

2018 Illinois and Western Indiana Health Alliance Group Medicare



Health Alliance Group Medicare Advantage HMO and POS service area

Health Alliance Group Medicare Advantage HMO and POS Plans are available to groups domiciled in all shaded counties in Illinois and the three shaded counties in Indiana.

Health Alliance Group Medicare Supplement Plans and Group Stand-Alone Prescription Drug Plans are available in all counties in Illinois. These plans are not available in Indiana.



Group Medicare–IL/IN	HMO Option 1 (available for groups only)	HMO Option 2 (available for groups only)
Monthly Premium	\$230	\$210
Member Benefits	In-Network Only	In-Network Only
Plan Year Deductible	\$0	\$0
Plan Year Out-of-Pocket Maximum	\$3,500	\$6,700
Be Healthy Annual Physical and Preventive Services*	\$0 copayment	\$0 copayment
Primary Care Office Visit	\$20 copayment	\$10 copayment
Specialist Office Visit	\$40 copayment	\$50 copayment
Outpatient Diagnostic Procedures/Tests/ Lab	\$0 copayment	20% coinsurance
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	\$5 copayment	\$150 copayment
Outpatient Radiological Services- X-rays	\$0 copayment	20% coinsurance
Outpatient Hospital Services- Surgery	\$150 copayment	20% coinsurance
Inpatient Hospital Care <i>Unlimited days each benefit period</i>	\$150 each day for days 1–7, \$0 each day for days 8–60, \$50 each day for days 61–90, \$0 each day for days 91 and beyond	\$247 each day for days 1–8, \$0 each day for days 9–60, \$100 each day for days 61–90, \$0 each day for days 91 and beyond
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	\$0 each day for days 1–20, \$125 each day for days 21–100	\$0 each day for days 1–20, \$160 each day for days 21–100
Emergency Care/Post Stabilization Care	\$80 copayment	\$80 copayment
Urgently Needed Care	\$25 copayment	\$65 copayment
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	20% coinsurance
Preferred-Brand (Abbott) Diabetic Test Strips and Blood Glucose Monitors	0% coinsurance	0% coinsurance
Non-Preferred Diabetic Test Strips and Blood Glucose Monitors	20% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)**	\$0 deductible	\$0 deductible
Tier 1 Preferred Generic at Walgreens	\$0 copayment	\$0 copayment
Tier 1 Preferred Generic Elsewhere	\$9 copayment	\$15 copayment
Tier 2 Generic	\$20 copayment	\$30 copayment
Tier 3 Preferred Brand	\$47 copayment	\$30 copayment
Tier 4 Non-Preferred Drug	25% coinsurance	\$100 copayment
Tier 5 Specialty Tier	25% coinsurance	25% coinsurance
Coverage Gap Stage One-month (30-day) supply	Prescription Drug Coverage continues through Medicare's Coverage Gap Stage.	
Catastrophic Coverage One-month (30-day) supply	After member's yearly out-of-pocket drug costs reach \$5,000, member pays the greater of: \$3.35 copay for generic drugs and \$8.35 copay for brand-name drugs, OR 5% coinsurance.	

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.

**All plans include 2 x 30-day copay for 90-day scripts filled at Walgreens & preferred pharmacies (2.5 x 30-day copays for 90-day scripts at all other contracted pharmacies).

