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Benefits details

	Humana Gold Plus H2486-006 (HMO) H2486-006-000 4 out of 5 stars (2021 plan year) Enroll	Humana Gold Plus H5619-059 (HMO) H5619-059-000 4 out of 5 stars (2021 plan year) Enroll
Summary		
Monthly premium	$0.00	$33.00
Medical deductible	$0	$0
Out-of-network maximum out-of-pocket	N/A	N/A
In-network maximum out-of-pocket	$6,700	$5,500
Combined maximum out-of-pocket	N/A	N/A
Drug deductible	$100 (excludes Tiers 1, 2 and 3)	$50 (excludes Tiers 1 and 2)
Initial coverage limit	$4,130	$4,130
Catastrophic coverage limit	$6,550	$6,550
Benefit details		
Outpatient care and services		
Acupuncture	**In-Network:** **Acupuncture:** Copayment for Acupuncture **$10.00** • Maximum 25 visits every year Prior Authorization Required for Acupuncture	**In-Network:** **Acupuncture:** Copayment for Acupuncture **$0.00** • Maximum 25 visits every year Prior Authorization Required for Acupuncture
Additional Services	**Additional Services:** Fitness Benefit Copayment for Alternative Therapies **$20.00** • Maximum 25 visits per year Prior Authorization Required for Additional Services **Meal Benefit:** Meal Benefit • Maximum of 56 Meals in 28 days for Meal Benefit Prior Authorization Required for Meal Benefit	**Additional Services:** Fitness Benefit Copayment for Alternative Therapies **$20.00** • Maximum 25 visits per year Prior Authorization Required for Additional Services **Meal Benefit:** Meal Benefit • Maximum of 56 Meals in 28 days for Meal Benefit Prior Authorization Required for Meal Benefit
Ambulance Services	**In-Network:** **Ground Ambulance:** Copayment for Ground Ambulance Services **$290.00** **Air Ambulance:** Coinsurance for Air Ambulance Services **20%** Please see Evidence of Coverage for Prior Authorization rules	**In-Network:** **Ground Ambulance:** Copayment for Ground Ambulance Services **$290.00** **Air Ambulance:** Coinsurance for Air Ambulance Services **20%** Please see Evidence of Coverage for Prior Authorization rules

Chiropractic Services	**In-Network:** **Chiropractic Services:** Copayment for Medicare-covered Chiropractic Services **$20.00** Copayment for Routine Care **$20.00** • Maximum 12 Routine Care every year Prior Authorization Required for Chiropractic Services Referral Required for Chiropractic Services	**In-Network:** **Chiropractic Services:** Copayment for Medicare-covered Chiropractic Services **$20.00** Copayment for Routine Care **$20.00** • Maximum 12 Routine Care every year Prior Authorization Required for Chiropractic Services Referral Required for Chiropractic Services
Dental Services	**In-Network:** **Preventive Dental:** Copayment for Oral Exams **$0.00** • Maximum 3 visits (Please see Evidence of Coverage for details) Copayment for Prophylaxis (Cleaning) **$0.00** • Maximum 2 visits every year Copayment for Dental X-Rays **$0.00** • Maximum 1 visit every year **Comprehensive Dental:** Copayment for Medicare-covered Benefits **$50.00** Prior Authorization Required for Comprehensive Dental Referral Required for Comprehensive Dental	**In-Network:** **Preventive Dental:** Copayment for Oral Exams **$0.00** • Maximum 3 visits (Please see Evidence of Coverage for details) Copayment for Prophylaxis (Cleaning) **$0.00** • Maximum 2 visits every year Copayment for Dental X-Rays **$0.00** • Maximum 3 visits (Please see Evidence of Coverage for details) Maximum Plan Benefit of **$1000.00** every year for Preventive and Non-Medicare Covered Comprehensive combined **Comprehensive Dental:** Copayment for Medicare-covered Benefits **$40.00** Copayment for Restorative Services **$0.00** • Maximum 2 visits every year Copayment for Extractions **$0.00** • Maximum 2 visits every year Maximum Plan Benefit of **$1000.00** every year for Preventive and Non-Medicare Covered Comprehensive combined Prior Authorization Required for Comprehensive Dental Referral Required for Comprehensive Dental
Diabetes Supplies and Services	**In-Network:** **Diabetic Supplies and Services:** Copayment for Medicare-covered Diabetic Supplies **$0.00** Coinsurance for Medicare-covered Diabetic Supplies **10%** to **20%** Copayment for Medicare-covered Diabetic Therapeutic Shoes or Inserts **$0.00** Prior Authorization Required for Diabetic Supplies and Services Diabetic Supplies and Services limited to those from specified manufacturers(Please see Evidence of Coverage)	**In-Network:** **Diabetic Supplies and Services:** Copayment for Medicare-covered Diabetic Supplies **$0.00** Coinsurance for Medicare-covered Diabetic Supplies **10%** to **20%** Copayment for Medicare-covered Diabetic Therapeutic Shoes or Inserts **$0.00** Prior Authorization Required for Diabetic Supplies and Services Diabetic Supplies and Services limited to those from specified manufacturers(Please see Evidence of Coverage)
Diagnostic Tests, Lab and Radiology Services, and X-Rays	**In-Network:** **Outpatient Diag Procs/Tests/Lab Services:** Copayment for Medicare-covered Diagnostic Procedures/Tests **$0.00** to **$50.00** Copayment for Medicare-covered Lab Services **$0.00** Prior Authorization Required for Outpatient Diag Procs/Tests/Lab Services Referral Required for Outpatient Diag Procs/Tests/Lab Services **Outpatient Diag/Therapeutic Rad Services:** Copayment for Medicare-covered Diagnostic Radiological Services **$50.00** to **$390.00** Coinsurance for Medicare-covered Diagnostic	**In-Network:** **Outpatient Diag Procs/Tests/Lab Services:** Copayment for Medicare-covered Diagnostic Procedures/Tests **$0.00** to **$40.00** Copayment for Medicare-covered Lab Services **$0.00** Prior Authorization Required for Outpatient Diag Procs/Tests/Lab Services Referral Required for Outpatient Diag Procs/Tests/Lab Services **Outpatient Diag/Therapeutic Rad Services:** Copayment for Medicare-covered Diagnostic Radiological Services **$40.00** to **$360.00** Coinsurance for Medicare-covered Diagnostic

