2018 Summary of Benefits

BlueMedicare Classic (HMO) H1026-057
BlueMedicare Classic Plus (HMO) H1026-059

Hernando, Hillsborough, Pasco and Polk

HMO coverage is offered by Health Options, Inc., DBA Florida Blue HMO, an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

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BlueMedicare Classic (HMO) and BlueMedicare Classic Plus (HMO)

Summary of Benefits

January 1, 2018 - December 31, 2018

This booklet provides a summary of what BlueMedicare Classic (HMO) and BlueMedicare Classic Plus (HMO) cover. It also explains what you pay for covered services and supplies. To get a complete list of services we cover, contact your local agent or call our Customer Service Department. You may also view the “Evidence of Coverage” for these plans on our website, **www.BlueMedicareFL.com.** The Evidence of Coverage includes a complete list of services we cover.

Things to Know About BlueMedicare Classic (HMO) and BlueMedicare Classic Plus (HMO)

Eligibility requirements

To join, you must:

- be entitled to Medicare Part A; and
- be enrolled in Medicare Part B; and
- live in our service area.

Our service area includes the following counties in Florida: Hernando, Hillsborough, Pasco and Polk (Classic) or Polk (Classic Plus).

Which doctors, hospitals, and pharmacies can I use?

We have a network of doctors, hospitals and other providers. In most cases, you must receive care from network providers. Your plan generally does not cover care you receive from out-of-network providers. There are three exceptions to this requirement:

- We cover emergency care and urgently needed services you receive from out-of-network providers.
- If providers in our network cannot provide a type of Medicare-covered care you need, we will cover the care if you receive it from an out-of-network provider. You must receive approval from our plan before seeking care from an out-of-network provider in this situation.
- We will cover care you receive at an out-of-network Medicare-certified dialysis facility.

In most situations, you must use our network pharmacies to fill your prescriptions for covered Part D drugs. You may save money by using a **preferred** retail pharmacy instead of a **standard** one. You can also use our mail order pharmacy to have your prescription delivered to your home.

Find doctors, pharmacies and our comprehensive formulary (list of covered Part D drugs) on our website, **www.BlueMedicareFL.com.**

What do we cover?

Our plan includes *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 Medicare Part D drugs. In addition, we cover drugs covered under Medicare Part B, such as chemotherapy drugs and certain other drugs your doctor gives you.

Hours of Operation

From October 1 to February14 we’re open 8 a.m. – 8 p.m. local time, 7 days a week.

From February 15 to September 30 we’re open 8 a.m. – 8 p.m. local time, Monday through Friday.

Phone Numbers and Website

If you are a current member of one of these plans, call 1-800-926-6565

If you are not currently a member of one of these plans, call 1-855-601-9465

TTY users: Call 1-800-955-8770

Our website: **www.BlueMedicareFL.com**

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.

This document is available in other formats such as Braille and large print.

This information is available for free in other languages. Please call our Member Services number at 1-800-926-6565. (TTY users should call 1-800-955-8770.) Hours are 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 to February 14, except for Thanksgiving and Christmas. From February 15th to September 30th, we are open Monday - Friday, 8:00 a.m. – 8:00 p.m., local time.

Esta información está disponible de manera gratuita en otros idiomas. Comuníquese con Atención al cliente al 1-800-926-6565. (Usuarios de equipo telescritor TTY llamen al 1-877-955-8773.) Estamos abiertos de 8:00 a.m. a 8:00 p.m. hora local los siete días de la semana, desde el 1 de octubre hasta el 14 de febrero, excepto el día de Acción de Gracias (Thanksgiving) y el día de Navidad. Desde el 15 de febrero al 30 de septiembre, estamos abiertos de lunes a viernes de 8:00 a.m. a 8:00 p.m. hora local.

Florida Blue HMO is an HMO plan with a Medicare contract. Enrollment in Florida Blue HMO depends on contract renewal.

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 1 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.

