IU HEALTH PLANS MEDICARE SELECT PLUS (HMO)

(a Medicare Advantage Health Maintenance Organization (HMO) offered by INDIANA UNIVERSITY HEALTH PLANS, INC. with a Medicare contract)

Summary of Benefits

January 1, 2019 - December 31, 2019
This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

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 **IU HEALTH PLANS MEDICARE SELECT PLUS (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **IU HEALTH PLANS MEDICARE SELECT PLUS (HMO)** covers and what you pay.

- If you want to compare our plan 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://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.

Sections in this booklet

- Things to Know About **IU HEALTH PLANS MEDICARE SELECT PLUS (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at 1-800-455-9776 (TTY:1-800-743-3333).

Things to Know About IU HEALTH PLANS MEDICARE SELECT PLUS (HMO)

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

IU HEALTH PLANS MEDICARE SELECT PLUS (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-800-455-9776 (TTY:1-800-743-3333).
- If you are not a member of this plan, call toll-free 1-800-455-9776 (TTY:1-800-743-3333).
- Our website: http://www.iuhealthplans.org

Who can join?

To join IU HEALTH PLANS MEDICARE SELECT PLUS (HMO), 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 Indiana: Boone, Clinton, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, Tippecanoe.

Which doctors, hospitals, and pharmacies can I use?

IU HEALTH PLANS MEDICARE SELECT PLUS (HMO) has 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.

You can see our plan's provider and pharmacy directory at our website (http://www.iuhealthplans.org).

Or, call us and we will send you a copy of the provider and pharmacy directories.

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. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **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. 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, http://www.iuhealthplans.org.
- 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 six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it 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 benefit stages that occur: Initial Coverage, Coverage Gap (if applicable), and Catastrophic Coverage.

Indiana University Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Indiana University Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Indiana University Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact IU Health Plans Customer Service at (800) 455-9776 and ask for the Civil Rights Coordinator.

If you believe that Indiana University Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Indiana University Health Plans, 950 N Meridian St, Suite 400, Indianapolis, IN 46204, (800) 455-9776 , TTY: (800) 743-3333, Fax (317) 963-9801, HealthPlansCompliance@iuhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, IU Health Plans' Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue,

SW Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Indiana University Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. IU Health Plans no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

IU Health Plans:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas capacitados.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - Intérpretes capacitados.
  - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con IU Health Plans Customer Service at (800).455.9776, Civil Rights Coordinator.

Si considera que Indiana University Health Plans no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: Civil Rights Coordinator, Indiana University Health Plans, 950 N. Meridian St, Suite 400, Indianapolis, IN 46204, 800.455.9776, TTY: 800.743.3333, Fax (317) 963-9801, HealthPlansCompliance@iuhealth.org. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, IU Health Plans' Civil Rights Coordinator está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

Indiana University Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。[IU Health Plans] 不因種族、膚色、民族血統、年齡、殘障或性別而排斥任何人或以不同的方式對待他們。

Indiana University Health Plans：

- 向殘障人士免費提供各種援助和服務，以幫助他們與我們進行有效溝通，如：
  - 合格的手語翻譯員
  - 以其他格式提供的書面資訊（大號字體、音訊、無障礙電子格式、其他格式）
- 向母語非英語的人員免費提供各種語言服務，如：
  - 合格的翻譯員
  - 以其他語言書寫的資訊

如果您需要此類服務，請聯絡 Civil Rights Coordinator.

如果您認爲 Indiana University Health Plans 未能提供此類服務或者因種族、膚色、民族血統、年齡、殘障或性別而透過其他方式歧視您，您可以向 Civil Rights Coordinator 提交投訴，郵寄地址爲 950 N. Meridian St, Suite 400, Indianapolis, IN 46204，電話號碼爲 800.455.9776（聽障專線）號碼爲 800.743.3333，傳眞爲 317.963.9801，電子信箱HealthPlansCompliance@iuhealth.org。您可以親自提交投訴，或者以郵寄、傳眞或電郵的方式提交投訴。如果您在提交投訴方面需要幫助，IU Health Plans’ Civil Rights Coordinator 可以幫助您。

您還可以向 U.S. Department of Health and Human Services（美國衛生及公共服務部）的 Office for Civil Rights（民權辦公室）提交民權投訴，透過 Office for Civil Rights Complaint Portal 以電子方式投訴：https://ocrportal.hhs.gov/ocr/portal/lobby.jsf，或者透過郵寄或電話的方式投訴：

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C.20201

1-800-368-1019，800-537-7697 (TDD)（聾人用電信設備）

登入 http://www.hhs.gov/ocr/office/file/index.html 可獲得投訴表格。

Health Plans

Multi-Language Insert

English: ATTENTION: Our Customer Solutions Center has free language interpreter services available for non-English speakers. Call 1-800-455-9776. (TTY: 1-800-743-3333)

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-455-9776. (TTY: 1-800-743-3333).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-455-9776（TTY：1-800-743-3333）。

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-455-9776 (TTY: 1-800-743-3333).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-455-9776 (ATS: 1-800-743-3333).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụhỗtrợngôn ngữmiễn phí dành cho bạn. Gọi số 1-800-455-9776 (TTY: 1-800-743-3333)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-455-9776 (TTY: 1-800-743-3333).

