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	Ages 65-66 $179.40 Ages 67-69 $192.40 Ages 70+ $219.40
MEDICARE PLAN TYPE	Advantage	Supplemental	Advantage	Supplemental	Advantage	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.