Premiums and Benefits	BlueMedicare Classic (HMO)	BlueMedicare Classic Plus (HMO)
Monthly Plan Premium	You pay $0.00 per month. You must continue to pay your Medicare Part B premium.	You pay $0.00 per month. You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: $6,500 for services from in-network providers. If you reach the limit on out-of-pocket costs, we will pay the full cost of covered medical services and supplies for the rest of the year. **Note:** (*Amounts you pay for Part D drugs and dental, hearing and vision services not covered under Medicare Part A or Part B do not count toward your out-of-pocket maximum.)*	Your yearly limit(s) in this plan: $5,800 for services from in-network providers. If you reach the limit on out-of-pocket costs, we will pay the full cost of covered medical services and supplies for the rest of the year. **Note:** (*Amounts you pay for Part D drugs and dental, hearing and vision services not covered under Medicare Part A or Part B do not count toward your out-of-pocket maximum.)*
Inpatient Hospital Coverage	***Prior Authorization is required for non-emergency Inpatient Hospital stays.*** • Days 1-7: $225 copay per day • After day 7: You pay nothing	***Prior Authorization is required for non-emergency Inpatient Hospital stays.*** • Days 1-7: $150 copay per day • After day 7: You pay nothing
Outpatient Hospital Coverage	Up to a $150 copay. Please call us or see the plan's Evidence of Coverage for specific cost-sharing for services received in an outpatient hospital setting.	Up to a $100 copay. Please call us or see the plan's Evidence of Coverage for specific cost-sharing for services received in an outpatient hospital setting.
Doctor Visits	• You pay nothing per primary care visit • $40 copay per specialist[1] visit	• You pay nothing per primary care visit • $25 copay per specialist[1] visit
Preventive Care	You pay nothing. Covered preventive services include: • Alcohol misuse screening and counseling • Annual "Wellness" visit • Bone mass measurements • Cardiovascular disease screening tests • Colorectal cancer screening • Counseling to prevent Tobacco use	You pay nothing. Covered preventive services include: • Alcohol misuse screening and counseling • Annual "Wellness" visit • Bone mass measurements • Cardiovascular disease screening tests • Colorectal cancer screening • Counseling to prevent Tobacco use

Services marked with a [1] may require approval in advance (a referral) from your Primary Care Provider (PCP) in order for the plan to cover them. If you do not get a referral for these services, you may have to pay the full cost of them.

Premiums and Benefits	Blue Medicare Classic (HMO)	Blue Medicare Classic Plus (HMO)
Preventive Care *(continued)*	• Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma screening • Hepatitis B Virus screening • Hepatitis B Virus vaccine and administration • Hepatitis C Virus screening • Human Immunodeficiency Virus screening • Influenza virus vaccine and administration • Initial preventive physical examination • Intensive behavioral therapy for cardiovascular disease • Intensive behavioral therapy for obesity • Lung cancer screening • Medical nutrition therapy • Pneumococcal vaccine and administration • Prostate cancer screening • Screening for Cervical Cancer with human Papillomavirus tests • Screening for sexually transmitted infections (STIs) and HIBC to prevent STIs • Screening mammography • Screening pap tests • Screening pelvic examinations • Ultrasound screening abdominal aortic aneurysm Any additional preventive services approved by Medicare during the contract year will be covered.	• Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma screening • Hepatitis B Virus screening • Hepatitis B Virus vaccine and administration • Hepatitis C Virus screening • Human Immunodeficiency Virus screening • Influenza virus vaccine and administration • Initial preventive physical examination • Intensive behavioral therapy for cardiovascular disease • Intensive behavioral therapy for obesity • Lung cancer screening • Medical nutrition therapy • Pneumococcal vaccine and administration • Prostate cancer screening • Screening for Cervical Cancer with human Papillomavirus tests • Screening for sexually transmitted infections (STIs) and HIBC to prevent STIs • Screening mammography • Screening pap tests • Screening pelvic examinations • Ultrasound screening abdominal aortic aneurysm Any additional preventive services approved by Medicare during the contract year will be covered.

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Premiums and Benefits	BlueMedicare Classic (HMO)	BlueMedicare Classic Plus (HMO)
Emergency Care	**Medicare Covered Emergency Care** $80 copay per visit If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. **Additional Emergency Care Services** Worldwide Emergency Care $80 copay Emergency coverage is provided worldwide. **Worldwide emergency coverage does not include emergency transportation.** If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.	**Medicare Covered Emergency Care** $80 copay per visit If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. **Additional Emergency Care Services** Worldwide Emergency Care $125 copay Emergency coverage is provided worldwide. **Worldwide emergency coverage does not include emergency transportation.** If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	**Medicare Covered Urgently Needed Services** • $10 copay at a Convenient Care Center • $50 copay at an Urgent Care Center **Additional Urgently Needed Services** Worldwide Urgently Needed Services $80 copay Emergency coverage is provided worldwide. **Worldwide emergency coverage does not include emergency transportation.**	**Medicare Covered Urgently Needed Services** • $10 copay at a Convenient Care Center • $30 copay at an Urgent Care Center **Additional Urgently Needed Services** Worldwide Urgently Needed Services $125 copay Emergency coverage is provided worldwide. **Worldwide emergency coverage does not include emergency transportation.**