	Radiological Services **20%** Coinsurance for Medicare-covered Therapeutic Radiological Services **20%** Copayment for Medicare-covered X-Ray Services **$0.00** to **$15.00** Prior Authorization Required for Outpatient Diag/Therapeutic Rad Services Referral Required for Outpatient Diag/Therapeutic Rad Services	Radiological Services **20%** Coinsurance for Medicare-covered Therapeutic Radiological Services **20%** Copayment for Medicare-covered X-Ray Services **$0.00** to **$15.00** Prior Authorization Required for Outpatient Diag/Therapeutic Rad Services Referral Required for Outpatient Diag/Therapeutic Rad Services
Doctor Office Visits	**In-Network:** **Doctor Office Visit:** Copayment for Primary Care Office Visit **$0.00**	**In-Network:** **Doctor Office Visit:** Copayment for Primary Care Office Visit **$0.00**
Doctor Specialty Visit	**In-Network:** **Doctor Specialty Visit:** Copayment for Physician Specialist Office Visit **$50.00** Prior Authorization Required for Doctor Specialty Visit Referral Required for Doctor Specialty Visit	**In-Network:** **Doctor Specialty Visit:** Copayment for Physician Specialist Office Visit **$40.00** Prior Authorization Required for Doctor Specialty Visit Referral Required for Doctor Specialty Visit
Durable Medical Equipment	**In-Network:** **Durable Medical Equipment:** Coinsurance for Medicare-covered Durable Medical Equipment **20%** Prior Authorization Required for Durable Medical Equipment	**In-Network:** **Durable Medical Equipment:** Coinsurance for Medicare-covered Durable Medical Equipment **20%** Prior Authorization Required for Durable Medical Equipment
Emergency Care	**Emergency Care:** Copayment for Emergency Care **$90.00** Copayment for Medicare Covered Emergency Care waived if you are admitted to the hospital within 24 hours **Worldwide Coverage:** Copayment for Worldwide Emergency Coverage **$90.00** Copayment for Worldwide Emergency Transportation **$90.00**	**Emergency Care:** Copayment for Emergency Care **$90.00** Copayment for Medicare Covered Emergency Care waived if you are admitted to the hospital within 24 hours **Worldwide Coverage:** Copayment for Worldwide Emergency Coverage **$90.00** Copayment for Worldwide Emergency Transportation **$90.00**
Hearing Services	**In-Network:** **Hearing Exams:** Copayment for Medicare Covered Benefits **$50.00** Copayment for Routine Hearing Exams **$0.00** • Maximum 1 visit every year Copayment for Fitting/Evaluation for Hearing Aid **$0.00** • Maximum 1 visit every year Prior Authorization Required for Hearing Exams Referral Required for Hearing Exams **Hearing Aids:** Copayment for Hearing Aids **$499.00** to **$799.00** • Maximum 2 Hearing Aids every year $499 copayment per ear per year for advanced level hearing aid purchase or $799 copayment per ear per year for premium level hearing aid purchase.	**In-Network:** **Hearing Exams:** Copayment for Medicare Covered Benefits **$40.00** Copayment for Routine Hearing Exams **$0.00** • Maximum 1 visit every year Copayment for Fitting/Evaluation for Hearing Aid **$0.00** • Maximum 1 visit every year Prior Authorization Required for Hearing Exams Referral Required for Hearing Exams **Hearing Aids:** Copayment for Hearing Aids **$399.00** to **$699.00** • Maximum 2 Hearing Aids every year $399 copayment per ear per year for advanced level hearing aid purchase or $699 copayment per ear per year for premium level hearing aid purchase.
Home Health Care	**In-Network:** **Home Health Services:** Copayment for Medicare-covered Home Health Services **$0.00**	**In-Network:** **Home Health Services:** Copayment for Medicare-covered Home Health Services **$0.00**

