

Benefits	What You Pay With Silver Rx Plan with Medicare Only	What You Pay With Silver Rx Plan with Medicare and full Medicaid
Monthly Plan Premium	\$27.50 ⁽¹⁾	\$0 ⁽¹⁾
Annual Out-Of-Pocket Maximum	\$90,000	\$90,000
Retail Pharmacy (30-Day Supply)	\$9-Generic; \$43-Brand (preferred); \$95-Brand (non-preferred); 33% Specialty	\$0/\$1.10/\$2.50-Generic and \$0/\$3.30/\$6.30 for all other drugs. ⁽²⁾
Inpatient Hospital	\$1,100 deductible for each benefit period ⁽³⁾ Days 1-60: \$0 ⁽³⁾ ; Days 61-90: \$275 per day ⁽³⁾ ; Days 91-150: \$550 per lifetime reserve day ⁽³⁾⁽⁴⁾	\$0 ⁽³⁾⁽⁴⁾
Primary Care Physician Visit/ Specialist Visit	20% coinsurance/ 20% coinsurance	\$0 \$0
Emergency Care	20% coinsurance Worldwide coverage	\$0
Durable Medical Equipment (DME)	20% coinsurance for Medicare-covered items ⁽³⁾	\$0 ⁽³⁾
Diabetes Self-Monitoring and Supplies	20% coinsurance	\$0
Preventive Healthcare Services	20% coinsurance	\$0
Podiatry	20% coinsurance for each Medicare-covered visit \$0 copayment for each routine visit, up to 6 visits per year	\$0 copayment for each Medicare-covered visit \$0 copayment for each routine visit, up to 6 visits per year
Transportation	\$0 copayment for up to 24 one-way trips to plan-approved locations per year ⁽³⁾⁽⁵⁾	\$0 copayment for up to 24 one-way trips to plan-approved locations per year ⁽³⁾⁽⁵⁾
Vision (includes glasses and contact lenses)	20% coinsurance for Medicare-covered benefits \$10 copayment for a routine eye exam \$0 copayment; \$200 annually towards eyewear	\$0 copayment for Medicare-covered benefits \$0 copayment for a routine eye exam \$0 copayment; \$200 annually towards eyewear
Dental Care	20% coinsurance for Medicare-covered benefits \$15 copayment for a routine preventive office visit \$0 copayment for dentures - 2 dental plates, either full or partial, once every 3 years; denture adjustments	\$0 copayment for Medicare-covered benefits \$0 copayment for a routine preventive office visit \$0 copayment for dentures - 2 dental plates, either full or partial, once every 3 years; denture adjustments
Over-The-Counter drugs and other products	You receive \$19 monthly to spend on Over-The-Counter purchases	You receive \$19 monthly to spend on Over-The-Counter purchases

Cost sharing is the same in-network or out-of-network. Silver Rx Plan has an annual \$155 Part B deductible which is generally paid for those who have Medicaid.

(1) You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.

(2) If you are in a Long Term Care Facility, you pay \$0 for your prescription drugs.

(3) Prior authorization required.

(4) Plan covers 60 lifetime reserve days. Lifetime reserve days can only be used once.

(5) A reimbursable out-of-network benefit amount applies for non-network providers. Contact plan for details.

Benefits	What You Pay with Gold Rx Plan
Monthly Plan Premium	\$0 ⁽¹⁾
Annual Out-Of-Pocket Maximum	\$3,400
Retail Pharmacy (30-Day Supply)	\$4-Generic; \$45-Brand (preferred); \$95-Brand (non-preferred); 33% Specialty
Inpatient Hospital	NO deductible; Days 1-10: \$225 ⁽²⁾ ; Days 11-90: \$0 ⁽²⁾ ; Days 91-150: \$0 ⁽²⁾⁽³⁾
Primary Care Physician Visit/ Specialist Visit	\$15 copayment/ \$35 copayment
Emergency Care	\$50 copayment; Worldwide coverage
Durable Medical Equipment (DME)	20% coinsurance for Medicare-covered items – in-network ⁽²⁾ 40% coinsurance for Medicare-covered items – out-of-network ⁽²⁾
Diabetes Self-Monitoring and Supplies	\$0 copayment
Preventive Healthcare Services	\$0 copayment
Podiatry	\$35 copayment for each Medicare-covered visit; \$0 copayment for each routine visit, up to 6 visits per year
Transportation	\$0 copayment for 12 one-way trips to plan-approved locations per year ⁽²⁾⁽⁴⁾
Vision (includes glasses and contact lenses)	\$35 for Medicare-covered benefits; \$10 copayment for routine eye exam \$0 copayment; \$150 annually towards eyewear
Dental Care	\$0 copayment for Medicare-covered benefits \$10 copayment for a routine preventive office visit \$0 copayment for denture adjustments (any 2 of the 4 denture adjustments per year)
Over-The-Counter drugs and other products	Not covered

