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 (330) 363-7407 or 1-800-577-5084. TTY users should call 711. A Customer Service Representative is available to assist you at the above phone numbers, Monday through Friday from 8:00 a.m. to 8:00 p.m. (October 1st – March 31st, we are available 7 days a week, 8:00 a.m. to 8:00 p.m.)

Understanding 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 www.pthp.com or call Customer Service at (330) 363-7407 or 1-800-577-5084 (TTY users should call 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.

☐ 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.

Understanding 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.

☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

2023 PrimeTime Health Plan
Summary of Benefits
Aultimate (HMO-POS) E00060 (includes drug coverage)
Classic (HMO-POS) E00055 (includes drug coverage)
Plus (HMO-POS) E00045 (includes drug coverage)
Basic MA – Only (HMO-POS) E00035 (no drug coverage)

This is a summary of drug and health services covered by plans offered by PrimeTime Health Plan January 1, 2023 – December 31, 2023. This Summary of Benefits doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call Customer Service and request the "Evidence of Coverage" or view it online at www.pthp.com. You can reach Customer Service at 330-363-7407 or 1-800-577-5084 (TTY users call 711). Our Call Center is open Monday through Friday, from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, the Call Center is open seven days a week, from 8:00 a.m. to 8:00 p.m. Or visit our website at www.pthp.com.

You are eligible for membership in our plan as long as you have both Medicare Part A and Part B, you are a United States citizen or are lawfully present in the United States, and you live in our service area. Our service area includes the following counties in Ohio: Carroll, Columbiana, Harrison, Holmes, Medina, Mahoning, Portage, Summit, Stark, Trumbull, Tuscarawas, & Wayne.

PrimeTime Health Plan has a network of doctors, hospitals, pharmacies, and other providers. You must receive your care from a network provider. In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Exceptions are noted in italics in the chart.* To find participating providers and pharmacies, please call us or visit our website at www.pthp.com.

Out-of-network/non-contracted providers are under no obligation to treat PrimeTime Health Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online www.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.

PrimeTime Health Plan is an HMO-POS plan with a Medicare contract. Enrollment in PrimeTime Health Plan depends on contract renewal. This information is available in alternative formats such as large print, audio CD, or other alternate formats. Please call Customer Service if you need plan information in another format or language.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Monthly plan premium You must continue to pay your Medicare Part B premium.	You pay $0	You pay $0	You pay $39	You pay $89
Part B Premium Reduction	$25 a month	Not Available	Not Available	Not Available
Medical deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out-of-Pocket responsibility (does not include prescription drugs) The maximum you will pay in copays and coinsurance for the year**.**	In-network: $3,400 annually	In-network: $4,300 annually	In-network: $4,100 annually	In-network: $3,900 annually
Inpatient hospital coverage Prior authorization may be required for these services. Please contact the plan for more information. Our plan covers an unlimited number of days for an inpatient hospital stay.	In-network: Days 1-6: You pay $275 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $310 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $295 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $285 per day Days 7 and beyond: You pay a $0 copay
Outpatient hospital coverage Prior authorization may be required for these services. Please contact the plan for more information.				

