2014 Summary of Benefits

Blue Medicare Advantage Classic (HMO)
Blue Medicare Advantage Plus (HMO)
Blue Medicare Advantage Premier (HMO)

Introduction to the Summary of Benefits Report
for Blue Cross Blue Shield of Arizona Advantage
January 1, 2014 – December 31, 2014
MARICOPA COUNTY AND PART OF PINAL COUNTY

Thank you for your interest in Blue Cross Blue Shield of Arizona Advantage (BCBSAZ Advantage). Our plan is offered by MediSun, Inc. which is also called Blue Cross Blue Shield of Arizona Advantage, a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call BCBSAZ Advantage and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Blue Cross Blue Shield of Arizona Advantage. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call BCBSAZ Advantage at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare BCBSAZ Advantage and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS BCBSAZ ADVANTAGE (HMO) AVAILABLE?

There is more than one plan listed in this Summary of Benefits.
The service area for this plan includes: Maricopa and Pinal* Counties, AZ. Only the following zip codes in Pinal County are included – 85117, 85118, 85119, 85120, 85140, 85142, 85143, 85178, 85217, 85218, 85219, 85220, 85240 and 85243. You must live in one of these areas to join the plan.

* denotes partial county

WHO IS ELIGIBLE TO JOIN BCBSAZ ADVANTAGE?

You can join BCBSAZ Advantage if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in BCBSAZ unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

BCBSAZ Advantage has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at www.AZBlueMedicare.com. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither the plan nor the Original Medicare Plan will pay for these services except in limited situations (for example, emergency care).

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

BCBSAZ Advantage has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.AZBlueMedicare.com. Our customer service number is listed at the end of this introduction.

WHAT IF MY DOCTOR PRESCRIBES LESS THAN A MONTH'S SUPPLY?

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand [and generic] drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

BCBSAZ Advantage does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

BCBSAZ Advantage uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.AZBlueHealthCare.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of BCBSAZ Advantage, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of BCBSAZ Advantage, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact BCBSAZ Advantage for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact BCBSAZ Advantage for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable osteoporosis drugs for some women.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs administered through Durable Medical Equipment.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on http://www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan.

Our customer service number is listed below. Please call BCBSAZ Advantage for more information about BCBSAZ Advantage.

Visit us at www.AZBlueMedicare.com or, call us.
Customer Service Hours for October 1 – February 14.
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. – 8:00 p.m. Mountain.
Customer Service Hours for February 15 – September 30.
Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. – 8:00 p.m. Pacific.

Current and Prospective members should call toll-free (800) 446-8331. For questions related to the Medicare Advantage Program. TTY/TDD 711.

Current and Prospective members should call locally (623) 974-7430 or (480) 684-6167. For questions related to the Medicare Advantage Program. TTY/TDD 711.

Current and Prospective members should call toll-free (800) 446-8331. For questions related to the Medicare Part D Prescription Drug program. TTY/TDD 711

Current and Prospective members should call locally (623) 974-7430 or (480) 684-6167. For questions related to the Medicare Part D Prescription Drug program. TTY/TDD 711

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento puede estar disponible en una lengua no inglesa. Para la información adicional, llame el servicio de cliente en el número de teléfono puesto en una lista encima.

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
IMPORTANT INFORMATION				
1 – Premium and Other Important Information	In 2013 the monthly Part B Premium was $104.90 and may change for 2014 and the annual Part B deductible amount was $147 and may change for 2014.	**General**	**General**	**General**
		$0 monthly plan premium in addition to your monthly Medicare Part B premium.	$17 monthly plan premium in addition to your monthly Medicare Part B premium.	$55 monthly plan premium in addition to your monthly Medicare Part B premium.
	If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.	Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
		In-Network	**In-Network**	**In-Network**
	Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	$6,700 out-of-pocket limit for Medicare-covered services.	$6,700 out-of-pocket limit for Medicare-covered services.	$6,700 out-of-pocket limit for Medicare-covered services.

