COMPARISON OF BENEFITS FOR THE MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS

MAPD PPO plans

All benefits are based on Medicare-covered services

Services	BCBSOK – MAPD	Humana MAPD PPO
Hospitalization Semiprivate room (private room if medically necessary) Nursing services, medications and all meals Laboratory tests, X-rays and other radiology services Inpatient physician and surgical services, including anesthesia Necessary medical supplies and appliances Blood and its administration Operating room, special care units and rehabilitation services	You pay $0	You pay $0
Organ Transplants Must be performed in a Medicare-approved transplant facility	You pay $0	You pay $0
Skilled Nursing Facility (Inpatient Services) Semiprivate room, regular nursing services and all meals Physical, occupational and speech therapy Drugs and necessary medical equipment and supplies furnished by the facility Blood and its administration Inpatient radiology and pathology Use of appliances such as wheelchairs	You pay $0	You pay $0

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Services	BCBSOK – MAPD	Humana MAPD PPO
Outpatient Hospital Services Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility	You pay $0	You pay $0 after $175 deductible
Urgent Care Services Urgently needed services worldwide	You pay $0	You pay $0 If you have lab services, you pay $0 after $175 deductible This would not apply to worldwide services
Emergency Services Emergency services needed worldwide	You pay $0	You pay $0
Ambulance Services When medically necessary	You pay $0	You pay $0 after $175 deductible
Professional Services Office visit Consultation, diagnosis and treatment by a specialist Medical and surgical care Allergy tests and treatment (serum) Diagnostic tests and treatment Medical supplies including casts, dressings and splints	You pay $0	You pay $0 after $175 deductible
Physical, Occupational and Speech Therapy Services	You pay $0	You pay $0 after $175 deductible
Laboratory Services	You pay $0	You pay $0 after $175 deductible
X-Ray/Diagnostic Radiology	You pay $0	You pay $0 after $175 deductible
Hearing Examinations	You pay $0	You pay $0 for Medicare covered services after $175 deductible
Chiropractic Limited to manual manipulation of the spine as medically necessary	You pay $0	You pay $0 for Medicare covered services after $175 deductible

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Services	BCBSOK – MAPD	Humana MAPD PPO
Part-Time or Intermittent Skilled Nursing Care Home health aide in conjunction with skilled care, physical, speech and occupational therapy Medical supplies and equipment (excluding medications) provided by the agency	You pay $0	You pay $0 for Part A services and $0 after $175 deductible for Part B services
Durable Medical Equipment Durable medical equipment and supplies Prosthetic devices Therapeutic shoes/inserts for severe diabetes	You pay $0	You pay $0 for Medicare covered services after $175 deductible
Bariatric Surgery	You pay $0	You pay $0
National Diabetes Prevention Program	You pay $0	You pay $0
Telehealth/Telemedicine	You pay $0	In-Network: PCP, Specialist, Behavioral Health & Substance Abuse, Urgently Needed Care You pay $0 Out-of-Network: N/A

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Medicare preventive services

The MAPD PPO plans cover many Part B preventive services, such as your annual flu vaccination, wellness visit and screening mammogram, at 100% when you use a doctor or other health care provider who is a Medicare-eligible provider.

For your plan to cover preventive services, you must follow the guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of preventive services as governed by Medicare go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2024 Medicare & You handbook.

Pharmacy copay structure for Part D network benefits

General information	BCBSOK – MAPD	
This plan uses a formulary Some drugs require prior authorization. Quantity limits and step therapy apply to certain drugs Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before changes are made to your plan's formulary	**Preferred Pharmacy***	**Standard Pharmacy**
	30-Day Supply	**30-Day Supply**
	$5 copay Tier 1	$12 copay Tier 1
	$15 copay Tier 2	$22 copay Tier 2
	$40 copay Tier 3	$47 copay Tier 3
	$90 copay Tier 4	$97 copay Tier 4
	Insulin - No more than $35 copay	Insulin - No more than $35 copay
	Specialty Tier 5	Specialty Tier 5
	33% coinsurance to **$5,030**	33% coinsurance to **$5,030**
	15% coinsurance to **$8,000** TrOOP	15% coinsurance to **$8,000** TrOOP
	60- or 90-Day Supply	**60- or 90-Day Supply**
	$10 copay Tier 1 (60 day)	$24 copay Tier 1 (60 day)
	$15 copay Tier 1 (90 day)	$36 copay Tier 1 (90 day)
	$30 copay Tier 2 (60 day)	$44 copay Tier 2 (60 day)
	$45 copay Tier 2 (90 day)	$66 copay Tier 2 (90 day)
	$80 copay Tier 3 (60 day)	$94 copay Tier 3 (60 day)
	$120 copay Tier 3 (90 day)	$141 copay Tier 3 (90 day)
	$180 copay Tier 4 (60 day)	$194 copay Tier 4 (60 day)
	$270 copay Tier 4 (90 day)	$291 copay Tier 4 (90 day)
	Tier 5	Tier 5
	33% coinsurance to **$5,030**, then	33% coinsurance to **$5,030**, then
	15% Coinsurance to **$8,000** TrOOP	15% Coinsurance to **$8,000** TrOOP
	Coinsurance applies at both Preferred and Standard pharmacy	Coinsurance applies at both Preferred and Standard pharmacy
	Pharmacy MOOP – **$8,000**	Pharmacy MOOP – **$8,000**
	*Preferred pharmacies include but are not limited to Walgreens, Walmart and other independent pharmacies as indicated in the provider directory.	