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Outpatient hospital coverage (continued) • **Ambulatory Surgical Center**	In-network: You pay 25% of the cost. Annual maximum out-of-pocket of $1,200.	In-network: You pay a $350 copay for outpatient surgery.	In-network: You pay a $300 copay for outpatient surgery.	In-network: You pay a $200 copay for outpatient surgery.
• **Outpatient Observation**	You pay 25% of the cost for observation services.	You pay 25% of the cost for observation services.	You pay 25% of the cost for observation services.	You pay 25% of the cost for observation services.
Doctor visits • **Primary Care Physician**	In-network: You pay a $0 copay per visit	In-network: You pay a $5 copay per visit	In-network: You pay a $0 copay per visit	In-network: You pay a $0 copay per visit
• **Specialist**	You pay a $40 copay per visit	You pay a $40 copay per visit	You pay a $35 copay per visit	You pay a $30 copay per visit
Preventive care	All plans In-network: You pay a $0 copay Any additional preventive services approved by Medicare during the contract year will be covered.			
Emergency care If you are admitted to the hospital within 23 hours, you do not have to pay your share of the cost for emergency care. World-wide coverage. *The plan covers emergency care that you get from an out-of-network provider.*	You pay an $110 copay per visit	You pay a $110 copay per visit	You pay an $110 copay per visit	You pay a $110 copay per visit
Urgently needed services If you are admitted to the hospital within 23 hours, you do not have to pay a copay for urgent care. World-wide coverage. *The plan covers urgent care that you get from an out-of-network provider.*	Inside the United States: You pay a $60 copay per visit Outside the United States: You pay an $110 copay per visit	Inside the United States: You pay a $60 copay per visit Outside the United States: You pay a $110 copay per visit	Inside the United States: You pay a $60 copay per visit Outside the United States: You pay an $110 copay per visit	Inside the United States: You pay a $60 copay per visit Outside the United States: You pay a $110 copay per visit

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Diagnostic services/labs/ imaging Prior authorization may be required for these services. Please contact the plan for more information.				
• **Diagnostic radiology services** (such as MRIs, CT scans)	In-network: You pay a $250 copay	In-network: You pay a $190 copay	In-network: You pay a $190 copay	In-network: You pay a $175 copay
• **Diagnostic tests and procedures**	You pay a $100 copay	You pay a $100 copay	You pay a $80 copay	You pay a $60 copay
• **Lab services** *For lab services, you may use any in-network or out-of-network qualified provider.*	You pay a $0 - $35 copay	You pay a $0 - $35 copay	You pay a $0 - $30 copay	You pay a $0 - $25 copay
• **Outpatient x-rays**	You pay a $100 copay	You pay a $100 copay	You pay a $80 copay	You pay a $60 copay
• **Therapeutic radiology services** (such as radiation treatment for cancer)	All plans: You pay 20% of the cost			
Hearing services • **Medical exam** Exam to diagnose and treat hearing and balance issues	In-network: You pay a $0 copay	In-network: You pay a $25 copay	In-network: You pay a $5 copay	In-network: You pay a $0 copay
• **Routine exam**	You pay a $0 copay (one routine hearing exam every three years)	You pay a $25 copay (one routine hearing exam every three years)	You pay a $5 copay (one routine hearing exam every three years)	You pay a $0 copay (one routine hearing exam every three years)
• **Hearing aids** We will allow two hearing aid devices every three years.	All plans: You pay a copayment of $595, $695, or $895 per hearing aid depending on the brand and model selected. Call Amplifon at 1-866-921-2299 to access these copayment rates. Hearing aids purchased from a non-Amplifon provider are eligible for reimbursement of $100 per hearing aid. Hearing aid copays do not count towards your out-of-pocket limit.			

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Dental services • **Medical exam** Prior authorization may be required for these services. Please contact the plan for more information.	In-network: You pay a $40 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	In-network: You pay a $40 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	In-network: You pay a $35 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	In-network: You pay a $30 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).
• **Supplemental dental coverage** These services do not count towards your out-of-pocket limit. *You may use any qualified dental provider.*	Reimbursement for non-Medicare covered dental services up to a maximum of $200 annually. For example: reimbursement for routine exams, x-rays, cleanings, fluoride, diagnostic services, restorative, endodontics, periodontics, extractions, orthodontia and prosthodontics.	Reimbursement for non-Medicare covered dental services up to a maximum of $550 annually. For example: reimbursement for routine exams, x-rays, cleanings, fluoride, diagnostic services, restorative, endodontics, periodontics, extractions, orthodontia and prosthodontics.	Reimbursement for non-Medicare covered dental services up to a maximum of $800 annually. For example: reimbursement for routine exams, x-rays, cleanings, fluoride, diagnostic services, restorative, endodontics, periodontics, extractions, orthodontia and prosthodontics.	Reimbursement for non-Medicare covered dental services up to a maximum of $1,100 annually. For example: reimbursement for routine exams, x-rays, cleanings, fluoride, diagnostic services, restorative, endodontics, periodontics, extractions, orthodontia and prosthodontics.
Vision services • **Medical exam** Exam to diagnose and treat diseases and conditions of the eye (including annual diabetic retinopathy exam).	In-network: You pay a $40 copay	In-network: You pay a $40 copay	In-network: You pay a $35 copay	In-network: You pay a $30 copay
• **Eyeglasses or contact lenses after cataract surgery**	All plans: You pay 20% of the cost			