Group Medicare–IL/IN	HMO Basic (available for groups and individuals)	HMO 40 (available for groups and individuals)	HMO 20 (available for groups and individuals)	HMO Basic Rx (available for groups and individuals)	HMO 40 Rx (available for groups and individuals)	HMO 20 Rx (available for groups and individuals)
Monthly Premium	\$0	\$39	\$85	\$33	\$72	\$116
Member Benefits	In-Network Only	In-Network Only	In-Network Only	In-Network Only	In-Network Only	In-Network Only
Plan Year Deductible	\$0	\$0	\$0	\$0	\$0	\$0
Plan Year Out-of-Pocket Maximum	\$6,700	\$4,700	\$4,000	\$6,700	\$4,700	\$4,000
Be Healthy Annual Physical and Preventive Services*	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Primary Care Office Visit	\$25 copayment	\$10 copayment	\$20 copayment	\$25 copayment	\$10 copayment	\$20 copayment
Specialist Office Visit	\$50 copayment	\$45 copayment	\$40 copayment	\$50 copayment	\$45 copayment	\$40 copayment
Outpatient Diagnostic Procedures/Tests/Lab	20% coinsurance	\$10 copayment	\$10 copayment	20% coinsurance	\$10 copayment	\$10 copayment
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	\$150 copayment	\$150 copayment	\$5 copayment	\$150 copayment	\$150 copayment	\$5 copayment
Outpatient Radiological Services- X-rays	20% coinsurance	\$10 copayment	\$0 copayment	20% coinsurance	\$10 copayment	\$0 copayment
Outpatient Hospital Services- Surgery	20% coinsurance	\$200 copayment	\$200 copayment	20% coinsurance	\$200 copayment	\$200 copayment
Inpatient Hospital Care <i>Unlimited days each benefit period</i>	\$249.50 each day for days 1–8, \$0 each day for days 9–60, \$100 each day for days 61–90, \$0 each day for days 91 and beyond	\$225 each day for days 1–7, \$0 each day for days 8–60, \$75 each day for days 61–90, \$0 each day for days 91 and beyond	\$200 each day for days 1–7, \$0 each day for days 8 and beyond	\$249.50 each day for days 1–8, \$0 each day for days 9–60, \$100 each day for days 61–90, \$0 each day for days 91 and beyond	\$225 each day for days 1–7, \$0 each day for days 8–60, \$75 each day for days 61–90, \$0 each day for days 91 and beyond	\$200 each day for days 1–7, \$0 each day for days 8 and beyond
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$0 each day for days 1–20, \$167.50 each day for days 21–100
Emergency Care/Post Stabilization Care	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment
Urgently Needed Care	\$65 copayment	\$40 copayment	\$25 copayment	\$65 copayment	\$40 copayment	\$25 copayment
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Preferred-Brand (Abbott) Diabetic Test Strips and Blood Glucose Monitors	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance
Non-Preferred Diabetic Test Strips and Blood Glucose Monitors	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)**	N/A	N/A	N/A	\$0 deductible	\$0 deductible	\$0 deductible
Tier 1 Preferred Generic at Walgreens	N/A	N/A	N/A	\$0 copayment	\$0 copayment	\$0 copayment
Tier 1 Preferred Generic Elsewhere	N/A	N/A	N/A	\$9 copayment	\$9 copayment	\$9 copayment
Tier 2 Generic	N/A	N/A	N/A	\$20 copayment	\$20 copayment	\$20 copayment
Tier 3 Preferred Brand	N/A	N/A	N/A	\$47 copayment	\$47 copayment	\$47 copayment
Tier 4 Non-Preferred Drug	N/A	N/A	N/A	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 Specialty Tier	N/A	N/A	N/A	33% coinsurance	33% coinsurance	33% coinsurance
Coverage Gap Stage One-month (30-day) supply	N/A	N/A	N/A	From \$3,750 until member's yearly out-of-pocket drug costs reach \$5,000, member pays 44% of generic drugs and 35% for brand-name drugs after the 50% manufacturer discount and 10% brand name coverage.		
Catastrophic Coverage One-month (30-day) supply	N/A	N/A	N/A	After member's yearly out-of-pocket drug costs reach \$5,000, member pays the greater of: \$3.35 copay for generic drugs and \$8.35 copay for brand-name drugs, OR 5% coinsurance.		

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.

**All Rx plans include 2 x 30-day copay for 90-day scripts filled at Walgreens & preferred pharmacies (2.5 x 30-day copays for 90-day scripts at all other contracted pharmacies), and 44%/35% generic/brand coverage for non-low income members in the coverage gap.

