# 2018 Providence Medicare Advantage Plan Information

Thank you for your interest in applying for the Providence Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Providence within 7 days of the application receipt.

| Enrollment Packet – click links below to view the information |
|---|
| Star Rating<br>Download Application<br>Summary of Benefits: Choice & Extra / Enrich / Prime / Compass & Latitude<br>Pharmacy & Provider Search<br>Formulary |

| Initial Enrollment Period (IEP) |
|---|
| If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan. |
| **Annual Enrollment Period (AEP)** |
| Applications must be signed and dated on, or between October 15th and December 7th. *If they are signed prior to October 15th they will be returned to you with a new application.* If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year. |
| **Special Enrollment Period (SEP)** |
| There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc… |

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: Click here
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: https://medicare-oregon.com/

Y0062_MULTIPLAN_CDA INSURANCE Oregon Accepted 2017

PROVIDENCE
Medicare Advantage Plans

A division of Providence Health Assurance

# Summary of Benefits

## January 1, 2018 – December 31, 2018

Providence Medicare Compass + RX (HMO-POS)
Providence Medicare Latitude + RX (HMO-POS)

These Plans are available in Crook, Deschutes, Hood River, Jefferson and Wheeler Counties.

# 2018

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Providence Medicare Advantage Plans is an HMO, HMO-POS, and HMO SNP plan with a Medicare and Oregon Health Plan contract. Enrollment in Providence Medicare Advantage Plans depends on contract renewal.

## SECTION I- INTRODUCTION TO SUMMARY OF BENEFITS

This booklet gives you 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, please refer to the "Evidence of Coverage." To obtain a copy of the EOC please contact customer service at 1-800-603-2340 or visit us online to request one at **www.ProvidenceHealthAssurance.com**.

### 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 **Providence Medicare Compass + RX (HMO-POS) or Providence Medicare Latitude + RX (HMO-POS)**

### TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what **Providence Medicare Compass + RX (HMO-POS) and Providence Medicare Latitude + RX (HMO-POS)** cover and what you pay.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on **http://www.medicare.gov**.
- 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 **http://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 **Providence Medicare Compass + RX (HMO-POS), and Providence Medicare Latitude + RX (HMO-POS)**

- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Optional Benefits (you may pay an extra premium for these benefits)

### THINGS TO KNOW ABOUT PROVIDENCE MEDICARE COMPASS + RX (HMO-POS) OR PROVIDENCE MEDICARE LATITUDE + RX (HMO-POS)

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific Standard Time.

**PROVIDENCE MEDICARE COMPASS + RX (HMO-POS) OR PROVIDENCE MEDICARE LATITUDE + RX (HMO-POS) PHONE NUMBERS AND WEBSITE**

- If you are member of this plan, call toll free 1-800-603-2340, TTY users call 711.
- If you are not a member of this plan, call toll free 1-800-457-6064, TTY users call 711.
- Our website: **www.ProvidenceHealthAssurance.com**

## WHO CAN JOIN

To join **Providence Medicare Compass + RX (HMO-POS) or Providence Medicare Latitude + RX (HMO-POS)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Oregon: Crook, Deschutes, Hood River, Jefferson and Wheeler.

**Providence Medicare Compass + RX (HMO-POS) or Providence Medicare Latitude + RX (HMO-POS)** cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

## WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

**Providence Medicare Compass + RX (HMO-POS) and Providence Medicare Latitude + RX (HMO-POS)** have a network of doctors, hospitals, pharmacies, and other providers. For some services you can 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.

## WHAT DO WE COVER?

Like all Medicare health plans, we cover everything that Original Medicare covers and more.

- **Our plan members get all of the benefits covered by Original Medicare.**
- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs on our RX plans. In addition, we cover Part B drugs such as 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, **www.providencehealthassurance.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 each 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 benefits stages that occur after you meet your deductible as applicable: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Providence Health Assurance for details.