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Vision services (continued) • **Annual routine eye exam** These services do not count towards your out-of- pocket limit. *You may use any qualified vision provider.*	You pay a $0 copay	You pay a $0 copay	You pay a $0 copay	You pay a $0 copay
• **Glasses/Contact Lenses** These services do not count towards your out-of- pocket limit. *You may use any qualified vision provider.*	Reimbursement up to a maximum of $200 annually.	Reimbursement up to a maximum of $300 annually.	Reimbursement up to a maximum of $300 annually.	Reimbursement up to a maximum of $300 annually.
Mental health services • **Inpatient visit** Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required for these services. Please contact the plan for more information.	In-network: Days 1-6: You pay $275 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $310 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $295 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $285 per day Days 7 and beyond: You pay a $0 copay
• **Outpatient group or individual therapy visit**	You pay a $35 copay per visit	You pay a $40 copay per visit	You pay a $35 copay per visit	You pay a $30 copay per visit

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Skilled nursing facility (SNF) Our plan covers up to 100 days in a SNF. Prior authorization may be required for services. Please contact the plan for more information.	In-network: Days 1-20: You pay $20 per day Days 21-39: You pay $150 per day Days 40-100: You pay a $0 copay	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $150 per day Days 46-100: You pay a $0 copay	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $135 per day Days 46-100: You pay a $0 copay	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $120 per day Days 46-100: You pay a $0 copay
Rehabilitation Services Annual maximum out-of-pocket cost applies to Medicare-covered acupuncture, physical, occupational, speech and language therapies combined. • **Cardiac Rehab** Prior authorization required after 36 visits	In-network: You pay a $0 copay per visit	In-network: You pay a $0 copay per visit	In-network: You pay a $0 copay per visit	In-network: You pay a $0 copay per visit
• **Pulmonary Rehab** Prior authorization required after 36 visits	You pay a $0 copay per visit	You pay a $0 copay per visit	You pay a $0 copay per visit	You pay a $0 copay per visit
• **Occupational Therapy**	You pay a $35 copay per visit $1,050 combined annual out-of-pocket max	You pay a $30 copay per visit $900 combined annual out-of-pocket max	You pay a $30 copay per visit $900 combined annual out-of-pocket max	You pay a $20 copay per visit $600 combined annual out-of-pocket max
• **Physical/Speech & Language Therapy**	You pay a $35 copay per visit $1,050 combined annual out-of-pocket max	You pay a $30 copay per visit $900 combined annual out-of-pocket max	You pay a $30 copay per visit $900 combined annual out-of-pocket max	You pay a $20 copay per visit $600 combined annual out-of-pocket max
• **Acupuncture**	You pay a $35 copay per visit $1,050 combined annual out-of-pocket max	You pay a $30 copay per visit $900 combined annual out-of-pocket max	You pay a $30 copay per visit $900 combined annual out-of-pocket max	You pay a $20 copay per visit $600 combined annual out-of-pocket max