Group Medicare–IL/IN	POS Option 1 (available for groups only)		POS Option 2 (available for groups only)		POS Option 3 (available for groups only)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Premium	\$249		\$319		\$376	
Member Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible	\$0		\$0		\$0	
Plan Year Out-of-Pocket Maximum	\$4,000	\$5,100 (in- and out-of-network combined)	\$4,000	\$5,100 (in- and out-of-network combined)	\$4,000	\$5,100 (in- and out-of-network combined)
Be Healthy Annual Physical and Preventive Services*	\$0 copayment	\$30 copayment	\$0 copayment	\$30 copayment	\$0 copayment	\$30 copayment
Primary Care Office Visit	\$20 copayment	\$40 copayment	\$20 copayment	\$40 copayment	\$20 copayment	\$40 copayment
Specialist Office Visit	\$30 copayment	\$40 copayment	\$30 copayment	\$40 copayment	\$30 copayment	\$40 copayment
Outpatient Diagnostic Procedures/Tests/Lab	\$0 copayment	\$30 copayment	\$0 copayment	\$30 copayment	\$0 copayment	\$30 copayment
Outpatient Radiological Services-Complex Diagnostic (e.g. MRI/CT Scans)	\$0 copayment	\$30 copayment	\$0 copayment	\$30 copayment	\$0 copayment	\$30 copayment
Outpatient Radiological Services- X-rays	\$0 copayment	\$30 copayment	\$0 copayment	\$30 copayment	\$0 copayment	\$30 copayment
Outpatient Hospital Services- Surgery	\$175 copayment	\$250 copayment	\$175 copayment	\$250 copayment	\$175 copayment	\$250 copayment
Inpatient Hospital Care <i>Unlimited days each benefit period</i>	\$195 each day for days 1–10, \$0 each day for days 11 and beyond	25% coinsurance	\$195 each day for days 1–10, \$0 each day for days 11 and beyond	25% coinsurance	\$195 each day for days 1–10, \$0 each day for days 11 and beyond	25% coinsurance
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	\$20 each day for days 1–20, \$75 each day for days 21–100	\$25 each day for days 1–20, \$125 each day for days 21–100	\$20 each day for days 1–20, \$75 each day for days 21–100	\$25 each day for days 1–20, \$125 each day for days 21–100	\$20 each day for days 1–20, \$75 each day for days 21–100	\$25 each day for days 1–20, \$125 each day for days 21–100
Emergency Care/Post Stabilization Care	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment
Urgently Needed Care	\$30 copayment	\$30 copayment	\$30 copayment	\$30 copayment	\$30 copayment	\$30 copayment
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Preferred-Brand (Abbott) Diabetic Test Strips and Blood Glucose Monitors	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance
Non-Preferred Diabetic Test Strips and Blood Glucose Monitors	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)**	\$0 deductible		\$0 deductible		\$0 deductible	
Tier 1 Preferred Generic at Walgreens	\$0 copayment		\$0 copayment		\$0 copayment	
Tier 1 Preferred Generic Elsewhere	\$20 copayment		\$15 copayment		\$10 copayment	
Tier 2 Generic	\$40 copayment		\$30 copayment		\$20 copayment	
Tier 3 Preferred Brand	\$40 copayment		\$30 copayment		\$20 copayment	
Tier 4 Non-Preferred Drug	\$100 copayment		\$100 copayment		\$100 copayment	
Tier 5 Specialty Tier	25% coinsurance		25% coinsurance		25% coinsurance	
Coverage Gap Stage One-month (30-day) supply	Prescription Drug Coverage continues through Medicare's Coverage Gap Stage.					
Catastrophic Coverage One-month (30-day) supply	After member's yearly out-of-pocket drug costs reach \$5,000, member pays the greater of: \$3.35 copay for generic drugs and \$8.35 copay for brand-name drugs, OR 5% coinsurance.					

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.

**All plans include 2 x 30-day copay for 90-day scripts filled at Walgreens & preferred pharmacies (2.5 x 30-day copays for 90-day scripts at all other contracted pharmacies).