	Prior Authorization Required for Home Health Services Referral Required for Home Health Services	Prior Authorization Required for Home Health Services Referral Required for Home Health Services
Optional Benefits	**In-Network:** **Optional Supplemental Benefits:** MyOption Enhanced Dental HMO	N/A
Outpatient Mental Health Care	**In-Network:** **Outpatient Mental Health Services:** Copayment for Medicare-covered Individual Sessions **$10.00** Copayment for Medicare-covered Group Sessions **$10.00** Prior Authorization Required for Outpatient Mental Health Services Referral Required for Outpatient Mental Health Services	**In-Network:** **Outpatient Mental Health Services:** Copayment for Medicare-covered Individual Sessions **$0.00** Copayment for Medicare-covered Group Sessions **$0.00** Prior Authorization Required for Outpatient Mental Health Services Referral Required for Outpatient Mental Health Services
Outpatient Prescription Drugs	**In-Network:** **Outpatient Part B RX Drugs:** Coinsurance for Medicare Part B Chemotherapy Drugs **20%** Coinsurance for Other Medicare Part B Drugs **20%** Prior Authorization Required for Outpatient Part B RX Drugs	**In-Network:** **Outpatient Part B RX Drugs:** Coinsurance for Medicare Part B Chemotherapy Drugs **20%** Coinsurance for Other Medicare Part B Drugs **20%** Prior Authorization Required for Outpatient Part B RX Drugs
Outpatient Rehabilitation Services	**In-Network:** **Cardiac and Pulmonary Rehabilitation Services:** Copayment for Medicare-covered Cardiac Rehabilitation Services **$10.00** Copayment for Medicare-covered Intensive Cardiac Rehabilitation Services **$10.00** Copayment for Medicare-covered Pulmonary Rehabilitation Services **$10.00** Prior Authorization Required for Cardiac and Pulmonary Rehabilitation Services Referral Required for Cardiac and Pulmonary Rehabilitation Services **Occupational Therapy Rehabilitation Services:** Copayment for Medicare-covered Occupational Therapy Services **$40.00** Coinsurance for Medicare-covered Occupational Therapy Services **20%** Prior Authorization Required for Occupational Therapy Rehabilitation Services Referral Required for Occupational Therapy Rehabilitation Services **Physical Therapy and Speech-Language Pathology Services:** Copayment for Medicare-covered Physical Therapy and Speech-Language Pathology Service **$40.00** Coinsurance for Medicare-covered Physical Therapy and Speech-Language Pathology Service **20%** Prior Authorization Required for Physical Therapy and Speech-Language Pathology Services Referral Required for Physical Therapy and Speech-Language Pathology Services	**In-Network:** **Cardiac and Pulmonary Rehabilitation Services:** Copayment for Medicare-covered Cardiac Rehabilitation Services **$5.00** Copayment for Medicare-covered Intensive Cardiac Rehabilitation Services **$5.00** Copayment for Medicare-covered Pulmonary Rehabilitation Services **$5.00** Prior Authorization Required for Cardiac and Pulmonary Rehabilitation Services Referral Required for Cardiac and Pulmonary Rehabilitation Services **Occupational Therapy Rehabilitation Services:** Copayment for Medicare-covered Occupational Therapy Services **$40.00** Coinsurance for Medicare-covered Occupational Therapy Services **20%** Prior Authorization Required for Occupational Therapy Rehabilitation Services Referral Required for Occupational Therapy Rehabilitation Services **Physical Therapy and Speech-Language Pathology Services:** Copayment for Medicare-covered Physical Therapy and Speech-Language Pathology Service **$40.00** Coinsurance for Medicare-covered Physical Therapy and Speech-Language Pathology Service **20%** Prior Authorization Required for Physical Therapy and Speech-Language Pathology Services Referral Required for Physical Therapy and Speech-Language Pathology Services
Outpatient Services/Surgery	**In-Network:** **Outpatient Hospital Services:**	**In-Network:** **Outpatient Hospital Services:**