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Pharmacy copay structure for Part D network benefits

General information	Humana MAPD PPO
This plan uses a formulary Some drugs require prior authorization Quantity limits and step therapy apply to certain drugs Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before changes are made to your plan's formulary	**Pharmacy Deductible** No Pharmacy Deductible **30-Day Supply** $5 copay Tier 1 Generic or Preferred Generic $45 copay Tier 2 Preferred Brand $75 copay Tier 3 Non-Preferred Brand $100 copay Tier 4 Specialty $0 copay Buproban, Nicotrol, Chantix and generic statins Insulin – No more than $35 copay **90-Day Supply** $10 copay Tier 1 $90 copay Tier 2 $150 copay Tier 3 N/A Tier 4 (30-Day Only) $0 copay Buproban, Nicotrol, Chantix and generic statins **Catastrophic Coverage** **Member pays $0 in the Catastrophic Coverage phase.** Maximum out-of-pocket **$8,000**

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

MAPD HMO plans

All benefits are based on Medicare-covered services

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
Hospitalization Semiprivate room (private room if medically necessary) Nursing services and medications Laboratory tests, X-rays and other radiology services Inpatient physician and surgical services, including anesthesia Necessary medical supplies and appliances Blood and its administration Operating room, special care units and rehabilitation services	$50 copay each day for days 1-5 $0 copay each day for days 6 and beyond for a Medicare-covered stay in a network hospital Prior authorization required, except in an emergency You are covered for unlimited days each benefit period. A benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row. Copays apply for each admission	$50/day – days 1-5 $0 – days 6-90 per admission You are covered for unlimited days each benefit period Prior authorization required, except in an emergency
Organ Transplants Cornea, heart, heart-lung, kidney, liver, lung, bone marrow, intestinal and multivisceral, pancreas and stem cell Must be performed in a Medicare-approved transplant facility	$50 copay each day for days 1-5 $0 copay each day for days 6 and beyond Prior authorization required	$50/day – days 1-5 $0 – days 6-90 per admission You are covered for unlimited days each benefit period Prior authorization required, except in an emergency
Outpatient Hospital Services Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility	$0 copay for each visit Prior authorization required	$0 copay per surgery in an ambulatory surgery center $200 copay per surgery in an outpatient hospital
Radiation therapy	$0 copay Prior authorization required	$40 copay
Blood	$0 copay	$0 copay

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
In-Area Urgent Care Services	$10 copay for each visit	$15 copay for each visit
Out-of-Area Urgent Care Services During a temporary absence from service area	$10 copay for each visit worldwide	$15 copay for each visit within the U.S.
Emergency Services	$90 copay for each Medicare-covered visit worldwide Waived if admitted inpatient to hospital within 48 hours for same condition	$75 copay for each visit nationwide; all-inclusive Waived if admitted inpatient to hospital or for outpatient surgery within 24 hours for same condition
Ambulance Services Medically necessary services as covered by Medicare	$50 copay Waived if admitted inpatient to hospital	$50 copay Waived if admitted inpatient to hospital
Skilled Nursing Facility (Inpatient Services) Semiprivate room and regular nursing services Physical, occupational and speech therapy Drugs and necessary medical equipment and supplies furnished by facility Blood and its administration Inpatient radiology and pathology Use of appliances such as wheelchairs	$0 copay for days 1-20 $100 copay for days 21-100 for each benefit period No prior hospital stay required Prior authorization required All services listed at left are inclusively covered under the skilled nursing facility copayment	$0 copay per day for days 1-20 $184 copay for days 21-100 No prior hospital stay required Prior authorization required All services listed at left are inclusively covered under the skilled nursing facility copayment

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
Professional Services Office visit Consultation, diagnosis and treatment by a specialist Medical and surgical care Allergy tests and treatment (serum) Diagnostic tests and treatment Medical supplies including casts, dressings and splints	$0 copay for each PCP visit $10 copay for each specialist visit	$0 copay for each PCP visit $20 copay for each specialist visit
X-Ray/Diagnostic Radiology Services	$0 copay	$0 copay
Laboratory Services	$0 copay for each diagnostic procedure and test Prior authorization may apply	$0 copay
Physical, Occupational and Speech Therapy Services	$0 copay for each visit Prior authorization required	$20 copay for each visit Prior authorization required
Hearing Examinations	$0 copay for routine hearing tests $0 copay for diagnostic hearing exams **You may be reimbursed for hearing aids using your Wallet Benefit. Annual limits apply.**	$0 copay for each PCP diagnostic evaluation $20 copay for each specialist exam to diagnose and treat hearing and balance issues $500 per year allowance for hearing aids
Chiropractic Limited to manual manipulation of the spine as medically necessary	$10 copay each visit	$20 copay each visit No prior authorization required