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IMPORTANT INFORMATION CONTINUED				
2 – Doctor and Hospital Choice (For more information, see Emergency – #15 and Urgently Needed Care – #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).
INPATIENT CARE				
3 – Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2013 the amounts for each benefit period were: Days 1 – 60: $1184 deductible Days 61 – 90: $296 per day Days 91 – 150: $592 per lifetime reserve day These amounts may change for 2014. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**In-Network** Plan covers 90 days each benefit period. $1000 out-of-pocket limit every stay. For Medicare-covered hospital stays: Days 1 – 5: $200 copay per day. Days 6 – 90: $0 copay per day. Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve days.	**In-Network** Plan covers 90 days each benefit period. $875 out-of-pocket limit every stay. For Medicare-covered hospital stays: Days 1 – 5: $175 copay per day. Days 6 – 90: $0 copay per day. Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve days.	**In-Network** Plan covers 90 days each benefit period. $225 out-of-pocket limit every stay. For Medicare-covered hospital stays: Days 1 – 3: $75 copay per day. Days 4 – 90: $0 copay per day. Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve days.

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INPATIENT CARE CONTINUED				
4 – Inpatient Mental Health Care	In 2013 the amounts for each benefit period were: Days 1 – 60: $1184 deductible Days 61 – 90: $296 per day Days 91 – 150: $592 per lifetime reserve day These amounts may change for 2014. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: Days 1 – 10: $140 copay per day. Days 11 – 90: $0 copay per day. Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve day.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: Days 1 – 10: $140 copay per day. Days 11 – 90: $0 copay per day. Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve day.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: Days 1 – 10: $140 copay per day. Days 11 – 90: $0 copay per day. Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve days.

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
INPATIENT CARE CONTINUED				
5 – Skilled Nursing Facility (SNF)	In 2013 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 – 20: $0 per day Days 21 – 100: $148 per day These amounts may change for 2014.	**General** Authorization rules may apply.	**General** Authorization rules may apply.	**General** Authorization rules may apply.
(in a Medicare-certified skilled nursing facility)	100 days for each benefit period. A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1 – 10: $0 copay per day. Days 11 – 20: $25 copay per day. Days 21 – 100: $120 copay per day.	**In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1 – 10: $0 copay per day Days 11 – 20: $25 copay per day. Days 21 – 100: $100 copay per day.	**In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1 – 20: $0 copay per day. Days 21 – 100: $100 copay per day.

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INPATIENT CARE CONTINUED				
6 – Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	**In-Network** $0 copay for Medicare-covered home health visits.	**In-Network** $0 copay for Medicare-covered home health visits.	**In-Network** $0 copay for Medicare-covered home health visits
7 – Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from Medicare-certified hospice. You must consult with your plan before you select a hospice.	**General** You must get care from Medicare-certified hospice. You must consult with your plan before you select a hospice.	**General** You must get care from Medicare-certified hospice. You must consult with your plan before you select a hospice.
OUTPATIENT CARE				
8 – Doctor Office Visits	20% coinsurance	**In-Network** $10 copay for each Medicare-covered primary care doctor visit. $50 copay for each Medicare-covered specialist visit.	**In-Network** $5 copay for each Medicare-covered primary care doctor visit. $35 copay for each Medicare-covered specialist visit.	**In-Network** $5 copay for each Medicare-covered primary care doctor visit. $20 copay for each Medicare-covered specialist visit.
9 – Chiropractic Services	Supplemental routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).	**In-Network** $20 copay for each Medicare-covered chiropractic visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).	**In-Network** $20 copay for each Medicare-covered chiropractic visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).	**In-Network** $20 copay for each Medicare-covered chiropractic visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).

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OUTPATIENT CARE				
10 – Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** $50 copay for each Medicare-covered podiatry visit. Medicare-covered podiatry visits are for medically-necessary foot care.	**In-Network** $35 copay for each Medicare-covered podiatry visit. Medicare-covered podiatry visits are for medically-necessary foot care.	**In-Network** $25 copay for each Medicare-covered podiatry visit. Medicare-covered podiatry visits are for medically-necessary foot care.
11 – Outpatient Mental Health Care	20% coinsurance for most outpatient mental health services. Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**In-Network** $20 copay for each Medicare-covered individual therapy visit. $20 copay for each Medicare-covered group therapy visit. $20 copay for each Medicare-covered individual therapy visit with a psychiatrist. $20 copay for each Medicare-covered group therapy visit with a psychiatrist. $20 copay for Medicare-covered partial hospitalization program services.	**In-Network** $20 copay for each Medicare-covered individual therapy visit. $20 copay for each Medicare-covered group therapy visit. $20 copay for each Medicare-covered individual therapy visit with a psychiatrist. $20 copay for each Medicare-covered group therapy visit with a psychiatrist. $20 copay for Medicare-covered partial hospitalization program services.	**In-Network** $20 copay for each Medicare-covered individual therapy visit. $20 copay for each Medicare-covered group therapy visit. $20 copay for each Medicare-covered individual therapy visit with a psychiatrist. $20 copay for each Medicare-covered group therapy visit with a psychiatrist. $20 copay for Medicare-covered partial hospitalization program services.

