

2024 CHP MEDICARE PLAN SUMMARY COMPARISON

(Reflects Member's Responsibility)

MEDICARE PARTS A AND B MEDICAL COVERAGE												
PLAN NAME	PREMIUM PLANS AT A GLANCE				PLUS PLANS AT A GLANCE				BASIC PLANS AT A GLANCE			
MONTHLY COST PER PERSON	\$235.00		\$490.40		\$202.00		\$420.40		\$72.00		\$219.40	
MEDICARE PLAN TYPE	Advantage		Supplemental		Advantage		Supplemental		Advantage Plan		Supplemental	
INSURED BY	Humana, Inc.		The Hartford		Humana, Inc.		The Hartford		Humana, Inc.		The Hartford	
ANNUAL MEDICAL DEDUCTIBLE	\$50		\$240		\$50		\$240		\$50		\$240	
ANNUAL MEDICAL OUT-OF-POCKET MAXIMUM (OOP MAX)	\$500 then \$0 (incl. all Medical costs you pay)		\$240 then \$0 (incl. all Medical costs you pay)		\$500 then \$0 (incl. all Medical costs you pay)		\$500 then \$0 (incl. all Medical costs you pay)		\$500 then \$0 (incl. all Medical costs you pay)		\$2,000 then \$0 (incl. all Medical costs you pay)	
NETWORK REQUIREMENTS	All Medicare Providers (In- and Out-of-Network provisions apply)*		All Medicare Providers		All Medicare Providers (In- and Out-of-Network provisions apply)*		All Medicare Providers		All Medicare Providers (In- and Out-of-Network provisions apply)*		All Medicare Providers	
INPATIENT HOSPITAL	\$0		\$0		\$0		\$0		\$0		\$0	
OUTPATIENT MEDICAL	Copays or Coinsurance to OOP Max, then \$0		\$0 After Deductible		Copays or Coinsurance to OOP Max, then \$0		Copays or Coinsurance to OOP Max, then \$0		Copays or Coinsurance to OOP Max, then \$0		Copays or Coinsurance to OOP Max, then \$0	
SILVER SNEAKERS	Yes		Yes		Yes		Yes		Yes		Yes	
MEDICARE PART D - PRESCRIPTION COVERAGE (included with above)												
PLAN NAME	PREMIUM PLANS AT A GLANCE				PLUS PLANS AT A GLANCE				BASIC PLANS AT A GLANCE			
ANNUAL DEDUCTIBLE	\$0		\$0		\$0		\$0		\$545		\$545	
PHARMACY TYPE	30-Day Retail	90-Day Mail	30-Day Retail	90-Day Mail	30-Day Retail	90-Day Mail	30-Day Retail	90-Day Mail	30-Day Retail	90-Day Mail	30-Day Retail	90-Day Mail
PREFERRED GENERIC	\$15	\$25	\$15	\$25	\$15	\$45	\$15	\$45	\$5	\$5	\$5	\$5
GENERIC TIER	\$15	\$25	\$15	\$25	\$15	\$45	\$15	\$45	\$10	\$10	\$10	\$10
PREFERRED BRAND	\$30	\$60	\$30	\$60	\$40	\$120	\$40	\$120	20%	20%	20%	20%
NON-PREFERRED BRAND	\$60	\$120	\$60	\$120	\$80	\$240	\$80	\$240	45%	45%	45%	45%
SPECIALTY TIER	Same as above	Same as above	Same as above	Same as above	\$100	\$300	\$100	\$300	25%	25%	25%	25%

The above benefit chart illustrates the amount you pay and is for illustrative purposes only. For additional plan details please reference the CHP Guide for Medicare Members located at www.ConcordiaPlans.org/Medicare.

*In some cases an out-of-network provider will not bill Humana. If this occurs, you will need to pay the out-of-network provider and submit the claim to Humana for reimbursement.