Korean: 주의: 한국어를사용하시는경우, 언어지원서비스를무료로이용하실수있습니다. 1-800-455-9776 (TTY: 1-800-743-3333)번으로전화해주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-455-9776 (телетайп: 1-800-743-3333).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
1-800-455-9776 (رقم هاتف الصم والبكم 1-800-743-3333).

Hindi: ध्यान द:ï¿½
यï¿½द आप ï¿½हंदï¿½ बोलते हïï¿½ तो आपके लिए मुफ्त मïï¿½ भाषा सहायता सवे
एं उपलब्ध हा।ï¿½
1-800-455-9776 (TTY: 1-800-743-3333) पर कॉल करïï¿½।

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-455-9776 (TTY: 1-800-743-3333).

Portugues: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-455-9776 (TTY: 1-800-743-3333).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-455-9776 (TTY: 1-800-743-3333).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-455-9776 (TTY: 1-800-743-3333).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-455-9776（TTY:1-800-743-3333）まで、お電話にてご連絡ください。

Burmese: သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-800-455-9776 (TTY: 1-800-743-3333) သို့ ခေါ်ဆိုပါ။

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-455-9776 (TTY: 1-800-743-3333).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ¿½ ਪੰ ਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ¿½ ਭਾਸ਼ਾ ਵਿੱ ਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-455-9776 (TTY: 1-800-743-3333) 'ਤੇ ਕਾਲ ਕਰੋ।

Dutch: AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-455-9776 (TTY: 1-800-455-9776).

Summary of Benefits Report

for Contract H7220, Plan 009-002

IU HEALTH PLANS MEDICARE SELECT PLUS (HMO)

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

How much is the monthly premium?	**$0** per month. In addtion, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible for medical services. This plan has a **$200** deductible for Part D prescription drugs that applies to Tiers 3, 4, and 5.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • **$4,950** for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical and Hospital Benefits

Note:

- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

Inpatient Hospital Care[1,2]	• **$300** copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 Per day cost-sharing applies to each new inpatient admission to participating facilities in our plan.
Outpatient Hospital Coverage[1]	Observation: **$295** copay Outpatient Surgery: **$295** copay
Doctor's Office Visits	Primary Care Physician visit: **$10** copay

	Specialist visit: **$45** copay
Preventive Care and Annual Physical Exam	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes Prevention Program • Diabetes screenings • HIV screening • Lung cancer screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. Annual Physical Exam: You pay nothing
Emergency Care	**$90** copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services	**$65** copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1]	Diagnostic radiology services (such as MRIs, CT scans): **20%** of the cost Diagnostic tests and procedures: **20%** of the cost Lab services: **$10** copay Outpatient x-rays: **$25** copay

	Therapeutic radiology services (such as radiation treatment for cancer): **20%** of the cost
Hearing Services	Exam to diagnose and treat hearing and balance issues: **$45** copay Routine hearing exam: **$45** copay. You are covered for up to 1 every year. Hearing aid: **$699-$999** copay for each hearing aid, depending on the type
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay a **$10** annual deductible. Preventive dental services: Cleaning (1 every year): You pay nothing after you pay your deductible. Dental x-ray(s) (1 every year): You pay nothing after you pay your deductible. Oral exam (1 every year): You pay nothing after you pay your deductible.
Vision Services[2]	**Every year** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing Routine eye exam: You pay nothing Eyeglasses or contact lenses after cataract surgery: You pay the balance after benefit is applied **Every two years** Eyeglass frames (Up to $120, 20% off balance over $120): ***$20** copay Eyeglass lenses (Single, Bifocal, Trifocal, and Lenticular): ***$20** copay Eyeglass lenses (Standard Progressive): *$85 copay Eyeglass lenses (Premium Progressive Tiers): Tier 1: *$105 copay Tier 2: *$115 copay Tier 3: *$130 copay Tier 4: *$85 copay, 20% off retail price less the $120 Allowance Contact lenses (Conventional: $120 allowance, 15% off balance over $120 allowance) **You have the option of frames and lenses or frames and contacts only*
Mental Health Care[1,2]	Inpatient visit: • **$325** copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 Outpatient group therapy visit: **$40** copay Outpatient individual therapy visit: **$40** copay Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.