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Premiums and Benefits	BlueMedicare Classic (HMO)	BlueMedicare Classic Plus (HMO)
Diagnostic Services/Labs/ Imaging[1]	***Prior Authorization is required for certain services. Call Member Services for additional information.*** **Laboratory Services** • You pay nothing at an Independent Clinical Laboratory. • $35 copay at an outpatient hospital facility **X-Rays** • $25 copay at an Independent Diagnostic Testing Facility (IDTF) • $250 copay at an outpatient hospital facility **Advanced Imaging Services** (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan) • $75 copay at a specialist's office • $75 copay at an IDTF • $250 copay at an outpatient hospital facility **Radiation Therapy** 20% coinsurance	***Prior Authorization is required for certain services. Call Member Services for additional information.*** **Laboratory Services** • You pay nothing at an Independent Clinical Laboratory. • You pay nothing at an outpatient hospital facility **X-Rays** • $0 copay at an Independent Diagnostic Testing Facility (IDTF) • $120 copay at an outpatient hospital facility **Advanced Imaging Services** (e.g., Magnetic Resonance Imaging [MRI], Positron Emission Tomography [PET], Computer Tomography [CT] Scan) • $25 copay at a specialist's office • $25 copay at an IDTF • $150 copay at an outpatient hospital facility **Radiation Therapy** 20% coinsurance
Hearing Services	**Medicare-Covered Hearing Services[1]** Exams to diagnose and treat hearing and balance issues: $40 copay **Routine Hearing Services** • You pay nothing for 1 routine hearing exam per year. • Up to 2 hearing aids per year for either a $699 or $999 copay per aid. • $0 copay for one evaluation and fitting of hearing aids per year.	**Medicare-Covered Hearing Services[1]** Exams to diagnose and treat hearing and balance issues: $25 copay **Routine Hearing Services** • You pay nothing for 1 routine hearing exam per year. • $1,000 allowance every year towards the purchase of hearing devices. • $0 copay for one evaluation and fitting of hearing aids per year.

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Premiums and Benefits	BlueMedicare Classic (HMO)	BlueMedicare Classic Plus (HMO)
Dental Services	***Prior authorization is required for Medicare-covered comprehensive dental services.*** **Medicare-Covered Dental Services** (non-routine dental care such as setting fractures of the jaw or facial bones, jaw surgery, extraction of teeth to prepare for radiation therapy, services covered when provided by a physician) $40 copay **Additional Dental Services** Cleanings, oral exams, X-rays, extraction of erupted tooth or exposed root, adjustment of complete or partial denture You pay nothing.	***Prior authorization is required for Medicare-covered comprehensive dental services.*** **Medicare-Covered Dental Services** (non-routine dental care such as setting fractures of the jaw or facial bones, jaw surgery, extraction of teeth to prepare for radiation therapy, services covered when provided by a physician) $25 copay **Additional Dental Services** • Cleanings, Denture Adjustments, Oral Exams, X-rays. You pay nothing. • Dentures. You pay $296-$420 copay • Denture Repairs. You pay $21-$59 copay • Extractions. You pay $17-72 copay • Restorative services. You pay $15-$38 copay. • Root Planing. You pay $34-$61 copay.
Vision Services	• **Prior authorization is required for Medicare-covered vision care. Please call Member Services for additional information.**[1] • $40 copay for physician services to diagnose and treat eye diseases and conditions • You pay nothing for glaucoma screening (once per year for members at high risk of glaucoma). • You pay nothing for one diabetic retinal exam per year. • You pay nothing for one pair of eyeglasses or contact lenses after each cataract surgery. **Additional Vision Services** • You pay nothing for annual routine eye examination. • $100 allowance per year towards the purchase of lenses, frames or contact lenses.	• **Prior authorization is required for Medicare-covered vision care. Please call Member Services for additional information.**[1] • $25 copay for physician services to diagnose and treat eye diseases and conditions • You pay nothing for glaucoma screening (once per year for members at high risk of glaucoma). • You pay nothing for one diabetic retinal exam per year. • You pay nothing for one pair of eyeglasses or contact lenses after each cataract surgery. **Additional Vision Services** • You pay nothing for annual routine eye examination. • $200 allowance per year towards the purchase of lenses, frames or contact lenses.