You can see our plan's Provider and Pharmacy Directory at our website: **www.providencehealthassurance.com/providerdirectory** or, call us and we will send you a copy of the Provider and Pharmacy Directory.

| SECTION II- SUMMARY OF BENEFITS | | |
|---|---|---|
| | **Providence Medicare Compass + RX (HMO-POS)** | **Providence Medicare Latitude + RX (HMO-POS)** |
| **MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUM OUT-OF-POCKET RESPONSIBILITY** | | |
| **Monthly premium** | $99.00<br>In addition, you must continue to pay your Medicare Part B premium. | $169.00<br>In addition, you must continue to pay your Medicare Part B premium. |
| **Deductible** | There is no medical deductible for in or out-of-network services. | There is no medical deductible for in or out-of-network services. |
| **Out-of-pocket maximum** | Your yearly limit(s) in this plan<br>• In-network: $6,700<br>• Out-of-network: $10,000 | Your yearly limit(s) in this plan<br>• In-network: $5,500<br>• Out-of-network: $5,500 |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| **SERVICES WITH A[1] MAY REQUIRE PRIOR AUTHORIZATION**<br>**SERVICES WITH A[2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR** | | |
| | **Providence Medicare Compass + RX (HMO-POS)** | **Providence Medicare Latitude + Rx (HMO-POS)** |
| **Inpatient Hospital Coverage[1]** | In-network:<br>$360 copay per day for days 1 through 5<br>You pay $0 per day days 6 & beyond<br>Out-of-network: 40% of the cost | In-network:<br>$275 copay per day for days 1 through 5<br>You pay $0 per day days 6 & beyond<br>Out-of-network: 30% of the cost |
| **Outpatient Hospital Coverage[1]** | In-network<br>$475 copay outpatient surgery<br>Out-of-network<br>40% of the cost outpatient surgery | In-network<br>$250 copay outpatient surgery<br>Out-of-network<br>30% of the cost outpatient surgery |
| **Doctor's Visits** (Primary and Specialist)[2] | Primary Care Provider visit:<br>In-network: $20 copay<br>Out-of-network: 40% of the cost<br>Specialist visit:<br>In-network: $45 copay<br>Out-of-network: 40% of the cost | Primary Care Provider visit:<br>In-network: $15 copay<br>Out-of-network: 30% of the cost<br>Specialist visit:<br>In-network: $40 copay<br>Out-of-network: 30% of the cost |
| **Preventive Care** | In-network: You pay nothing<br>Out-of-network: 40% of the cost | In-network: You pay nothing<br>Out-of-network: 30% of the cost |
| **Emergency Care** | $80 copay<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. | $80 copay<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. |
| **Urgent Care** | $65 copay<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost of urgent care. | $50 copay<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost of urgent care. |