Group Medicare–IL/IN	POS Basic Rx (available for groups and individuals)		POS 30 Rx (available for groups and individuals)		POS 10 Rx (available for groups and individuals)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Premium	\$52		\$96		\$156	
Member Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible	\$0		\$0		\$0	
Plan Year Out-of-Pocket Maximum	\$6,700	\$10,000 (in- and out-of-network combined)	\$5,500	\$10,000 (in- and out-of-network combined)	\$4,500	\$5,750 (in- and out-of-network combined)
Be Healthy Annual Physical and Preventive Services*	\$0 copayment	\$50 copayment	\$0 copayment	\$50 copayment	\$0 copayment	\$30 copayment
Primary Care Office Visit	\$35 copayment	\$50 copayment	\$15 copayment	\$50 copayment	\$20 copayment	\$40 copayment
Specialist Office Visit	\$50 copayment	\$50 copayment	\$45 copayment	\$50 copayment	\$30 copayment	\$40 copayment
Outpatient Diagnostic Procedures/Tests/Lab	\$40 copayment	\$50 copayment	\$40 copayment	\$50 copayment	\$0 copayment	\$30 copayment
Outpatient Radiological Services-Complex Diagnostic (e.g. MRI/CT Scans)	\$40 copayment	\$50 copayment	\$40 copayment	\$50 copayment	\$0 copayment	\$30 copayment
Outpatient Radiological Services- X-rays	\$40 copayment	\$50 copayment	\$40 copayment	\$50 copayment	\$0 copayment	\$30 copayment
Outpatient Hospital Services- Surgery	25% coinsurance	25% coinsurance	\$275 copayment	\$300 copayment	\$200 copayment	\$275 copayment
Inpatient Hospital Care <i>Unlimited days each benefit period</i>	\$450 each day for days 1–4, \$0 each day for days 5 and beyond	\$600 each day for days 1–4, \$0 each day for days 5–90	\$290 each day for days 1–6, \$0 each day for days 7 and beyond	\$320 each day for days 1–8, \$0 each day for days 9–60, \$200 each day for days 61–90	\$195 each day for days 1–10, \$0 each day for days 11 and beyond	25% coinsurance
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$100 each day for days 1–20, \$200 each day for days 21–100	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$200 each day for days 1–20, \$400 each day for days 21–100	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$85 each day for days 1–20, \$225 each day for days 21–100
Emergency Care/Post Stabilization Care	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment
Urgently Needed Care	\$65 copayment	\$65 copayment	\$40 copayment	\$40 copayment	\$30 copayment	\$30 copayment
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Preferred-Brand (Abbott) Diabetic Test Strips and Blood Glucose Monitors	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance
Non-Preferred Diabetic Test Strips and Blood Glucose Monitors	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)**	\$0 deductible	\$0 deductible	\$0 deductible	\$0 deductible	\$0 deductible	\$0 deductible
Tier 1 Preferred Generic at Walgreens	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Tier 1 Preferred Generic Elsewhere	\$9 copayment	\$9 copayment	\$9 copayment	\$9 copayment	\$9 copayment	\$9 copayment
Tier 2 Generic	\$20 copayment	\$20 copayment	\$20 copayment	\$20 copayment	\$20 copayment	\$20 copayment
Tier 3 Preferred Brand	\$47 copayment	\$47 copayment	\$47 copayment	\$47 copayment	\$47 copayment	\$47 copayment
Tier 4 Non-Preferred Drug	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 Specialty Tier	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Coverage Gap Stage One-month (30-day) supply	From \$3,750 until member's yearly out-of-pocket drug costs reach \$5,000, member pays 44% of generic drugs and 35% for brand-name drugs after the 50% manufacturer discount and 10% brand name coverage.					
Catastrophic Coverage One-month (30-day) supply	After member's yearly out-of-pocket drug costs reach \$5,000, member pays the greater of: \$3.35 copay for generic drugs and \$8.35 copay for brand-name drugs, OR 5% coinsurance.					

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.

**All plans include 2 x 30-day copay for 90-day scripts filled at Walgreens & preferred pharmacies (2.5 x 30-day copays for 90-day scripts at all other contracted pharmacies), and 44%/35% generic/brand coverage for non-low income members in the coverage gap.