	Copayment for Medicare Covered Outpatient Hospital Services **$10.00** to **$300.00** Coinsurance for Medicare Covered Outpatient Hospital Services **20%** Prior Authorization Required for Outpatient Hospital Services Referral Required for Outpatient Hospital Services **Outpatient Observation Services:** Copayment for Medicare Covered Observation Services **$0.00** Prior Authorization Required for Outpatient Observation Services Referral Required for Outpatient Observation Services **Ambulatory Surgical Center Services:** Copayment for Ambulatory Surgical Center Services **$200.00** Prior Authorization Required for Ambulatory Surgical Center Services Referral Required for Ambulatory Surgical Center Services	Copayment for Medicare Covered Outpatient Hospital Services **$5.00** to **$360.00** Coinsurance for Medicare Covered Outpatient Hospital Services **20%** Prior Authorization Required for Outpatient Hospital Services Referral Required for Outpatient Hospital Services **Outpatient Observation Services:** Copayment for Medicare Covered Observation Services **$0.00** Prior Authorization Required for Outpatient Observation Services Referral Required for Outpatient Observation Services **Ambulatory Surgical Center Services:** Copayment for Ambulatory Surgical Center Services **$200.00** Prior Authorization Required for Ambulatory Surgical Center Services Referral Required for Ambulatory Surgical Center Services
Outpatient Substance Abuse	**In-Network:** **Outpatient Substance Abuse Services:** Copayment for Medicare-covered Individual Sessions **$10.00** Coinsurance for Medicare-covered Individual Sessions **20%** Copayment for Medicare-covered Group Sessions **$10.00** Coinsurance for Medicare-covered Group Sessions **20%** Prior Authorization Required for Outpatient Substance Abuse Services Referral Required for Outpatient Substance Abuse Services	**In-Network:** **Outpatient Substance Abuse Services:** Copayment for Medicare-covered Individual Sessions **$0.00** Coinsurance for Medicare-covered Individual Sessions **20%** Copayment for Medicare-covered Group Sessions **$0.00** Coinsurance for Medicare-covered Group Sessions **20%** Prior Authorization Required for Outpatient Substance Abuse Services Referral Required for Outpatient Substance Abuse Services
Over-the-Counter Items	**In-Network:** **Over-The-Counter (OTC) Items:** Copayment for Over-The-Counter (OTC) Items **$0.00** Maximum Plan Benefit of **$15.00** every month Nicotine Replacement Therapy (NRT) offerred as a Part C OTC benefit	**In-Network:** **Over-The-Counter (OTC) Items:** Copayment for Over-The-Counter (OTC) Items **$0.00** Maximum Plan Benefit of **$50.00** every three months Nicotine Replacement Therapy (NRT) offerred as a Part C OTC benefit
Podiatry Services	**In-Network:** **Podiatry Services:** Copayment for Medicare-Covered Podiatry Services **$50.00** Prior Authorization Required for Podiatry Services Referral Required for Podiatry Services	**In-Network:** **Podiatry Services:** Copayment for Medicare-Covered Podiatry Services **$40.00** Prior Authorization Required for Podiatry Services Referral Required for Podiatry Services
Preventive Services and Wellness/Education Programs	**In-Network:** $0.00 copay for Medicare Covered Preventive Services: Abdominal aortic aneurysm screening Alcohol misuse screenings & counseling Bone mass measurements (bone density) Cardiovascular disease screenings Cardiovascular disease (behavioral therapy) Cervical & vaginal cancer screening Colorectal cancer screenings Depression screenings	**In-Network:** $0.00 copay for Medicare Covered Preventive Services: Abdominal aortic aneurysm screening Alcohol misuse screenings & counseling Bone mass measurements (bone density) Cardiovascular disease screenings Cardiovascular disease (behavioral therapy) Cervical & vaginal cancer screening Colorectal cancer screenings Depression screenings