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Ambulance Prior authorization may be required for non-emergency services. Please contact the plan for more information. World-wide emergency coverage.	In-network: You pay a $200 copay per trip	In-network: You pay a $230 copay per trip	In-network: You pay a $210 copay per trip	In-network: You pay a $200 copay per trip
Transportation	All plans: Not covered			
Medicare Part B drugs Prior authorization may be required for services. Please contact the plan for more information. • **Chemotherapy drugs**	All plans In-Network: You pay 20% of the cost			
• **Other Part B drugs**	All plans: You pay 20% of the cost			
Foot Care (Podiatry Services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	All plans In-network: You pay a $35 copay			
Medical equipment/ supplies Prior authorization may be required for services. Please contact the plan for more information. • **Durable medical equipment** (wheel-chairs, oxygen, etc)	All plans In-network: You pay 20% of the cost			
• **Prosthetics/Medical supplies** (braces, artificial limbs, etc)	All plans: You pay 20% of the cost			

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Medical equipment/ supplies (continued) • **Medicare-covered diabetic testing supplies** (lancets, strips, & certain glucometers)	All plans: You pay 0% of the cost			
• **Medicare-covered diabetic supplies**	All plans: You pay 20% of the cost			
Home Delivered Meals	All plans: You pay a $0 copay. Benefit is limited to 5 days, up to 10 meals, and following an inpatient or observation hospital stay at a network facility, with a doctor's order, and in our service area with a contracted provider.			
Health and Wellness Education Programs • **The Silver&Fit® Exercise & Healthy Aging Program**	All plans: You pay a $0 copay for Health and Wellness Education benefits As a Silver&Fit member you can visit a participating fitness center or YMCA near you that takes part in the program at no cost to you. You also have the following no cost options available to you: Workout plans, Digital "On-Demand" workouts, Home Fitness Kits, Well-Being Club, Healthy Aging Coaching, Activity tracking with Silver&Fit Connected!™, and rewards.			
• **Tele-monitoring Services** Members diagnosed with these conditions may be eligible.	○ Heart Failure ○ Diabetes ○ Chronic Obstructive Pulmonary Disease (COPD) ○ Hypertension			
• **Stroke Prevention Program**	Offered to members who have health conditions that put them at higher risk for stroke			
• **24 Hour Nursing Hotline**	(330) 363-7600 or 1-855-409-6448			
• **In-Home Safety Assessment**	Evaluates your home for potential safety concerns. For example: proper lighting, fall hazards, and grab bars			
• **Behavioral Health Program**	Provides support, education and resources for members with conditions such as depression, bipolar disorder, and substance use disorder			

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Over-The-Counter (OTC) benefit Covered OTC items are health-related items and medications that are available without a prescription and are not covered by Medicare.	Not Available	Up to $50 per quarter on qualified OTC items.	Up to $50 per quarter on qualified OTC items.	Up to $75 per quarter on qualified OTC items.
AultmanNow Telehealth To access go to www.aultmannow.com or download the smart phone app	Primary Care Doctor visit: You pay a $0 copay Specialist visit: You pay a $40 copay	Primary Care Doctor visit: You pay a $5 copay Specialist visit: You pay a $40 copay	Primary Care Doctor visit: You pay a $0 copay Specialist visit: You pay a $35 copay	Primary Care Doctor visit: You pay a $0 copay Specialist visit: You pay a $30 copay
Papa Pals, Inc. Help with Instrumental Activities of Daily Living	You pay nothing for up to 40 hours of Companion Care and Caregiver support. ● House tasks: meal prep, organization, laundry ● Companionship: conversation, board games, reading, exercise ● Tech help: Setting up personal tech devices such as a phone or computer, assisting with telehealth appointments ● Transportation: To and from doctor appointments, grocery shopping, errands ● Virtual visits Assistance from a distance: virtual services and companionship			

Outpatient Part D Prescription Drug Coverage

Cost-sharing may change when you enter a new stage of the Part D benefit. For more information on the stages of the benefit, please contact the plan or view the Evidence of Coverage online at www.pthp.com.