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
Part-Time or Intermittent Skilled Nursing Care Home health aide in conjunction with skilled care Physical, speech and occupational therapy Medical supplies and equipment (excluding medications) provided by the agency	$0 copay for Medicare-covered home health visits Prior authorization required	$0 copay for home health visits Prior authorization required
Durable Medical Equipment Durable medical equipment and supplies	$0 to $50 copay or 20% coinsurance for each item Prior authorization required	20% coinsurance for each item Prior authorization required
Prosthetic devices	$0 copay for each device Prior authorization required	$0 if surgically implanted 20% coinsurance per external device Prior authorization required
Therapeutic shoes/inserts for severe diabetes	$0 copay for each orthotic Prior authorization required	$0 for each orthotic Prior authorization required
Bariatric Surgery	Inpatient: $50 copay each day for days 1-5 and $0 copay each day 6 and beyond Outpatient: $0 copay Prior authorization required	$50/day – days 1-5 $0 – days 6-90 inpatient copay. You are covered for unlimited days each benefit period. Prior authorization required
National Diabetes Prevention Program	0% coinsurance/$0 copay	0% coinsurance/$0 copay
Telehealth/Telemedicine	$0 copay for each PCP visit $10 copay for each specialist visit	Covered same as office visit if provider offers Telehealth/ Telemedicine services

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Medicare preventive services

The MAPD HMO plans cover many Part B preventive services, such as your annual flu vaccination, wellness visit and screening mammogram, at 100% when you use a network provider.

For your plan to cover preventive services, you must follow the guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of these preventive services as governed by Medicare go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2024 Medicare & You handbook.

Pharmacy copay structure for Part D network benefits

General information	CommunityCare Senior Health Plan
This plan uses a formulary Some drugs require prior authorization Quantity limits and step therapy apply to certain drugs Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before changes are made to your plan's formulary	30-Day Supply $0 copay Tier 1 preferred generic drugs Up to $10 copay Tier 2 generic drugs Up to $30 copay Tier 3 preferred brand drugs Up to $60 copay Tier 4 non-preferred drugs (including tobacco cessation) 33% coinsurance Tier 5 specialty drugs and certain injectables 90-Day Supply $0 copay Tier 1 preferred generic drugs Up to $20 copay Tier 2 generic drugs Up to $60 copay Tier 3 preferred brand drugs Up to $120 copay Tier 4 non-preferred drugs (including tobacco cessation) 33% coinsurance Tier 5 specialty drugs and certain injectables Mail order is available for up to a 90-day supply **Member pays $0 in the Catastrophic Coverage phase.** Maximum out-of-pocket **$8,000**.

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Pharmacy copay structure for Part D network benefits

General information	Generations by GlobalHealth	
Mandatory generic and brand formulary medications you get at a network pharmacy Some drugs require prior authorization Quantity limits and step therapy apply to certain drugs Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before changes are made to your plan's formulary	**Preferred Retail** 30-Day Supply $0 copay Tier 1 $15 copay Tier 2 $42 copay Tier 3 $95 copay Tier 4 33% coinsurance Tier 5 Insulin – No more than $35 copay 30- to 90-Day Supply $0 copay Tier 1 $0 copay Tier 2 $84 copay Tier 3 $190 copay Tier 4 Not covered Tier 5	**Standard Retail** 30-Day Supply $5 copay Tier 1 $20 copay Tier 2 $47 copay Tier 3 $100 copay Tier 4 33% coinsurance Tier 5 Insulin – No more than $35 copay 30- to 90-Day Supply $15 copay Tier 1 $60 copay Tier 2 $141 copay Tier 3 $300 copay Tier 4 Not covered Tier 5
	Preferred Mail Order 30-Day Supply $0 copay Tier 1 $15 copay Tier 2 $42 copay Tier 3 $95 copay Tier 4 33% coinsurance Tier 5 Insulin – No more than $35 copay 30- to 90-Day Supply $0 copay Tier 1 $0 copay Tier 2 $84 copay Tier 3 $190 copay Tier 4 Not covered Tier 5	**Standard Mail Order** 30-Day Supply $5 copay Tier 1 $20 copay Tier 2 $47 copay Tier 3 $100 copay Tier 4 33% coinsurance Tier 5 Insulin – No more than $35 copay 30- to 90-Day Supply $15 copay Tier 1 $60 copay Tier 2 $141 copay Tier 3 $300 copay Tier 4 Not covered Tier 5
	Member pays $0 in the Catastrophic Coverage phase. Maximum out-of-pocket **$8,000**	

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