

2024 Benefit Highlights for University of Iowa PPO Rx

Please use this Benefit Highlight in conjunction with your Evidence of Coverage (EOC) to understand all of your benefits.

2024 premium.	In-Network	Out-of-Network
Yearly Deductible	\$0	\$0
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Yearly Out-of-Pocket	\$1,700	\$2,000 Total IN and OON
Maximum (Danasita	Marshan Davis In Nativents	Combined
Services/Benefits	Member Pays In-Network	Member Pays Out-of- Network
Inpatient Hospital Care	10% coinsurance	40% coinsurance
Inpatient Services (in a Psychiatric Hospital)	10% coinsurance	40% coinsurance
Skilled Nursing Facility (SNF) Care (in a Medicare-certified skilled nursing facility)	10% coinsurance	40% coinsurance
Cardiac	Cardiac: \$0 copayment per visit	Cardiac: 40% coinsurance per
Rehabilitation	Intensive Cardiac: \$0 copayment per visit	visit
Services and	Pulmonary: \$0 copayment per visit	Intensive Cardiac: 40%
Pulmonary	Supervised Exercise Therapy: \$0 copayment per visit	coinsurance per visit
Rehabilitation		Pulmonary: 40% coinsurance
Services		per visit
		Supervised Exercise Therapy
F 0 1	F 0 0100	40% coinsurance per visit
Emergency Care and	Emergency Care: \$100 copayment per visit	Emergency Care: \$100
World Wide	World Wide Emergency Care: \$100 copayment per visit	copayment per visit
Emergency Care		World Wide Emergency Care
(You may go to any		\$100 copayment per visit
emergency room if you reasonably believe you		
need emergency care.)		
Urgently Needed	Urgent Care: \$65 copayment per visit	Urgent Care: \$65 copayment
Services	World Wide Urgent Care: \$65 copayment per visit	per visit
(This is NOT	world wide orgent care, 403 copayment per visit	World Wide Urgent Care: \$6
emergency care, and in		copayment per visit
most cases, is out of the		copayment per visit
service area.)		
Partial	10% coinsurance	40% coinsurance
Hospitalization		

1 32,377

Home Health Agency	10% coinsurance	40% coinsurance
Care		
Hospice Care	\$0 copayment per visit. You must get care from a Medicar	
Physician/Practitioner	\$5 copayment per visit	40% coinsurance
Services, including	Telehealth: \$5 copayment per visit	Telehealth: 40% coinsurance
doctor's visits		
(Primary Care		
Provider)		
Chiropractic Services	Medicare Covered: \$5 copayment per visit	Medicare Covered: 40%
	Non-Medicare Covered: Not Covered	coinsurance
		Non-Medicare Covered: Not
		Covered
Physician/Practitioner	\$5 copayment per visit	40% coinsurance per visit
Services, including	Telehealth: \$5 copayment per visit	Telehealth: 40% coinsurance
doctor's office visits		
(Specialist Office		
Visits)		
Outpatient Mental	0% coinsurance per visit; 10% coinsurance facility	40% coinsurance
Health Care		
Acupuncture	Medicare Covered: \$5 copayment per visit	Medicare Covered: \$5
	Non-Medicare Covered: \$5 copayment per visit, 15 visit	copayment per visit
	max.	Non-Medicare Covered: \$5
		copayment per visit, 15 visit
		max.
Podiatry Services	Diabetic Foot care: \$5 copayment per visit	Diabetic Foot care: 40%
	Podiatry Services: \$5 copayment per visit	coinsurance per visit
		Podiatry Services: 40%
		coinsurance per visit
Outpatient	Physical Therapy: 10% coinsurance	Physical Therapy: 40%
Rehabilitation	Speech Therapy: 10% coinsurance	coinsurance
Services	Occupational Therapy: 10% coinsurance	Speech Therapy: 40%
		coinsurance
		Occupational Therapy: 40%
		coinsurance
Virtual Primary Care	\$0 copayment per visit	Not Covered
(Virtual Only)	See EOC for complete details	
Opioid Treatment	\$5 copayment per visit	40% coinsurance
Services		
Outpatient Diagnostic	Labs: 10% coinsurance	Labs: 40% coinsurance
Test and Therapeutic	A1c: \$0 copayment per test	A1c: 40% coinsurance
Services and Supplies	Complex Diagnostic: 10% coinsurance	Complex Diagnostic: 40%
(Labs & Radiological	General Diagnostic: 10% coinsurance	coinsurance
Services)	Therapeutic: 10% coinsurance	General Diagnostic: 40%
	X Rays: 10% coinsurance	coinsurance
		Therapeutic: 40% coinsurance
		X Rays: 40% coinsurance
Outpatient Hospital	Surgery: 10% coinsurance	Surgery: 40% coinsurance
Services	Observation Services: 10% coinsurance	Observation Services: 40%
		coinsurance

Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	10% coinsurance	40% coinsurance
Outpatient Substance Abuse Services	0% coinsurance per visit; 10% coinsurance facility	40% coinsurance
Ambulance Services	Ground Ambulance: 10% coinsurance Air Ambulance: 10% coinsurance World Wide Ground Ambulance: 10% coinsurance World Wide Air Ambulance: 10% coinsurance	Ground Ambulance: 40% coinsurance Air Ambulance: 40% coinsurance World Wide Ground Ambulance: 40% coinsurance World Wide Air Ambulance: 40% coinsurance
Transportation (Non-medically necessary)	Not Covered	Not Covered
Durable Medical Equipment and Related Supplies (wheelchairs, oxygen, etc.)	Bed Rails: 0% coinsurance Other: 20% coinsurance	Bed Rails: 20% coinsurance Other: 20% coinsurance
Durable Medical Equipment - Prosthetics and Related Supplies	Prosthetic Devices (braces, artificial limbs and eyes, etc.) 20% coinsurance Other: 20% coinsurance	Prosthetic Devices (braces, artificial limbs and eyes, etc.) 20% coinsurance Other: 20% coinsurance
Durable Medical Equipment – Diabetic Supplies	Preferred Test Strips covered at 0% coinsurance Non-Preferred Test Strips covered with approval at 0% All other diabetic supplies have a member coinsurance of 10% Diabetic Shoes or Inserts 10% coinsurance	Preferred Test Strips covered at 20% Non-Preferred Test Strips covered with approval at 20% All other diabetic supplies have a member coinsurance of 20% Diabetic Shoes or Inserts 20% coinsurance
Services to Treat Kidney Disease	Dialysis Services: \$0 copayment per service Kidney Disease Education Services: \$0 copayment per service	Dialysis Services: 40% coinsurance Kidney Disease Education Services: 40% coinsurance
Meals for Chronic Conditions	Plan provides the meal benefit post discharge to any CHF, Diabetes member, any member with 2 or more of the top 5 chronic conditions (Asthma, CHF, COPD, Diabetes, Vascular) who has an inpatient stay for any reason or is discharged from SNF. Additionally, members discharged from Inpatient Hospital with home care. Plan provides up to 2 home delivered meals per day. Plan provides meals for up to 14 days. Up to 3 instances.	
Over-the-Counter (OTC) products	Not Covered	Not Covered
Immunizations	\$0 copayment per service	40% coinsurance