Phase 1: Deductible Stage*	You must pay the full cost of your Tier 3, Tier 4, and Tier 5 drugs until you have paid the deductible. The amount of the deductible is listed in the chart below. For drugs in Tier 1, Tier 2, or the Insulin Savings Program you do not pay a deductible and will receive coverage immediately at the copay amount listed below.
Phase 2: Initial Coverage Stage	During this stage, the plan pays its share of the cost of your generic drugs and you pay your share of the cost. After you (or others on your behalf) have met your Tiers 3, 4, and 5 deductible, the plan pays its share of the costs of your Tiers 3, 4, and 5 drugs and you pay your share. You pay the following copays/coinsurance until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

The below copays/coinsurance are for prescriptions purchased from network pharmacies. Costs will differ based on whether the prescriptions are filled at a preferred pharmacy, standard pharmacy, or mail order pharmacy. Refer to your pharmacy directory for information on which pharmacies are preferred or standard. Cost will also differ based on the number of days' supply. Long-Term Care (LTC) pharmacies can fill up to a 31-day supply at the 30-day copays/ coinsurance listed below.

Annual Deductible*	**Aultimate (HMO-POS)**	**Classic (HMO-POS)**	**Plus (HMO-POS)**
*Applies to drugs in Tiers 3, 4, & 5	$150	$125	$75

Preferred Pharmacy - Retail (up to a 90 day supply)

Tier and Name	**Aultimate (HMO-POS)**			**Classic (HMO-POS)**			**Plus (HMO-POS)**		
	30 day	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**
1 - Preferred Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
2 - Generic Drugs	$15 copay	$30 copay	$45 copay	$8 copay	$16 copay	$24 copay	$8 copay	$16 copay	$24 copay
3 - Preferred Brand Drugs*	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay
- Insulin Savings Program	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay
4 - Non-preferred Drugs*	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay
5 - Specialty Drugs*	29% of the cost	Not Available	Not Available	30% of the cost	Not Available	Not Available	31% of the cost	Not Available	Not Available

Standard Pharmacy - Retail (up to a 90 day supply)									
	30 day	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**
1 - Preferred Generic Drugs	$10 copay	$20 copay	$30 copay	$10 copay	$20 copay	$30 copay	$10 copay	$20 copay	$30 copay
2 - Generic Drugs	$20 copay	$40 copay	$60 copay	$18 copay	$36 copay	$54 copay	$16 copay	$32 copay	$48 copay
3 - Preferred Brand Drugs*	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay
- Insulin Savings Program	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay
4 - Non-preferred Drugs*	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
5 - Specialty Drugs*	29% of the cost	Not Available	Not Available	30% of the cost	Not Available	Not Available	31% of the cost	Not Available	Not Available
Mail Order Pharmacy (up to a 90 day supply)									
	30 day	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**
1 - Preferred Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
2 - Generic Drugs	$15 copay	$30 copay	$45 copay	$8 copay	$16 copay	$20 copay	$8 copay	$16 copay	$20 copay
3 - Preferred Brand Drugs*	$45 copay	$90 copay	$125 copay	$45 copay	$90 copay	$125 copay	$45 copay	$90 copay	$125 copay
- Insulin Savings Program	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay
4 - Non-preferred Drugs*	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay
5 - Specialty Drugs*	29% of the cost	Not Available	Not Available	30% of the cost	Not Available	Not Available	31% of the cost	Not Available	Not Available
***Tier 3, 4 and 5 copays apply after you have met the annual deductible. The Insulin Savings Program is not subject to deductible.**									

Phase 3: Coverage Gap Stage	While in the coverage gap you will continue to pay the same copay for tier 1drugs, tier 2 drug, and covered insulins and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap. The Medicare Coverage Gap Discount Program provides manufacturer discounts on tier 3, 4 and 5 drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs and you pay no more than 25% of the cost for generic drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs and moves you through the coverage gap. You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount $7,400, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.
Phase 4: Catastrophic Coverage Stage	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this stage, the plan will pay most of the cost for your drugs. You will pay whichever is the *larger* amount: • – *either* – coinsurance of 5% of the cost of the drug • – *or* – $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.