copay	Drug)	\$279 copay
	\$279 copay	II	\$279 copay	ll .	\$279 copay
Drug)	\$279 copay	Drug)	\$279 copay	Drug)	\$279 copay
Drug) Tier 5		Drug) Tier 5		Drug) Tier 5	
Drug) Tier 5 (Specialty	Not	Drug) Tier 5 (Specialty	Not	Drug) Tier 5 (Specialty	Not
Drug) Tier 5 (Specialty Tier)	Not	Drug) Tier 5 (Specialty Tier)	Not	Drug) Tier 5 (Specialty Tier)	Not

Tier One-month supply Tier One-month supply Tier 1 (Preferred Generic) \$0 Copay Tier 1 (Preferred Generic) \$0 Copay Tier 2 (Generic) \$12 copay Tier 2 (Generic) \$10 copay Tier 3 (Preferred Brand) \$40 copay Tier 3 (Preferred Brand) \$40 copay Tier 4 (Non-Preferred Drug) \$93 copay Tier 4 (Non-Preferred Drug) \$93 copay Tier 5 (Specialty 33% Tier) Tier 5 (Specialty 33% Tier) Tier 5 (Specialty 33% Tier) Tier Dusulin Saver \$25 copay Tier Dusulin Saver Tier Dusulin	Mail Order		Mail Order		Mail Order	
Preferred Generic	Tier		Tier		Tier	
Generic \$0 Copay Tier 2 (Generic \$12 copay Tier 2 (Generic \$12 copay Tier 3 (Preferred Brand \$40 copay Tier 4 (Non-Preferred Drug \$93 copay Tier 5 (Specialty and Saver \$25 copay \$10 copa			l I		II .	
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Brand						
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Non-	· ·	\$40 copay	·	\$40 copay	,	\$40 copay
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Insulin Saver \$25 copay Saver \$10 copay Saver \$5 copay	Tier)	coinsurance	Tier)	coinsurance	Tier)	coinsurance
Saver \$25 copay Saver \$10 copay Saver \$5 copay Tier Two-month supply Tier Two-month supply Tier 1 Tier 2 Generic) \$0 Copay Tier 2 Generic) \$0 Copay Tier 2 Tier 3 Tier 3 Tier 3 Preferred Brand) \$80 copay Tier 3 Tier 4 Tier 5 T	II					
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(Preferred Brand)\$80 copay(Preferred Brand)\$80 copay(Preferred Brand)\$80 copayTier 4 (Non-Preferred Drug)Tier 4 (Non-Preferred Drug)(Non-Preferred Drug)Tier 4 (Non-Preferred Drug)(Non-Preferred Drug)Preferred Drug)Preferred Drug)Tier 5 (SpecialtyTier 5 (SpecialtyTier 5 (SpecialtyTier 5 (SpecialtyNotTier 5 (Specialty	(Generic)	\$24 copay	(Generic)	\$20 copay	(Generic)	\$0 Copay
Brand) \$80 copay Brand) \$80 copay Tier 4	Tier 3		Tier 3		Tier 3	
Tier 4 (Non- Preferred Drug) \$186 copay Tier 5 (Specialty Not Tier 5 (Specialty Not Tier 5) Tier 4 (Non- Preferred Drug) \$186 copay Tier 5 (Specialty Not Tier 5)	(Preferred		(Preferred		(Preferred	
(Non- Preferred Drug)	Brand)	\$80 copay	Brand)	\$80 copay	Brand)	\$80 copay
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Drug)\$186 copayDrug)\$186 copayDrug)\$186 copayTier 5Tier 5Tier 5Tier 5(SpecialtyNot(SpecialtyNot	(Non-		(Non-		(Non-	
Tier 5 Tier 5 Specialty Not Special Not	Preferred		Preferred		Preferred	
(Specialty Not (Specialty Not (Specialty Not	Drug)	\$186 copay	Drug)	\$186 copay	Drug)	\$186 copay
	Tier 5		Tier 5		Tier 5	
Tier) Applicable Tier) Applicable Tier) Applicable	(Specialty	Not	(Specialty	I II	(Specialty	Not
The state of the s	Tier)	Applicable	Tier)	Applicable	Tier)	Applicable