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OUTPATIENT CARE				
12 – Outpatient Substance Abuse Care	20% coinsurance	**In-Network** $20 copay for Medicare-covered individual substance abuse outpatient treatment visits. $20 copay for Medicare-covered group substance abuse outpatient treatment visits.	**In-Network** $20 copay for Medicare-covered individual substance abuse outpatient treatment visits. $20 copay for Medicare-covered group substance abuse outpatient treatment visits.	**In-Network** $20 copay for Medicare-covered individual substance abuse outpatient treatment visits. $20 copay for Medicare-covered group substance abuse outpatient treatment visits.
13 – Outpatient Services	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services.	**General** Authorization rules may apply. **In-Network** $0 to $250 copay for each Medicare-covered ambulatory surgical center visit. $0 to $250 copay for each Medicare-covered outpatient hospital facility visit. **See page page 50 for additional information about Outpatient Services.**	**General** Authorization rules may apply. **In-Network** $0 to $200 copay for each Medicare-covered ambulatory surgical center visit. $0 to $200 copay for each Medicare-covered outpatient hospital facility visit. **See page page 50 for additional information about Outpatient Services.**	**General** Authorization rules may apply. **In-Network** $0 to $125 copay for each Medicare-covered ambulatory surgical center visit. $0 to $125 copay for each Medicare-covered outpatient hospital facility visit. **See page page 50 for additional information about Outpatient Services.**
14 – Ambulance Services (medically necessary ambulance services)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered ambulance benefits. $150 copay for Medicare-covered ambulance benefits. **See page page 50 for additional information about Ambulance Services.**	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered ambulance benefits. $125 copay for Medicare-covered ambulance benefits. **See page page 50 for additional information about Ambulance Services.**	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered ambulance benefits. $50 copay for Medicare-covered ambulance benefits. **See page page 50 for additional information about Ambulance Services.**

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OUTPATIENT CARE				
15 – Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	**General** $65 copay for Medicare-covered emergency room visits. Not covered outside the U.S. and its territories except under limited circumstances. Contact plan for details. If you are admitted to the hospital within 1-day for the same condition, you pay $0 for the emergency room visit. **See page 50 for additional information about Emergency Services.**	**General** $65 copay for Medicare-covered emergency room visits. Not covered outside the U.S. and its territories except under limited circumstances. Contact plan for details. If you are admitted to the hospital within 1-day for the same condition, you pay $0 for the emergency room visit. **See page 50 for additional information about Emergency Services.**	**General** $50 copay for Medicare-covered emergency room visits. Not covered outside the U.S. and its territories except under limited circumstances. Contact plan for details. If you are admitted to the hospital within 1-day for the same condition, you pay $0 for the emergency room visit. **See page 50 for additional information about Emergency Services.**
16 – Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay. If you are admitted to the hospital within 3 days for the same condition, you pay $0 for the urgently-needed-care visit. NOT covered outside the U.S. except under limited circumstances.	**General** $25 copay for Medicare-covered urgently-needed-care visits. **See page 50 for additional information about Urgently Needed Care.**	**General** $25 copay for Medicare-covered urgently-needed-care visits. **See page 50 for additional information about Urgently Needed Care.**	**General** $15 copay for Medicare-covered urgently-needed-care visits. **See page 50 for additional information about Urgently Needed Care.**
17 – Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered.	**General** Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** $10 copay for Medicare-covered Occupational Therapy visits. $10 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits.	**General** Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** $10 copay for Medicare-covered Occupational Therapy visits. $10 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits.	**General** Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** $10 copay for Medicare-covered Occupational Therapy visits. $10 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits.