pneumonia vaccine— for people with Medicare who are at risk, hepatitis B vaccine)  Annual Wellness Visit, Physical Exam: Not Covered  Annual Wellness: 40%  coinsurance  Physical Exam: Not Covered  A0% coinsurance  Cordiovascular, abdominal aortic ancurysm, colorectal, paps macry-pelvic exams, prostate cancer, annual breast cancer: 40% coinsurance  following Welcome Visit: 50 copayment  For 30 copayment  So for 30 annual hours of in home support through  PAPA  Nursing Advice Line  (Non-Medicare  PAPA  Be Fit: Members will access up to \$360 per year towards fitness activities through the Medicare Flex Card.  (Excluded: Fitness equipment)  Welcome Visit: 50 copayment per visit  Cardiovascular, abdominal aortic ancurysm, colorectal, paps	(Flu vaccine,		
Annual Wellness   Annual Wellness: \$0 copayment per service   Annual Wellness: 40%   Coinsurance   Physical Exam: Not Covered   Physical Exam: Not Covered   Physical Exam: Not Covered   Annual Wellness: 40%   Coinsurance   Physical Exam: Not Covered   Annual Wellness: 40%   Coinsurance   Physical Exam: Not Covered   Annual Wellness: 40%   Coinsurance   Annual Wellness: 40%   Coinsurance   Physical Exam: Not Covered   A0% coinsurance   A0%			
Medicare who are at risk, hepatitis B vaccine)  Annual Wellness: \$0 copayment per service  Physical Exam: Not Covered  Exam/Visit  Bone Mass Measurement (for at-risk people with Medicare) Welcome to Medicare Preventative Visit (Preventive and Screening Services) Please see Nor For John Drugs  So opayment per service  So opayment Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: \$0 copayment  So for 30 annual hours of in home support through PAPA  So opayment per service  So opayment per service  So opayment  So for 30 annual hours of in home support through PAPA  Nursing Advice Line (Non-Medicare Covered)  Fitness Benefit  Wirtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Medicare Part B Prescription Drugs  Pan Maximum Advice and Chemotherapy Chemotherapy  Your plan will pay a maximum of \$200 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the \$200 maximum.			
risk, hepatitis B vaccine)  Annual Wellness: \$0 copayment per service			
Annual Wellness Visit, Physical Exam/Visit Bone Mass Measurement (for at-risk people with Medicare) Welcome to Medicare Preventative Visit (Preventive and Screening Services Please see Plysical Exam: Not Covered Cardiovascular, abdominal aortic aneurysm, colorectal, pap smears/pelvic exams, prostate cancer, annual breast cancer: 30 copayment eraser App smears/pelvic exams, prostate cancer, annual breast cancer: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, etc. Glaucoma, barium enemas			
Annual Wellness Visit, Physical Exam: Not Covered Physical Exam: Not Covered Coinsurance Physical Exam: Not Covered Physical Exam: Not Covered Physical Exam: Not Covered Coinsurance Physical Exam: Not Covered Physical Exam: Not Covered Coinsurance Physical Exam: Not Covered 40% coinsurance Covered Physical Exam: Not Covered 40% coinsurance Gilaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: \$0 copayment Perstrict A0% coinsurance Physic exams, prostate cancer, annual breast cancer: 40% coinsurance Physical Exam: Not Covered A0% coinsurance Physical Exam: Not Covered Physical Exam: Not Covered A0% coinsurance Physical Exam: Not Covered Physical Exam: Not Covered Physical Exam: Not Covered Physical Exam: Not			
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Exam/Visit   So copayment per service   So copayment per service   40% coinsurance			
Bone Mass   Measurement (for at-risk people with Medicare)   Welcome to Medicare   Preventative Visit (Preventive and Services Please see preventative Flier for list of services.)   So for 30 annual hours of in home support through PAPA   So for 30 annual hours of in home supp		Physical Exam: Not Covered	
Measurement (for at-risk people with Medicare)  Welcome to Medicare Preventative Visit (Preventive and Screening Services Please see preventative Flier for list of services.)  In-Home Support Companion Benefit  Nursing Advice Line (Non-Medicare Covered)  Fitness Benefit  Be Fit: Members will access up to \$360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)  Virtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Dental Services  Your plan will pay a maximum of \$200 per plan year for non-Medicare-covered dental Services. You will be responsible for any cost above the \$200 maximum.  Cardiovascular, abdominal aortic aneurysm, colorectal, pap smears/pelvic exams, prostate cancer, annual breast cancer; 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance aneur: 40% coinsurance for Bar b			
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Medicare)         Cardiovascular, abdominal aortic aneurysm, colorectal, pap smears/pelvic exams, prostate cancer, annual breast cancer: \$0 copayment         Cardiovascular, abdominal aortic aneurysm, colorectal, pap smears/pelvic exams, prostate cancer, annual breast cancer: \$0 copayment         Cardiovascular, abdominal aortic aneurysm, colorectal, pap smears/pelvic exams, prostate cancer: \$0 copayment           Please see preventative Flier for list of services.)         Following Welcome Visit: \$0 copayment         S0 copayment         prostate cancer, annual breast cancer: \$0 coinsurance         cancer: \$0% coinsurance         Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: \$0 copayment           In-Home Support Companion Benefit         \$0 for 30 annual hours of in home support through PAPA         \$0 for 30 annual hours of in home support through PAPA           Nursing Advice Line (Non-Medicare Covered)         \$0 copayment per service         \$0 copayment per service           Fitness Benefit         Be Fit: Members will access up to \$360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)         Be Fit: Members will access up to \$360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)           Virtual Visits (Acute Care Services)         \$0 copayment per visit         \$0 copayment per visit           Wedicare Part B Prescription Drugs         Insulin: 10% coinsurance, no more than \$35 per month 10% coinsurance for Part B Drugs-Chemotherapy 10% coinsurance for Part B Drugs-Other (non-Chemotherapy)         Insulin: 20% coinsurance for Part B Drugs-Oth			