Group Medicare–IL/IN	POS Basic (available for groups and individuals)		POS 30 (available for groups and individuals)		POS 10 (available for groups and individuals)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Premium	\$23		\$59		\$124	
Member Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible	\$0		\$0		\$0	
Plan Year Out-of-Pocket Maximum	\$6,700	\$10,000 (in- and out-of-network combined)	\$5,500	\$10,000 (in- and out-of-network combined)	\$4,500	\$5,750 (in- and out-of-network combined)
Be Healthy Annual Physical and Preventive Services*	\$0 copayment	\$50 copayment	\$0 copayment	\$50 copayment	\$0 copayment	\$30 copayment
Primary Care Office Visit	\$35 copayment	\$50 copayment	\$15 copayment	\$50 copayment	\$20 copayment	\$40 copayment
Specialist Office Visit	\$50 copayment	\$50 copayment	\$45 copayment	\$50 copayment	\$30 copayment	\$40 copayment
Outpatient Diagnostic Procedures/Tests/Lab	\$40 copayment	\$50 copayment	\$40 copayment	\$50 copayment	\$0 copayment	\$30 copayment
Outpatient Radiological Services-Complex Diagnostic (e.g. MRI/CT Scans)	\$40 copayment	\$50 copayment	\$40 copayment	\$50 copayment	\$0 copayment	\$30 copayment
Outpatient Radiological Services- X-rays	\$40 copayment	\$50 copayment	\$40 copayment	\$50 copayment	\$0 copayment	\$30 copayment
Outpatient Hospital Services- Surgery	25% coinsurance	25% coinsurance	\$275 copayment	\$300 copayment	\$200 copayment	\$275 copayment
Inpatient Hospital Care <i>Unlimited days each benefit period</i>	\$450 each day for days 1–4, \$0 each day for days 5 and beyond	\$600 each day for days 1–4, \$0 each day for days 5–90	\$290 each day for days 1–6, \$0 each day for days 7 and beyond	\$320 each day for days 1–8, \$0 each day for days 9–60, \$200 each day for days 61–90	\$195 each day for days 1–10, \$0 each day for days 11 and beyond	25% coinsurance
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$100 each day for days 1–20, \$200 each day for days 21–100	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$200 each day for days 1–20, \$400 each day for days 21–100	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$85 each day for days 1–20, \$225 each day for days 21–100
Emergency Care/Post Stabilization Care	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment
Urgently Needed Care	\$65 copayment	\$65 copayment	\$40 copayment	\$40 copayment	\$30 copayment	\$30 copayment
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Preferred-Brand (Abbott) Diabetic Test Strips and Blood Glucose Monitors	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance
Non-Preferred Diabetic Test Strips and Blood Glucose Monitors	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)	N/A	N/A	N/A	N/A	N/A	N/A
Tier 1 Preferred Generic at Walgreens	N/A	N/A	N/A	N/A	N/A	N/A
Tier 1 Preferred Generic Elsewhere	N/A	N/A	N/A	N/A	N/A	N/A
Tier 2 Generic	N/A	N/A	N/A	N/A	N/A	N/A
Tier 3 Preferred Brand	N/A	N/A	N/A	N/A	N/A	N/A
Tier 4 Non-Preferred Drug	N/A	N/A	N/A	N/A	N/A	N/A
Tier 5 Specialty Tier	N/A	N/A	N/A	N/A	N/A	N/A
Coverage Gap Stage One-month (30-day) supply	N/A	N/A	N/A	N/A	N/A	N/A
Catastrophic Coverage One-month (30-day) supply	N/A	N/A	N/A	N/A	N/A	N/A

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.

Group Medicare – PDP	PDP Option 1 (available for groups only)	PDP Option 2 (available for groups only)
Monthly Premium	\$65	\$156
Member Benefits		
Plan Year Deductible	N/A	N/A
Plan Year Out-of-Pocket Maximum	N/A	N/A
Be Healthy Annual Physical and Preventive Services	N/A	N/A
Primary Care Office Visit	N/A	N/A
Specialist Office Visit	N/A	N/A
Outpatient Diagnostic Procedures/Tests/ Lab	N/A	N/A
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	N/A	N/A
Outpatient Radiological Services- X-rays	N/A	N/A
Outpatient Hospital Services- Surgery	N/A	N/A
Inpatient Hospital Care <i>Unlimited days each benefit period</i>	N/A	N/A
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	N/A	N/A
Emergency Care/Post Stabilization Care	N/A	N/A
Urgently Needed Care	N/A	N/A
Durable Medical Equipment and Prosthetic Devices	N/A	N/A
Preferred-Brand (Abbott) Diabetic Test Strips and Blood Glucose Monitors	N/A	N/A
Non-Preferred Diabetic Test Strips and Blood Glucose Monitors	N/A	N/A
Prescription Drugs (30-day supply)* (deductibles exclude Tiers 1 and 2)	\$0 deductible	\$150 deductible
Tier 1 Preferred Generic at Walgreens	\$0 copayment	\$0 copayment
Tier 1 Preferred Generic Elsewhere	\$20 copayment	\$20 copayment
Tier 2 Generic	\$47 copayment	\$47 copayment
Tier 3 Preferred Brand	\$47 copayment	\$47 copayment
Tier 4 Non-Preferred Drug	\$100 copayment	\$100 copayment
Tier 5 Specialty Tier	25% coinsurance	25% coinsurance
Coverage Gap Stage One-month (30-day) supply	From \$3,750 until member's yearly out-of-pocket drug costs reach \$5,000, member pays 44% of generic drugs and 35% for brand-name drugs after the 50% manufacturer discount and 10% brand name coverage.	Prescription Drug Coverage continues through Medicare's Coverage Gap Stage.
Catastrophic Coverage One-month (30-day) supply	After member's yearly out-of-pocket drug costs reach \$5,000, member pays the greater of: \$3.35 copay for generic drugs and \$8.35 copay for brand-name drugs, OR 5% coinsurance.	

* All plans include 2 x 30-day copay for 90-day scripts filled at Walgreens & preferred pharmacies (2.5 x 30-day copays for 90-day scripts at all other contracted pharmacies). PDP Option 1 only: 44%/35% generic/brand coverage for non-low income members in the coverage gap.