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
18 – Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered durable medical equipment. You may pay less if you purchase these items from the plan's preferred manufacturers/vendors. Contact the plan for a list of non-preferred and preferred manufacturers/vendors.	**General** Authorization rules may apply. **In-Network** 15% of the cost for Medicare-covered durable medical equipment. You may pay less if you purchase these items from the plan's preferred manufacturers/vendors. Contact the plan for a list of non-preferred and preferred manufacturers/vendors.	**General** Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered durable medical equipment. You may pay less if you purchase these items from the plan's preferred manufacturers/vendors. Contact the plan for a list of non-preferred and preferred manufacturers/vendors.
19 – Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices. 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices. 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices. 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.
20 – Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training. 20% coinsurance for diabetes supplies. 20% coinsurance for diabetic therapeutic shoes or inserts.	**In-Network** $0 copay for Medicare-covered Diabetes self-management training. 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies. 20% of the cost for Medicare-covered Therapeutic shoes or inserts. Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $10 to $50 may apply.	**In-Network** $0 copay for Medicare-covered Diabetes self-management training. 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies. 20% of the cost for Medicare-covered Therapeutic shoes or inserts. Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $5 to $35 may apply.	**In-Network** $0 copay for Medicare-covered Diabetes self-management training. 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies. 20% of the cost for Medicare-covered Therapeutic shoes or inserts. Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $5 to $20 may apply.

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
21 – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays. $0 copay for Medicare-covered lab services. Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** $0 to $10 copay for Medicare-covered lab services. $0 to $5 copay [or 0% to 20% of the cost] for Medicare-covered diagnostic procedures and tests. $5 to $300 copay [or 20% of the cost] for Medicare-covered X-rays. $5 to $300 copay [or 20% of the cost] for Medicare-covered diagnostic radiology services (not including X-rays). $20 copay [or 20% of the cost] for Medicare-covered therapeutic radiology services. If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $10 to $50 may apply. If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $10 to $50 may apply. **See page page 51 for additional information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services.**	**General** Authorization rules may apply. **In-Network** 0% of the cost for Medicare-covered lab services. 0% to 20% of the cost for Medicare-covered diagnostic procedures and tests. $0 to $275 copay [or 20% of the cost] for Medicare-covered X-rays. $0 to $275 copay [or 20% of the cost] for Medicare-covered diagnostic radiology services (not including X-rays). $15 copay [or 20% of the cost] for Medicare-covered therapeutic radiology services. If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $5 to $35 may apply. If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $5 to $35 may apply. **See page page 51 for additional information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services.**	**General** Authorization rules may apply. **In-Network** 0% of the cost for Medicare-covered lab services. 0% to 20% of the cost for Medicare-covered diagnostic procedures and tests. $0 to $250 copay [or 20% of the cost] for Medicare-covered X-rays. $0 to $250 copay [or 20% of the cost] for Medicare-covered diagnostic radiology services (not including X-rays). $10 copay [or 20% of the cost] for Medicare-covered therapeutic radiology services. If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $5 to $20 may apply. If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $5 to $20 may apply. **See page page 51 for additional information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services.**

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
22 – Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services. 20% coinsurance for Pulmonary Rehabilitation services. 20% coinsurance for Intensive Cardiac Rehabilitation services.	**General** Authorization rules may apply. **In-Network** $15 copay for Medicare-covered Cardiac Rehabilitation Services. $15 copay for Medicare-covered Intensive Cardiac Rehabilitation Services. $15 copay for Medicare-covered Pulmonary Rehabilitation Services.	**General** Authorization rules may apply. **In-Network** $10 copay for Medicare-covered Cardiac Rehabilitation Services. $10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services. $10 copay for Medicare-covered Pulmonary Rehabilitation Services.	**General** Authorization rules may apply. **In-Network** $10 copay for Medicare-covered Cardiac Rehabilitation Services. $10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services. $10 copay for Medicare-covered Pulmonary Rehabilitation Services
PREVENTIVE SERVICES, WELLNESS/EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS				
23 – Preventive Services	No coinsurance, copayment or deductible for the following: – Abdominal Aortic Aneurysm Screening – Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. – Cardiovascular Screening – Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine for people with Medicare who are at risk	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare.	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare.	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare.