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Premiums and Benefits	BlueMedicare Classic (HMO)	BlueMedicare Classic Plus (HMO)
Mental Health Services	***Prior authorization is required for non-emergency services.*** **Inpatient Mental Health Services** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental health services provided in a general hospital. • Days 1-5: $300 copay per day • Days 6-90: You pay nothing. ***Prior authorization is required for non-emergency services.*** **Outpatient Mental Health Services** $40 copay	***Prior authorization is required for non-emergency services.*** **Inpatient Mental Health Services** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental health services provided in a general hospital. • Days 1-5: $275 copay per day • Days 6-90: You pay nothing. ***Prior authorization is required for non-emergency services.*** **Outpatient Mental Health Services** $40 copay
Skilled Nursing Facility (SNF)	***Prior authorization is required for SNF stays.*** Our plan covers up to 100 days in a SNF per benefit period. • Days 1-20: You pay nothing. • Days 21-100: $160 copay per day	***Prior authorization is required for SNF stays.*** Our plan covers up to 100 days in a SNF per benefit period. • Days 1-20: You pay nothing. • Days 21-100: $150 copay per day
Physical Therapy[1]	***Prior authorization is required for all therapy services.*** Occupational, physical therapy and speech and language therapy visits • $40 copay for services received in a specialist's office, free-standing facility or an outpatient hospital facility A $1,980 yearly Medicare limit applies to outpatient physical and speech therapy services. This limit is for 2017 and may change in 2018. A separate $1,980 yearly Medicare limit applies to outpatient occupational therapy services. This limit is for 2017 and may change in 2018.	***Prior authorization is required for all therapy services.*** Occupational, physical therapy and speech and language therapy visits • $30 copay for services received in a specialist's office, free-standing facility or an outpatient hospital facility A $1,980 yearly Medicare limit applies to outpatient physical and speech therapy services. This limit is for 2017 and may change in 2018. A separate $1,980 yearly Medicare limit applies to outpatient occupational therapy services. This limit is for 2017 and may change in 2018.
Ambulance	***Prior authorization is required for non-emergency ambulance services.*** In- and Out-of-Network $250 copay for each Medicare-covered trip (one-way)	***Prior authorization is required for non-emergency ambulance services.*** In- and Out-of-Network $250 copay for each Medicare-covered trip (one-way)

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Premiums and Benefits	BlueMedicare Classic (HMO)	BlueMedicare Classic Plus (HMO)
Transportation (Routine)	Not covered	24 one-way trips per year to plan-approved medical and pharmacy locations
Medicare Part B Drugs	***Prior authorization is required for Medicare Part B-covered prescription drugs except for allergy injections.*** • $5 copay for allergy injections • 20% coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs	***Prior authorization is required for Medicare Part B-covered prescription drugs except for allergy injections.*** • $5 copay for allergy injections • 20% coinsurance for chemotherapy drugs and other Medicare Part B-covered drugs
Foot Care *(podiatry services)*	Diagnosis and treatment of injuries and diseases of the feet. Routine care for members with certain conditions affecting the lower limbs. $40 copay	Diagnosis and treatment of injuries and diseases of the feet. Routine care for members with certain conditions affecting the lower limbs. $30 copay
Medical Equipment/ Supplies	***Prior authorization is required for certain equipment/supplies. Call Member Services for additional information.*** **Durable Medical Equipment** • You pay nothing for equipment except motorized wheelchairs and electric scooters. • 20% coinsurance for motorized wheelchairs and electric scooters **Prosthetics** 20% coinsurance **Diabetic Supplies** You pay nothing.	***Prior authorization is required for certain equipment/supplies. Call Member Services for additional information.*** **Durable Medical Equipment** • You pay nothing for equipment except motorized wheelchairs and electric scooters. • 20% coinsurance for motorized wheelchairs and electric scooters **Prosthetics** 20% coinsurance **Diabetic Supplies** You pay nothing.
Wellness Programs	• SilverSneakers® fitness program by Tivity Health. • Diabetes Prevention Program - An evidence-based program designed to delay or prevent participants' progression to type 2 diabetes. You pay nothing to participate in these programs.	• SilverSneakers® fitness program by Tivity Health. • Diabetes Prevention Program - An evidence-based program designed to delay or prevent participants' progression to type 2 diabetes. You pay nothing to participate in these programs.