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Preventative Visit (Preventive and Screening Services Please see preventative Flier for list of services.)  In-Home Support Companion Benefit  Nursing Advice Line (Non-Medicare Covered)  Fitness Benefit  Fitness Benefit  Virtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Dental Services  Your plan will pay a maximum of \$200 per plan year for non-Medicare-covered dental Screening Services, annual breast cancer; 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance So for 30 annual hours of in home support through PAPA  So copayment per service  \$0 copayment per visit  Be Fit: Members will access up to \$360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)  Virtual Visits (Acute Care Services)  Insulin: 10% coinsurance, no more than \$35 per month 10% coinsurance for Part B Drugs-Other (non- Chemotherapy)  Dental Services  Your plan will pay a maximum of \$200 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the \$200 maximum.			
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Screening Services Please see preventative Flier for list of services.)  In-Home Support Companion Benefit  Nursing Advice Line (Non-Medicare Covered)  Fitness Benefit  Be Fit: Members will access up to \$360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)  Virtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Be Insulin: 10% coinsurance, no more than \$35 per month 10% coinsurance for Part B Drugs-Chemotherapy 10% coinsurance for Part B Drugs-Chemotherapy 10% coinsurance for Part B Drugs-Other (non-Chemotherapy)  Dental Services (Non-Medicare-covered dental services. You will be responsible for any cost above the \$200 maximum.	Preventative Visit	pap smears/pelvic exams, prostate cancer, annual breast	aortic aneurysm, colorectal,
Please see preventative Flier for list of services.)  In-Home Support Companion Benefit  Nursing Advice Line (Non-Medicare Covered)  Fitness Benefit  Be Fit: Members will access up to \$360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)  Virtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Medicare Part B Prescription Drugs  Dental Services  (Non-Medicare  Your plan will pay a maximum of \$200 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the \$200 maximum.	(Preventive and	cancer: \$0 copayment	pap smears/pelvic exams,
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preventative Flier for list of services.)    So for 30 annual hours of in home support through Companion Benefit   So for 30 annual hours of in home support through PAPA   So for 30 annual hours of in home support through PAPA	Please see		
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In-Home Support Companion Benefit  Nursing Advice Line (Non-Medicare Covered)  Fitness Benefit  Be Fit: Members will access up to \$360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)  Virtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Medicare Part B Chemotherapy)  Dental Services  (Non-Medicare  \$0 copayment per service  \$0 copayment per visit access up to \$360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)  \$0 copayment per visit	inst of services.)		
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Nursing Advice Line (Non-Medicare Covered)   S0 copayment per service   \$0 copayment per service   \$0 copayment per service	In Home Cyanasat	\$0 for 20 appeal house of in home gument through	
Nursing Advice Line (Non-Medicare Covered)  Be Fit: Members will access up to \$360 per year towards fitness Benefit  Be Fit: Members will access up to \$360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)  Virtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Insulin: 10% coinsurance, no more than \$35 per month 10% coinsurance for Part B Drugs-Chemotherapy 10% coinsurance for Part B Drugs-Other (non- Chemotherapy)  Dental Services (Non-Medicare  Your plan will pay a maximum of \$200 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the \$200 maximum.	1		· ·
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Medicare Flex Card. (Excluded: Fitness equipment)  Virtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Insulin: 10% coinsurance, no more than \$35 per month 10% coinsurance for Part B Drugs-Chemotherapy 10% coinsurance for Part B Drugs-Other (non-Chemotherapy)  Chemotherapy)  Dental Services (Non-Medicare  Medicare Flex Card. (Excluded: Fitness equipment)  \$0 copayment per visit  Insulin: 20% coinsurance, no more than \$35 per month 20% coinsurance for Part B Drugs-Chemotherapy 20% coinsurance for Part B Drugs-Other (non-Chemotherapy)  Your plan will pay a maximum of \$200 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the \$200 maximum.		<u> </u>	
Virtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Insulin: 10% coinsurance, no more than \$35 per month 10% coinsurance for Part B Drugs-Chemotherapy 10% coinsurance for Part B Drugs-Other (non-Chemotherapy)  Chemotherapy)  Dental Services (Non-Medicare  (Non-Medicare  (Non-Medicare)  So copayment per visit  \$0 copayment per visit  \$1 Insulin: 20% coinsurance, no more than \$35 per month 20% coinsurance for Part B Drugs-Chemotherapy 20% coinsurance for Part B Drugs-Other (non-Chemotherapy)  Your plan will pay a maximum of \$200 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the \$200 maximum.		(Excluded: Fitness equipment)	fitness activities through the
Virtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Insulin: 10% coinsurance, no more than \$35 per month 10% coinsurance for Part B Drugs-Chemotherapy 10% coinsurance for Part B Drugs-Other (non-Chemotherapy)  Chemotherapy)  Dental Services (Non-Medicare  Your plan will pay a maximum of \$200 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the \$200 maximum.			Medicare Flex Card.
Virtual Visits (Acute Care Services)  Medicare Part B Prescription Drugs  Insulin: 10% coinsurance, no more than \$35 per month 10% coinsurance for Part B Drugs-Chemotherapy 10% coinsurance for Part B Drugs-Other (non-Chemotherapy)  Chemotherapy)  Dental Services (Non-Medicare  Your plan will pay a maximum of \$200 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the \$200 maximum.			(Excluded: Fitness equipment)
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(Non-Medicare services. You will be responsible for any cost above the \$200 maximum.	Dantal Carata	Vana alaa will aasaa aasai aasaa fidaaa 1	10/
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	`	•	200 maximum.
Covered): Preventive – Annual Cleaning: \$0 copayment	,		
Including but not Preventive – Supplemental Oral Exam: \$0 copayment	_	Preventive – Supplemental Oral Exam: \$0 copayment	
limited to oral exam,	· ·		
cleaning, x-rays,			
fluoride treatment, See EOC for Complete Details		See EOC for Complete Details	
	fillings, dentures,		
	denture adjustments		