| SERVICES WITH A[1] MAY REQUIRE PRIOR AUTHORIZATION<br>SERVICES WITH A[2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR | | |
|---|---|---|
| | **Providence Medicare Compass + RX (HMO-POS)** | **Providence Medicare Latitude + Rx (HMO-POS)** |
| **Diagnostic Services/Labs/ Imaging[1]** | Diagnostic radiology services (such as MRIs, ultrasounds, CT Scans):<br>In-network: 20% of the cost<br>Out-of-network: 40% of the cost<br><br>Diagnostic test and procedures:<br>In-network: 20% of the cost<br>Out-of-network: 40% of the cost<br><br>Lab Services:<br>In-network: $15 copay per day<br>Out-of-network: 40% of the cost<br><br>Outpatient x-rays:<br>In-network: $15 copay per day<br>Out-of-network: 40% of the cost<br><br>Therapeutic radiology services:<br>In-network: 20% of the cost<br>Out-of-network: 40% of the cost | Diagnostic radiology services (such as MRIs, ultrasounds, CT Scans):<br>In-network: 20% of the cost<br>Out-of-network: 30% of the cost<br><br>Diagnostic test and procedures:<br>In-network: 20% of the cost<br>Out-of-network: 30% of the cost<br><br>Lab services:<br>In-network: $10 copay per day<br>Out-of-network: 30% of the cost<br><br>Outpatient x-rays:<br>In-network: $15 copay per day<br>Out-of-network: 30% of the cost<br><br>Therapeutic radiology services:<br>In-network: 20% of the cost<br>Out-of-network: 30% of the cost |
| **Hearing Services[2]** | In-network: $45 copay<br>Out-of-network: 40% of the cost<br><br>Medicare-covered | In-network: $40 copay<br>Out-of-network: 30% of the cost<br><br>Medicare-covered |
| **Dental Services[2]** | In-network: $45 copay<br>Out-of-network: 40% of the cost<br><br>Medicare-covered | In-network: $40 copay<br>Out-of-network: 30% of the cost<br><br>Medicare-covered |
| **Vision Services** | Routine eye exam: In & out of network: $0 copay up to $60 allowance per calendar year from any qualified, licensed provider<br><br>Routine eyeglasses or contact lenses:<br>In-network: $300 benefit per calendar year from any qualified licensed provider<br>Out-of-network: $300 benefit per calendar year from any qualified licensed provider | Routine eye exam: In & out of network: $0 copay up to $60 allowance per calendar year from any qualified, licensed provider<br><br>Routine eyeglasses or contact lenses:<br>In-network: $300 benefit per calendar year from any qualified licensed provider<br>Out-of-network: $300 benefit per calendar year from any qualified licensed provider |
| **Mental Health Services[1]** | Inpatient visit:<br>In-network: $280 copay per day for days 1-5. You pay nothing for days 6 and beyond.<br>Out-of-network: 40% of the cost<br><br>Outpatient individual and group therapy visit:<br>In-network: $40 copay<br>Out-of-network: 40% of the cost | Inpatient visit:<br>In-network: $220 copay per day for days 1-6. You pay nothing for days 7 and beyond.<br>Out-of-network: 30% of the cost<br><br>Outpatient individual and group therapy visit:<br>In-network: $40 copay<br>Out-of-network: 30% of the cost |
| **Skilled Nursing Facility[1]** | In-network: You pay nothing for days 1-20<br>$160 copay per day for days 21-100<br>Out-of-network: 40% of the cost | In-network: You pay nothing for days 1-20<br>$150 copay per day for days 21-100<br>Out-of-network: 30% of the cost |

| SERVICES WITH A[1] MAY REQUIRE PRIOR AUTHORIZATION<br>SERVICES WITH A[2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR | | |
|---|---|---|
| | **Providence Medicare Compass + RX (HMO-POS)** | **Providence Medicare Latitude + Rx (HMO-POS)** |
| **Rehabilitation Services** | Occupational Therapy Visit:<br>In-network: $40 copay<br>Out-of-network: 40% of the cost<br><br>Physical therapy and Speech and Language therapy visit:<br>In-network: $40 copay<br>Out-of-network: 40% of the cost | Occupational Therapy Visit:<br>In-network: $40 copay<br>Out-of-network: 30% of the cost<br><br>Physical therapy and Speech and Language therapy visit:<br>In-network: $40 copay<br>Out-of-network: 30% of the cost |
| **Ambulance[1]** | $235 copay | $200 copay |
| **Transportation** | Not covered | Not covered |
| **Medicare Part B Drugs[1]** | In-network: 20% of the cost<br>Out-of-network: 40% of cost | In-network: 20% of the cost<br>Out-of-network: 30% of the cost |
| **Foot Care** (podiatry services)[2] | In-network: $45 copay<br>Out-of-network: 40% of the cost | In-network: $40 copay<br>Out-of-network: 30% of the cost |
| **Medical Equipment and Supplies[1]** | Durable medical equipment and supplies:<br>In-network: 20% of the cost<br>Out-of-network: 40% of the cost<br><br>Prosthetic devices:<br>In-network: 20% of the cost<br>Out-of-network: 40% of the cost<br><br>Diabetic supplies:<br>In-network: $0 copay<br>Out-of-network: 40% of the cost<br><br>Diabetic therapeutic shoes or inserts<br>In-network: 10% of the cost<br>Out-of-network: 40% of the cost | Durable medical equipment and supplies:<br>In-network: 20% of the cost<br>Out-of-network: 30% of the cost<br><br>Prosthetic devices:<br>In-network: 20% of the cost<br>Out-of-network: 30% of the cost<br><br>Diabetic supplies:<br>In-network: $0 copay<br>Out-of-network: 30% of the cost<br><br>Diabetic therapeutic shoes or inserts<br>In-network: 0% of the cost<br>Out-of-network: 30% of the cost |
| **Wellness Program** | $500 annual benefit for health and wellness classes offered at participating Providence facilities. | $500 annual benefit for health and wellness classes offered at participating Providence facilities. |