	Diabetes screenings Diabetes self-management training Glaucoma tests Hepatitis B (HBV) infection screening Hepatitis C screening test HIV screening Lung cancer screening Mammograms (screening) Nutrition therapy services Obesity screenings & counseling One-time Welcome to Medicare preventive visit Prostate cancer screenings(PSA) Sexually transmitted infections screening & counseling Shots: • Flu shots • Hepatitis B shots • Pneumococcal shots Tobacco use cessation Yearly "Wellness" visit	Diabetes screenings Diabetes self-management training Glaucoma tests Hepatitis B (HBV) infection screening Hepatitis C screening test HIV screening Lung cancer screening Mammograms (screening) Nutrition therapy services Obesity screenings & counseling One-time Welcome to Medicare preventive visit Prostate cancer screenings(PSA) Sexually transmitted infections screening & counseling Shots: • Flu shots • Hepatitis B shots • Pneumococcal shots Tobacco use cessation Yearly "Wellness" visit
Prosthetic Devices	**In-Network:** **Prosthetics/Medical Supplies:** Coinsurance for Medicare-covered Prosthetic Devices **20%** Coinsurance for Medicare-covered Medical Supplies **20%** Prior Authorization Required for Prosthetics/Medical Supplies	**In-Network:** **Prosthetics/Medical Supplies:** Coinsurance for Medicare-covered Prosthetic Devices **20%** Coinsurance for Medicare-covered Medical Supplies **20%** Prior Authorization Required for Prosthetics/Medical Supplies
Renal Dialysis	**In-Network:** **Dialysis Services:** Coinsurance for Medicare-covered Dialysis Services **20%** Prior Authorization Required for Dialysis Services Referral Required for Dialysis Services	**In-Network:** **Dialysis Services:** Coinsurance for Medicare-covered Dialysis Services **20%** Prior Authorization Required for Dialysis Services Referral Required for Dialysis Services
Transportation	**Transportation Services:** Copayment for Transportation Services **$0.00** Prior Authorization Required for Transportation Services Plan allows 24 one way trips to a Plan-approved location every year Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits. This benefit is not to exceed 50 miles per trip.	**Transportation Services:** Copayment for Transportation Services **$0.00** Prior Authorization Required for Transportation Services Plan allows 24 one way trips to a Plan-approved location every year Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits. This benefit is not to exceed 50 miles per trip.
Urgently Needed Care	**Urgent Care:** Copayment for Urgent Care **$0.00** to **$50.00** Cost share amount will apply based on the setting where the service is received: In-Network $0.00 PCP $50.00 Specialist $25.00 Urgent Care Center **Worldwide Coverage:** Copayment for Worldwide Urgent Coverage **$90.00**	**Urgent Care:** Copayment for Urgent Care **$0.00** to **$40.00** Cost share amount will apply based on the setting where the service is received: In-Network $0.00 PCP $40.00 Specialist $25.00 Urgent Care Center **Worldwide Coverage:** Copayment for Worldwide Urgent Coverage **$90.00**
Vision Services	**In-Network:** **Eye Exams:**	**In-Network:** **Eye Exams:**

	Copayment for Medicare Covered Benefits **$0.00** to **$50.00** Copayment for Routine Eye Exams **$0.00** • Maximum 1 Routine Eye Exam every year Prior Authorization Required for Eye Exams Referral Required for Eye Exams **Eyewear:** Copayment for Medicare-Covered Benefits **$0.00** Copayment for Contact Lenses **$0.00** • Maximum 1 Pair every year Copayment for Eyeglasses (lenses and frames) **$0.00** • Maximum 1 Pair every year Maximum Plan Benefit of **$100.00** every year for all Non-Medicare covered eyewear Prior Authorization Required for Eyewear Referral Required for Eyewear	Copayment for Medicare Covered Benefits **$0.00** to **$40.00** Copayment for Routine Eye Exams **$0.00** • Maximum 1 Routine Eye Exam every year Prior Authorization Required for Eye Exams Referral Required for Eye Exams **Eyewear:** Copayment for Medicare-Covered Benefits **$0.00** Copayment for Contact Lenses **$0.00** • Maximum 1 Pair every year Copayment for Eyeglasses (lenses and frames) **$0.00** • Maximum 1 Pair every year Maximum Plan Benefit of **$100.00** every year for all Non-Medicare covered eyewear Prior Authorization Required for Eyewear Referral Required for Eyewear