	Per day cost-sharing applies to each new inpatient admission to participating facilities in our plan.
Skilled Nursing Facility (SNF) [1,2]	Our plan covers up to 100 days in a SNF. • You pay nothing per day for days 1 through 20 • **$172** copay per day for days 21 through 100
Outpatient Rehabilitation[1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **$30** copay Occupational therapy visit: **$40** copay Physical therapy and speech and language therapy visit: **$40** copay
Ambulance	**$275** copay
Transportation	Not covered
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs[1]: **20%** of the cost Other Part B drugs[1]: **20%** of the cost
Foot Care (*podiatry services*)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **$45** copay
Durable Medical Equipment *(wheelchairs, oxygen, etc.)* [1]	**20%** of the cost
Prosthetic Devices *(braces, artificial limbs, etc.)*	Prosthetic devices: **20%** of the cost Related medical supplies: **20%** of the cost
Diabetes Supplies and Services	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: **20%** of the cost IU HEALTH PLANS MEDICARE SELECT PLUS (HMO) will only cover a select brand of test strips and monitors. Our plan will ONLY cover Lifescan® test strips and monitors. If this brand of test strips does not work with your current monitor IU HEALTH PLANS MEDICARE SELECT PLUS (HMO) will supply you with a Lifescan® monitor for no additional cost. Lancets are not restricted to specific manufacturers and/or brands.
Wellness Programs	**Fitness Benefit:** No cost membership at a participating fitness center or up to 2 fitness kits with the Home Fitness Program through the Silver&Fit® Exercise & Healthy Aging Program **Diabetes Prevention Program:** An evidence-based program designed to delay or prevent participants' progression to type 2 diabetes: You pay nothing
Acupuncture	Not covered
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **$20** copay
Home Health Care[1,2]	You pay nothing

Outpatient Substance Abuse	Group therapy visit: **$45** copay Individual therapy visit: **$45** copay
Outpatient Surgery[1,2]	Ambulatory surgical center: **$295** copay Outpatient hospital: **$295** copay
Over-the-Counter Items	Not Covered
Renal Dialysis	**20%** of the cost
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
Visitor Travel	You pay the in-network copay or coinsurance when visiting a Medicare-approved provider for non-emergency care while traveling outside of the state for more than 30 days and up to 9 consecutive months. Prior to traveling out-of-state, members must call the Customer Solutions Center at 1-800-455-9776 to activate their benefit.

Prescription Drug Benefits

Initial Coverage

You pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	**$6** copay	**$18** copay
Tier 2 (Non-Preferred Generic)	**$15** copay	**$45** copay
Tier 3 (Preferred Brand)	**$47** copay	**$141** copay
Tier 4 (Non-Preferred Brand)	**$100** copay	**$300** copay
Tier 5 (Specialty Tier)	**29%** of the cost	Not Offered
Tier 6 (Select Care)	**$0** copay	**$0** copay

Standard Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	**$6** copay	***$0** copay
Tier 2 (Non-Preferred Generic)	**$15** copay	***$0** copay
Tier 3 (Preferred Brand)	**$47** copay	**$141** copay
Tier 4 (Non-Preferred Brand)	**$100** copay	**$300** copay
Tier 5 (Specialty Tier)	**29%** of the cost	Not Offered
Tier 6 (Select Care)	**$0** copay	**$0** copay

*For 90-day mail order drugs in Tier 1 and Tier 2 at a $0 copay, you must use a CVS Caremark mail order pharmacy.

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.

Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,100**, you pay the greater of: • **5%** of the cost, or • **$3.40** copay for generic (including brand drugs treated as generic) and an **$8.50** copay for all other drugs.

Optional Benefits*(you must pay an extra premium each month for these benefits)*

PACKAGE 1: Dental Basic 750	*Benefits include:* Preventive & Diagnostic Care Basic Restorative
How much is the monthly premium?	Additional **$6** per month. You must keep paying your Medicare Part B premium and your **$0** monthly plan premium.
How much is the deductible?	There is an annual **$10** deductible.
Is there a limit on how much the plan will pay?	Up to **$750** per plan year for your optional dental benefits.
PACKAGE 2: Dental Enhanced 1000	*Benefits include:* Preventive & Diagnostic Care Basic Restorative Major Restorative
How much is the monthly premium?	Additional **$12** per month. You must keep paying your Medicare Part B premium and your **$0** monthly plan premium.
How much is the deductible?	There is an annual **$10** deductible.
Is there a limit on how much the plan will pay?	Up to **$1,000** per plan year for your optional dental benefits.
PACKAGE 3: Dental Enhanced 1500	*Benefits include:* Preventive & Diagnostic Care Basic Restorative Major Restorative
How much is the monthly premium?	Additional **$18** per month. You must keep paying your Medicare Part B premium and your **$0** monthly plan premium.
How much is the deductible?	There is an annual **$10** deductible.
Is there a limit on how much the plan will pay?	Up to **$1,500** per plan year for your optional dental benefits.