| Prescription Drug Benefits For Providence Medicare Compass + RX (HMO-POS) Plan ONLY | | | |
|---|---|---|---|
| **Initial Coverage** | You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.<br>You may get your drugs at network retail pharmacies and mail order pharmacies. | | |
| | **Preferred Retail and Mail Order Cost-Sharing** | | |
| | One-Month Supply | Two-Month Supply | Three-Month Supply |
| **Tier 1 (Preferred Generic)** | $10 copay | $20 copay | $24 copay |
| **Tier 2 (Generic)** | $18 copay | $36 copay | $43.20 copay |
| **Tier 3 (Preferred Brand)** | $47 copay | $94 copay | $112.80 copay |
| **Tier 4 (Non-preferred Drug)** | 25% of the cost | 25% of the cost | 25% of the cost |
| **Tier 5 (Specialty)** | 28% of the cost | Not offered | Not offered |
| | **Standard Retail Cost-Sharing** | | |
| | One-Month Supply | Two-Month Supply | Three-Month Supply |
| **Tier 1 (Preferred Generic)** | $12 copay | $24 copay | $36 copay |
| **Tier 2 (Generic)** | $20 copay | $40 copay | $60 copay |
| **Tier 3 (Preferred Brand)** | $47 copay | $94 copay | $141 copay |
| **Tier 4 (Non-preferred Drug)** | 25% of the cost | 25% of the cost | 25% of the cost |
| **Tier 5 (Specialty)** | 28% of the cost | Not offered | Not offered |
| If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. You may get drugs from a standard in-network pharmacy, but may pay more than you pay at a preferred in-network pharmacy.<br>Your yearly deductible for Part D (pharmacy) coverage is $250. You must pay this amount before the cost shares above apply.<br>Note: The Deductible is waived on Generic Tiers (Tiers 1 & 2). | | | |
| **Coverage Gap** | Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for the drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan’s cost for the covered brand name drugs and 44% of the plan’s cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. | | |
| **Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: 5% of the cost or $3.35 copay for generic (including brand drugs treated as generic) and an $8.35 copay for all other drugs. | | |

| Prescription Drug Benefits For Providence Medicare Latitude + RX (HMO-POS) Plan ONLY | | | |
|---|---|---|---|
| **Initial Coverage** | You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.<br><br>You may get you drugs at network retail pharmacies and mail order pharmacies. | | |
| | **Preferred Retail and Mail Order Cost-Sharing** | | |
| | One-Month Supply | Two-Month Supply | Three-Month Supply |
| **Tier 1 (Preferred Generic)** | $4 copay | $8 copay | $9.60 copay |
| **Tier 2 (Generic)** | $12 copay | $24 copay | $28.80 copay |
| **Tier 3 (Preferred Brand)** | $45 copay | $90 copay | $108 copay |
| **Tier 4 (Non-preferred Drug)** | 25% of the cost | 25% of the cost | 25% of the cost |
| **Tier 5 (Specialty)** | 33% of the cost | Not offered | Not offered |
| | **Standard Retail Cost-Sharing** | | |
| | One-Month Supply | Two-Month Supply | Three-Month Supply |
| **Tier 1 (Preferred Generic)** | $10 copay | $20 copay | $30 copay |
| **Tier 2 (Generic)** | $20 copay | $40 copay | $60 copay |
| **Tier 3 (Preferred Brand)** | $45 copay | $90 copay | $135 copay |
| **Tier 4 (Non-preferred Drug)** | 25% of the cost | 25% of the cost | 25% of the cost |
| **Tier 5 (Specialty)** | 33% of the cost | Not offered | Not offered |
| If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. You may get drugs from a standard in-network pharmacy, but may pay more than you pay at a preferred in-network pharmacy. | | | |
| **Coverage Gap** | Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for the drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan’s cost for the covered brand name drugs and 44% of the plan’s cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. | | |
| **Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: 5% of the cost, or $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copay for all other drugs. | | |