Inpatient care

Inpatient Hospital Care	**In-Network:** **Acute Hospital Services:** **$390.00** per day for days 1 to 5 **$0.00** per day for days 6 to 90 Prior Authorization Required for Acute Hospital Services Referral Required for Acute Hospital Services	**In-Network:** **Acute Hospital Services:** **$360.00** per day for days 1 to 5 **$0.00** per day for days 6 to 90 Prior Authorization Required for Acute Hospital Services Referral Required for Acute Hospital Services
Inpatient Mental Health Care	**In-Network:** **Psychiatric Hospital Services:** **$370.00** per day for days 1 to 5 **$0.00** per day for days 6 to 90 Prior Authorization Required for Psychiatric Hospital Services Referral Required for Psychiatric Hospital Services	**In-Network:** **Psychiatric Hospital Services:** **$350.00** per day for days 1 to 5 **$0.00** per day for days 6 to 90 Prior Authorization Required for Psychiatric Hospital Services Referral Required for Psychiatric Hospital Services
Skilled Nursing Facility (SNF)	**In-Network:** **Skilled Nursing Facility Services:** **$0.00** per day for days 1 to 20 **$178.00** per day for days 21 to 60 **$0.00** per day for days 61 to 100 Prior Authorization Required for Skilled Nursing Facility Services Referral Required for Skilled Nursing Facility Services	**In-Network:** **Skilled Nursing Facility Services:** **$0.00** per day for days 1 to 20 **$184.00** per day for days 21 to 60 **$0.00** per day for days 61 to 100 Prior Authorization Required for Skilled Nursing Facility Services Referral Required for Skilled Nursing Facility Services

Prescription drug benefits

30 day supply | 60 day supply | 90 day supply

Deductible coverage level

Drug deductible	$100 (excludes Tiers 1, 2 and 3)	$50 (excludes Tiers 1 and 2)
Tier 1	**Preferred Generic**	**Preferred Generic**
Preferred retail	$2.00	$2.00
Standard retail	$10.00	$10.00

Preferred mail order	$2.00	$2.00
Standard mail order	$10.00	$10.00
Tier 2	**Generic**	**Generic**
Preferred retail	$8.00	$8.00
Standard retail	$20.00	$20.00
Preferred mail order	$8.00	$8.00
Standard mail order	$20.00	$20.00
Tier 3	**Preferred Brand**	**Deductible applies**
Preferred retail	$47.00	Deductible applies
Standard retail	$47.00	Deductible applies
Preferred mail order	$47.00	Deductible applies
Standard mail order	$47.00	Deductible applies
Tier 4	**Deductible applies**	**Deductible applies**
Tier 5	**Deductible applies**	**Deductible applies**

Initial coverage level

Tier 1	**Preferred Generic**	**Preferred Generic**
Preferred retail	$2.00	$2.00
Standard retail	$10.00	$10.00
Preferred mail order	$2.00	$2.00
Standard mail order	$10.00	$10.00
Tier 2	**Generic**	**Generic**
Preferred retail	$8.00	$8.00
Standard retail	$20.00	$20.00
Preferred mail order	$8.00	$8.00
Standard mail order	$20.00	$20.00
Tier 3	**Preferred Brand**	**Preferred Brand**
Preferred retail	$47.00	$47.00
Standard retail	$47.00	$47.00
Preferred mail order	$47.00	$47.00
Standard mail order	$47.00	$47.00
Tier 4	**Non-Preferred Drug**	**Non-Preferred Drug**
Preferred retail	$100.00	$100.00
Standard retail	$100.00	$100.00

Preferred mail order	$100.00	$100.00
Standard mail order	$100.00	$100.00
Tier 5	**Specialty Tier**	**Specialty Tier**
Preferred retail	31%	32%
Standard retail	31%	32%
Preferred mail order	31%	32%
Standard mail order	31%	32%

Plan documents

Links to plan documents	Summary of Benefits Evidence of Coverage Star Ratings	Summary of Benefits Evidence of Coverage