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Premiums and Benefits	BlueMedicare Classic (HMO)	BlueMedicare Classic Plus (HMO)
Outpatient Surgery	***Prior Authorization is required for certain services. Please call Member Services for additional information.*** • $125 copayment in an ambulatory surgical center • $150 copayment for in an outpatient hospital facility	***Prior Authorization is required for certain services. Please call Member Services for additional information.*** • $50 copayment in an ambulatory surgical center • $100 copayment for in an outpatient hospital facility
Over-the-Counter Items	Not Covered.	$60 quarterly. Unused balances do not roll over to the next quarter.

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<table>
<tr><th>Premiums and Benefits</th><th colspan="4">BlueMedicare Classic (HMO)</th><th colspan="4">BlueMedicare Classic Plus (HMO)</th></tr>
<tr><td colspan="9">Part D Prescription Drug Benefits</td></tr>
<tr><td rowspan="9">Deductible Stage
These plans do not have a deductible.
Initial Coverage Stage
You begin in this stage when you fill your first prescription of the year.
During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.
You remain in this stage until your total yearly drug costs (total drug costs paid by you and any Part D plan) reach $3,750.
You may get your drugs at network retail pharmacies and mail order pharmacies.</td><td colspan="4">Cost-Sharing for a one-month supply (up to 31 days) of a covered Part D prescription drug)</td><td colspan="4">Cost-Sharing for a one-month supply (up to 31 days) of a covered Part D prescription drug)</td></tr>
<tr><td>Tier</td><td>Standard Retail</td><td>Preferred Retail</td><td>Mail Order</td><td>Tier</td><td>Standard Retail</td><td>Preferred Retail</td><td>Mail Order</td></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$14 copay</td><td>$4 copay</td><td>$4 copay</td><td>Tier 1 (Preferred Generic)</td><td>$10 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$20 copay</td><td>$13 copay</td><td>$13 copay</td><td>Tier 2 (Generic)</td><td>$11 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$40 copay</td><td>$40 copay</td><td>Tier 3 (Preferred Brand)</td><td>$45 copay</td><td>$35 copay</td><td>$35 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Brand)</td><td>$100 copay</td><td>$93 copay</td><td>$93 copay</td><td>Tier 4 (Non-Preferred Brand)</td><td>$90 copay</td><td>$80 copay</td><td>$80 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% of the cost</td><td>33% of the cost</td><td>33% of the cost</td><td>Tier 5 (Specialty Tier)</td><td>33% of the cost</td><td>33% of the cost</td><td>33% of the cost</td></tr>
<tr><td>Tier 6 (Select Care Drugs)</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td><td>Tier 6 (Select Care Drugs)</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td colspan="4">The cost-sharing information shown above is for a one-month supply of a covered Part D prescription drug purchased at a retail pharmacy (standard and preferred) and through our mail order pharmacy. Your cost-sharing may be different if you use a Long Term Care pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug. Please call us or see the plan’s “Evidence of Coverage” on our website (www.BlueMedicareFL.com) for complete information about your costs for covered drugs.</td><td colspan="4">The cost-sharing information shown above is for a one-month supply of a covered Part D prescription drug purchased at a retail pharmacy (standard and preferred) and through our mail order pharmacy. Your cost-sharing may be different if you use a Long Term Care pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug. Please call us or see the plan’s “Evidence of Coverage” on our website (www.BlueMedicareFL.com) for complete information about your costs for covered drugs.</td></tr>
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Premiums and Benefits	BlueMedicare Classic (HMO)	BlueMedicare Classic Plus (HMO)
Coverage Gap Stage	The Coverage Gap Stage begins after total yearly drug costs (what any Part D plan has paid and what you have paid) reach $3,750. During the Coverage Gap Stage: • **For generic drugs in Tier 1 (Preferred Generics), Tier 2 (Generics) and Tier 6 (Select Care Drugs)** you pay the same copays that you paid in the Initial Coverage Stage – or 44% of the cost, whichever is lower. • For generic drugs in all other tiers, you pay 44% of the price. • For brand-name drugs, you pay 35% of the cost (plus a portion of the dispensing fee) You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $5,000.	The Coverage Gap Stage begins after total yearly drug costs (what any Part D plan has paid and what you have paid) reach $3,750. During the Coverage Gap Stage: • **For generic drugs in Tier 1 (Preferred Generics), Tier 2 (Generics) and Tier 6 (Select Care Drugs)** you pay the same copays that you paid in the Initial Coverage Stage – or 44% of the cost, whichever is lower. • For generic drugs in all other tiers, you pay 44% of the cost. • For brand-name drugs, you pay 35% of the cost (plus a portion of the dispensing fee) You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $5,000.
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs 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	After your yearly out-of-pocket drug costs 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

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