Part D Insulin		Part D Insulin		Part D Insulin	
Saver	\$50 copay	Saver	\$20 copay	Saver	\$10 copay
Cavei	фоо сорау	Odver	ф20 сорау	Oavei	ф то сорау
	Three-		Three-		Three-
Tier	month	Tier	month	Tier	month
 ,	supply	<i>-</i>	supply		supply
Tier 1		Tier 1		Tier 1	
(Preferred Generic)	\$0 Copay	(Preferred Generic)	\$0 Copay	(Preferred Generic)	\$0 Copay
Tier 2	ъо Сорау	Tier 2	ъо Сорау	Tier 2	фо Сорау
(Generic)	\$36 copay	(Generic)	\$30 copay	(Generic)	\$0 Copay
Tier 3	ф30 сорау	Tier 3	ф30 сорау	Tier 3	фо Сорау
(Preferred		(Preferred		(Preferred	
Brand)	\$120 copay	Brand)	\$120 copay	Brand)	\$120 copay
Tier 4	*	Tier 4	*	Tier 4	7 - 2 - 3 - 3
(Non-		(Non-		(Non-	
Preferred		Preferred		Preferred	
Drug)	\$279 copay	Drug)	\$279 copay	Drug)	\$279 copay
Tier 5		Tier 5		Tier 5	
(Specialty	Not	(Specialty	Not	(Specialty	Not
Tier)	Applicable	Tier)	Applicable	Tier)	Applicable
Part D		Part D		Part D	
Insulin		Insulin		Insulin	
Saver	\$75 copay	Saver	\$30 copay	Saver	\$15 copay
Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.		Your cost-shadifferent if you Term Care plan out-of-net pharmacy, or purchase a losupply (up to a drug.	u use a Long narmacy, or work if you ong-term	Your cost-shadifferent if you Term Care phan out-of-network pharmacy, or purchase a losupply (up to drug.	u use a Long narmacy, or vork if you ng-term
Please call us or see the plan's "Evidence of Coverage" on our website CapitalBlueMedicare.com for complete information		plan's "Evide Coverage" o website CapitalBlueM	Please call us or see the plan's "Evidence of Coverage" on our vebsite CapitalBlueMedicare.com or complete information Please call us or see the plan's "Evidence of Coverage" on our CapitalBlueMedical for complete information about your costs for covered drugs.		nce of n our website edicare.com nformation sts for

	about your costs for covered drugs.	about your costs for covered drugs.	
	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,660.	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,660.	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,660.
Coverage Gap	After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$7,400, which is the end of the coverage gap. As part of the Part D Insulin Saver Program, you will continue to pay the same copays during the Coverage Gap Stage as you did in the Initial Coverage Stage (listed above) for insulins.	After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$7,400, which is the end of the coverage gap. As part of the Part D Insulin Saver Program, you will continue to pay the same copays during the Coverage Gap Stage as you did in the Initial Coverage Stage (listed above) for insulins.	After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$7,400, which is the end of the coverage gap. As part of the Part D Insulin Saver Program, you will continue to pay the same copays during the Coverage Gap Stage as you did in the Initial Coverage Stage (listed above) for insulins.
Catastrophic	After your yearly out-of- pocket drug costs reach \$7,400, you pay the greater of: • \$4.15 copay for generic (including	After your yearly out-of- pocket drug costs reach \$7,400, you pay the greater of: • \$4.15 copay for generic (including	After your yearly out-of- pocket drug costs reach \$7,400, you pay the greater of: • \$4.15 copay for generic (including
Amount	brand drugs treated as generic) and a \$10.35 copayment for all other drugs, or • 5% of the cost.	brand drugs treated as generic) and a \$10.35 copayment for all other drugs, or • 5% of the cost.	brand drugs treated as generic) and a \$10.35

DISCLAIMERS

This document is available in other alternate format.

Capital Blue Cross | WellSpan Health Value (PPO), Capital Blue Cross | WellSpan Health Advantage (PPO) and Capital Blue Cross | WellSpan Health AdvantagePlus (PPO) are PPO plans with a Medicare contract. Care management services are provided by WellSpan Health. Enrollment in Capital Blue Cross | WellSpan Health Value (PPO), Capital Blue Cross | WellSpan Health Advantage (PPO) and Capital Blue Cross | WellSpan Health AdvantagePlus (PPO) depends on contract renewal. Capital Blue Cross is an independent licensee of the Blue Cross Blue Shield Association. Other providers are available in the network.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Capital Blue Cross members, except in emergency situations. Please call our Member Services number or see your "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Capital Advantage Insurance Company.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-987-4213 (TTY 711).

Under	standing the Benefits
	Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit CapitalBlueMedicare.com or call 1-866-987-4213 (TTY 711) to view a copy of the EOC.
	Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor or pay the out-of-network cost.
	Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
	Review the formulary to make sure your drugs are covered.
Unde	rstanding Important Rules
	In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
	Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
	Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
	Out-of-network/non-contracted providers are under no obligation to treat Capital Blue Cross WellSpan Health Advantage (PPO), Capital Blue Cross WellSpan Health AdvantagePlus (PPO) and Capital Blue Cross WellSpan Health Value (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information.

THANK YOU

Connect with us

Contact Information: 1-866-987-4213, TTY: 711

Organization Name: Capital Blue Cross

Organization Website: CapitalBlueMedicare.com

Capital Blue Cross | WellSpan Health PPO is issued by Capital Advantage Insurance Company[®], a subsidiary of Capital Blue Cross, independent licensees of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies. Care management services are provided by WellSpan Health. Other providers are available in the network.