and repairs, crowns, bridge work, root canals and extractions.		
Dental Service (Medicare Covered)	Comprehensive Dental: \$35 copayment	
Vision Exams	Medicare Covered: \$0 Copayment Non-Medicare Covered: \$5 Copayment, 1 exam per year	Medicare Covered: 40% coinsurance Non-Medicare Covered: 40% coinsurance
Eyewear: Glasses/Contacts	Medicare Covered: \$0 copayment Non-Medicare Covered: Not Covered	Medicare Covered: \$0 copayment Non-Medicare Covered: Not Covered
Routine Hearing	Medicare Covered: 20% coinsurance Non-Medicare Covered: \$45 copayment	Medicare Covered: 20% coinsurance Non-Medicare Covered: Not Covered
Hearing Aids	Plan covers up to two TruHearing-branded hearing aids every year (one per ear). TruHearing Advanced digital hearing aid is \$699 and TruHearing Premium digital hearing aid is \$999. Must use a TruHearing network provider. See EOC for complete details.	Not Covered

**Pharmacy Highlights** 

Pharmacy Benefits	Member Pays In-Network
Deductible	\$0 (Out-of-Pocket Limit \$1,100)
Does coverage continue through the Gap?	Yes
Initial Coverage	
Tier 1: Preferred Generic, 30-day supply	\$0 copayment per prescription
Tier 2: Generic, 30-day supply	20% coinsurance per prescription
Tier 3: Preferred Brand, 30-day supply	50% coinsurance per prescription
Tier 4: Non-Preferred Drug,	50% coinsurance per prescription
30-day supply	
Tier 5: Specialty Tier, 30-day supply	50% coinsurance per prescription
Mail-Order	30-day supply same as 30-day copayment at Retail
	Pharmacies
	90-day supply is 2 x 30-day copayment at Retail Pharmacies
Retail (90-day)	3 x 30-day copayment
Coverage Gap	
The Coverage Gap Phase begins when your	Same copayments as Initial Coverage
total drug costs (your payments plus any Part	
D plan's payments) total \$5,030 until your	
year-to-date out-of-pocket drug costs reach	
\$8,000	± 1
Catastrophic Coverage (when out-of-pocke	
Generics & all other drugs	\$0 copayment
Out-of-Network Coverage	Coverage for medications out-of-network may be
× 11	available in special circumstances
Insulin	You won't pay more than \$35 for a one-month supply of each
	insulin product covered by our plan, no matter what cost-
	sharing tier it's on, even if you haven't paid your deductible.

This is a summary of benefits. Please refer to your Evidence of Coverage for additional information. Health Alliance Medicare is a PPO with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal.

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