Cost sharing is the same in-network or out-of-network except for Home Health and Durable Medical Equipment.

(1) You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.

(2) Prior authorization required.

(3) Plan covers 60 lifetime reserve days. Lifetime reserve days can only be used once.

(4) A reimbursable out-of-network benefit amount applies for non-network providers. Contact plan for details.

Benefits	What You Pay With the Gold Rx Advantage Plan if you <u>don't</u> have LIS assistance	What You Pay With the Gold Rx Advantage Plan if you <u>have</u> LIS assistance
Monthly Plan Premium	\$12 ⁽¹⁾	As low as \$0 ⁽¹⁾ depending on your level of LIS
Annual Out-Of-Pocket Maximum	\$3,400	\$3,400
Retail Pharmacy (30-Day Supply)	\$4-Generic; \$45-Brand (preferred); \$95-Brand (non-preferred); 33% Specialty	\$0/\$1.10/\$2.50/15% for Generic and \$0/\$3.30/\$6.30/15% for all other drugs.
Inpatient Hospital	NO deductible; Days 1-10: \$220 ⁽²⁾ ; Days 11-90: \$0 ⁽²⁾ ; Days 91-150: \$0 ⁽²⁾⁽³⁾	NO deductible; Days 1-10: \$220 ⁽²⁾ ; Days 11-90: \$0 ⁽²⁾ ; Days 91-150: \$0 ⁽²⁾⁽³⁾
Primary Care Physician Visit/ Specialist Visit	\$10 copayment/ \$25 copayment	\$10 copayment/ \$25 copayment
Emergency Care	\$50 copayment Worldwide coverage	\$50 copayment Worldwide coverage
Durable Medical Equipment (DME)	20% coinsurance for Medicare-covered items – in-network ⁽²⁾ 40% coinsurance for Medicare-covered items – out-of-network ⁽²⁾	20% coinsurance for Medicare-covered items – in-network ⁽²⁾ 40% coinsurance for Medicare-covered items – out-of-network ⁽²⁾
Diabetes Self-Monitoring and Supplies	\$0 copayment	\$0 copayment
Preventive Healthcare Services	\$0 copayment	\$0 copayment
Podiatry	\$30 copayment for each Medicare-covered visit \$0 copayment for each routine visit, up to 6 visits per year	\$30 copayment for each Medicare-covered visit \$0 copayment for each routine visit, up to 6 visits per year
Transportation	\$0 copayment for 12 one-way trips to plan-approved locations per year ⁽²⁾⁽⁴⁾	\$0 copayment for 12 one-way trips to plan-approved locations per year ⁽²⁾⁽⁴⁾
Vision (includes glasses and contact lenses)	\$10 for Medicare-covered benefits \$10 copayment for routine eye exam; \$0 copayment; \$150 annually towards eyewear	\$10 for Medicare-covered benefits \$10 copayment for routine eye exam; \$0 copayment; \$150 annually towards eyewear
Dental Care	\$0 copayment for Medicare-covered benefits \$10 copayment for a routine preventive office visit \$0 copayment for denture adjustments (any 2 of the 4 denture adjustments per year)	\$0 copayment for Medicare-covered benefits \$10 copayment for a routine preventive office visit \$0 copayment for denture adjustments (any 2 of the 4 denture adjustments per year)
Over-The-Counter drugs and other products	Not covered	Not covered

Cost sharing is the same in-network or out-of-network except for Home Health and Durable Medical Equipment.

(1) You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.

(2) Prior authorization required.

(3) Plan covers 60 lifetime reserve days. Lifetime reserve days can only be used once.

(4) A reimbursable out-of-network benefit amount applies for non-network providers. Contact plan for details.