| OPTIONAL SUPPLEMENTAL DENTAL<br>**Please note:**<br>Optional Benefits: You must pay an extra premium each month for these benefits[1]<br>Cost-Sharing: While you can see any dentist, our In-network providers have agreed to accept a contracted rate for the services they provide. This means cost-sharing will be lower if you see an In-network provider[2] | | |
|---|---|---|
| | **Providence Medicare Compass + RX (HMO-POS)** | **Providence Medicare Latitude + Rx (HMO-POS)** |
| **Option 1: Basic Dental** | Benefits include:<br>Preventive Dental<br>Comprehensive Dental | Benefits include:<br>Preventive Dental<br>Comprehensive Dental |
| **Monthly premium[1]** | Additional $33.70 per month. You must keep paying your Medicare Part B and monthly plan premium. | Additional $33.70 per month. You must keep paying your Medicare Part B and monthly plan premium. |
| **Deductible[1]** | In-network: $50<br>Out-of-network: $150 | In-network: $50<br>Out-of-network: $150 |
| **Annual Benefit Maximum[1,2]** | $1000 per year | $1000 per year |
| **Diagnostic and Preventive Care[1,2]** | In-network: you pay 0%<br>Out-of-network: You pay 20% | In-network: you pay 0%<br>Out-of-network: You pay 20% |
| **Basic Care[1,2]** | In-network: you pay 50%<br>Out-of-network: You pay 60%<br>• Fillings (Silver)<br>• Fillings (Composite) | In-network: you pay 50%<br>Out-of-network: You pay 60%<br>• Fillings (Silver)<br>• Fillings (Composite) |
| **Major Restorative Care[1,2]** | In-network: You pay 50%<br>Out-of-network: You pay 60% | In-network: You pay 50%<br>Out-of-network: You pay 60% |
| | | |
| **Option 2: Enhanced Dental** | Benefits include:<br>Preventive Dental<br>Comprehensive Dental | Benefits include:<br>Preventive Dental<br>Comprehensive Dental |
| **Monthly premium[1]** | Additional $46.50 per month. You must keep paying your Medicare Part B and monthly plan premium | Additional $46.50 per month. You must keep paying your Medicare Part B and monthly plan premium |
| **Deductible[1]** | In-network: $50<br>Out-of-network: $150 | In-network: $50<br>Out-of-network: $150 |
| **Annual Benefit Maximum[1,2]** | $1,500 per year | $1,500 per year |
| **Diagnostic and Preventive Care[1,2]** | In-network: you pay 0%<br>Out-of-network: You pay 20% | In-network: you pay 0%<br>Out-of-network: You pay 20% |
| **Basic Care[1,2]** | In-network: you pay 50%<br>Out-of-network: You pay 60%<br>• Fillings (Silver)<br>• Fillings (Composite) | In-network: you pay 50%<br>Out-of-network: You pay 60%<br>• Fillings (Silver)<br>• Fillings (Composite) |
| **Major Restorative Care[1,2]** | In-network: You pay 50%<br>Out-of-network: You pay 60% | In-network: You pay 50%<br>Out-of-network: You pay 60% |

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 1st 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.