

Benefits	What You Pay With Original Medicare	What You Pay With Our Gold Rx Plan
<b>Monthly Plan Premium</b>	You pay the Medicare Part B premium of \$96.40 <sup>(1)</sup>	<b>\$74<sup>(1)</sup></b>
<b>Annual Out-Of-Pocket Maximum</b>	There is no maximum.	\$3,400
<b>Retail Pharmacy (30-Day Supply)</b>	You pay 100% for most prescription drugs unless you enroll in a Medicare Part D Prescription Drug program <sup>(2)</sup>	\$9-Generic; \$37-Brand (preferred); \$95-Brand (non-preferred); 30% Specialty
<b>Inpatient Hospital</b>	\$1,100 deductible for each benefit period Days 1-60: \$0 Days 61-90: \$275 per day Days 91-150: \$550 per lifetime reserve day <sup>(3)</sup>	NO deductible; Days 1-10: \$245 <sup>(2)</sup> ; Days 11-90: \$0 <sup>(2)</sup> ; Days 91-150: \$0 <sup>(2)(3)</sup>
<b>Primary Care Physician Visit/Specialist Visit</b>	20% coinsurance/ 20% coinsurance	\$30 copayment/ \$45 copayment
<b>Emergency Care</b>	20% coinsurance	\$50 copayment; Worldwide coverage
<b>Durable Medical Equipment (DME)</b>	You pay 20% coinsurance for Medicare-approved amounts	35% of the cost for Medicare-covered items
<b>Diabetes Self-Monitoring and Supplies</b>	You pay 20% coinsurance for Medicare-approved amounts	\$0 copayment
<b>Preventive Healthcare Services</b>	You pay 20% coinsurance for Medicare-approved amounts	\$0 copayment
<b>Podiatry</b>	You pay 20% coinsurance for medically necessary foot care Routine care not covered	\$45 copayment for each Medicare-covered visit; \$0 copayment for each routine visit, up to 6 visits per year
<b>Transportation</b>	Not covered	\$0 copayment for 12 one-way trips to plan-approved locations per year <sup>(2)(4)</sup>
<b>Vision (includes glasses and contact lenses)</b>	You pay 20% coinsurance for Medicare-approved amounts Routine eye exams not covered Medicare pays for 1 pair of eyeglasses or contact lenses after cataract surgery	\$45 for Medicare-covered benefits; \$25 copayment for routine eye exam \$0 copayment; \$150 annually towards eyewear
<b>Dental Care</b>	You pay 20% coinsurance for Medicare-approved amounts Routine dental not covered Dentures not covered	\$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)

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.