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
PREVENTIVE SERVICES, WELLNESS/EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS Continued				
	– HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. – Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. – Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. – Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.			

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
PREVENTIVE SERVICES, WELLNESS/EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS Continued				
	– Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. – Screening and behavioral counseling interventions in primary care to reduce alcohol misuse – Screening for depression in adults – Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs – Intensive behavioral counseling for Cardiovascular Disease (bi-annual) – Intensive behavioral therapy for obesity – Welcome to Medicare Preventive Visits (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visits or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.			
24 – Kidney Disease and Conditions	20% coinsurance for renal dialysis. 20% coinsurance for kidney disease education services.	**In-Network** 20% of the cost for Medicare-covered renal dialysis. $0 copay for Medicare-covered kidney disease education services.	**In-Network** $25 copay for Medicare-covered renal dialysis. $0 copay for Medicare-covered kidney disease education services.	**In-Network** $25 copay for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services.

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
PRESCRIPTION DRUG BENEFITS				
25 – Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.AZBlueMedicare.com on the web. Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits.	**Drugs Covered under Medicare Part B** **General** 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.AZBlueMedicare.com on the web. Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits.	**Drugs Covered under Medicare Part B** **General** 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.AZBlueMedicare.com on the web. Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits.

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
PRESCRIPTION DRUG BENEFITS Continued				
		Your provider must get prior authorization from Blue Medicare Advantage Classic (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Blue Medicare Advantage Classic (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,850: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): Tier 1: Preferred Generic - $4 copay for a one-month (30-day) supply of drugs in this tier - $8 copay for two-month (60-day) supply of drugs in this tier - $12 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $14 copay for a one-month (30-day) supply of drugs in this tier - $28 copay for a two-month (60-day) supply of drugs in this tier - $42 copay for a three-month (90-day) supply of drugs in this tier	Your provider must get prior authorization from Blue Medicare Advantage Plus (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Blue Medicare Advantage Plus (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $3,200: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): Tier 1: Preferred Generic - $3 copay for a one-month (30-day) supply of drugs in this tier - $6 copay for a two-month (60-day) supply of drugs in this tier - $9 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $13 copay for a one-month (30-day) supply of drugs in this tier - $26 copay for a two-month (60-day) supply of drugs in this tier - $39 copay for a three-month (90-day) supply of drugs in this tier	Your provider must get prior authorization from Blue Medicare Advantage Premier (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Blue Medicare Advantage Premier (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $3,200: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): Tier 1: Preferred Generic - $2 copay for a one-month (30-day) supply of drugs in this tier - $4 copay for a two-month (60-day) supply of drugs in this tier - $6 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $12 copay for a one-month (30-day) supply of drugs in this tier - $24 copay for a two-month (60-day) supply of drugs in this tier - $36 copay for a three-month (90-day) supply of drugs in this tier

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
PRESCRIPTION DRUG BENEFITS Continued				
		Tier 3: Preferred Brand - $45 copay for a one-month (30-day) supply of drugs in this tier - $90 copay for a two-month (60-day) supply of drugs in this tier - $135 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $95 copay for a one-month (30-day) supply of drugs in this tier - $190 copay for a two-month (60-day) supply of drugs in this tier - $285 copay for a three-month (90-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 day supply at a time. They may also dispense less than a month's supply of generic drug at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): Tier 1: Preferred Generic - $4 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $14 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Preferred Brand - $45 copay for a one-month (31-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $95 copay for a one-month (31-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (31-day) supply of drugs in this tier	Tier 3: Preferred Brand - $40 copay for a one-month (30-day) supply of drugs in this tier - $80 copay for a two-month (60-day) supply of drugs in this tier - $120 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $90 copay for a one-month (30-day) supply of drugs in this tier - $180 copay for a two-month (60-day supply of drugs in this tier - $270 copay for a three-month (90-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 day supply at a time. They may also dispense less than a month's supply of generic drug at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): Tier 1: Preferred Generic - $3 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $13 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Preferred Brand - $40 copay for a one-month (31-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $90 copay for a one-month (31-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (31-day) supply of drugs in this tier	Tier 3: Preferred Brand - $30 copay for a one-month (30-day) supply of drugs in this tier - $60 copay for a two-month (60-day supply of drugs in this tier - $90 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $80 copay for a one-month (30-day) supply of drugs in this tier - $160 copay for a two-month (60-day supply of drugs in this tier - $240 copay for a three-month (90-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 day supply at a time. They may also dispense less than a month's supply of generic drug at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): Tier 1: Preferred Generic - $2 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $12 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Preferred Brand - $30 copay for a one-month (31-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $80 copay for a one-month (31-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (31-day) supply of drugs in this tier

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
PRESCRIPTION DRUG BENEFITS Continued				
		Mail Order Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): Tier 1: Preferred Generic - $8 copay for a two-month (60-day) supply of drugs in this tier - $12 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $28 copay for a two-month (60-day) supply of drugs in this tier - $42 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Preferred Brand - $90 copay for a two-month (60-day) supply of drugs in this tier - $135 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $190 copay for a two-month (60-day) supply of drugs in this tier - $285 copay for a three-month (90-day) supply of drugs in this tier	**Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): Tier 1: Preferred Generic - $6 copay for a two-month (60-day) supply of drugs in this tier - $9 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $26 copay for a two-month (60-day) supply of drugs in this tier - $39 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Preferred Brand - $80 copay for a two-month (60-day) supply of drugs in this tier - $120 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $180 copay for a two-month (60-day) supply of drugs in this tier - $270 copay for a three-month (90-day) supply of drugs in this tier	**Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): Tier 1: Preferred Generic - $4 copay for a two-month (60-day) supply of drugs in this tier - $6 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $24 copay for a two-month (60-day) supply of drugs in this tier - $36 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Preferred Brand - $60 copay for a two-month (60-day) supply of drugs in this tier - $90 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $160 copay for a two-month (60-day) supply of drugs in this tier - $240 copay for a three-month (90-day) supply of drugs in this tier
		Coverage Gap After your total yearly drug costs reach $2,850 you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,550. **Additional Coverage Gap** The plan covers some formulary brands (1% to 4% of formulary brand drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following:	**Coverage Gap** After your total yearly drug costs reach $3,200, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,550. **Additional Coverage Gap** The plan covers some formulary brands (1% to 4% of formulary brand drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following:	**Coverage Gap** After your total yearly drug costs reach $3,200, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,550. **Additional Coverage Gap** The plan covers some formulary brands (1% to 4% of formulary brand drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following:

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
PRESCRIPTION DRUG BENEFITS Continued				
		Retail Pharmacy Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic - $4 copay for one-month (30-day) supply of certain drugs covered within this tier - $8 copay for a two-month (60-day) supply of certain drugs covered within this tier - $12 copay for a three-month (90-day) supply of certain drugs covered within this tier **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic - $4 copay for a one-month (31-day) supply of certain drugs covered within this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic - $8 copay for a two-month (60-day) supply of certain drugs covered within this tier - $12 copay for a three-month (90-day) supply of certain drugs covered within this tier Please contact the plan for a complete list of drugs covered through the gap. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: – 5% coinsurance, or – $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs.	**Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic - $3 copay for one-month (30-day) supply of certain drugs covered within this tier - $6 copay for a two-month (60-day) supply of certain drugs covered within this tier - $9 copay for a three-month (90-day) supply of certain drugs covered within this tier **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic - $3 copay for a one-month (31-day) supply of certain drugs covered within this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic - $6 copay for a two-month (60-day) supply of certain drugs covered within this tier - $9 copay for a three-month (90-day) supply of certain drugs covered within this tier Please contact the plan for a complete list of drugs covered through the gap. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: – 5% coinsurance, or – $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs.	**Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic - $2 copay for one-month (30-day) supply of certain drugs covered within this tier - $4 copay for a two-month (60-day) supply of certain drugs covered within this tier - $6 copay for a three-month (90-day) supply of certain drugs covered within this tier **Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic - $2 copay for a one-month (31-day) supply of certain drugs covered within this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic - $4 copay for a two-month (60-day) supply of certain drugs covered within this tier - $6 copay for a three-month (90-day) supply of certain drugs covered within this tier Please contact the plan for a complete list of drugs covered through the gap. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: – 5% coinsurance, or – $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs.

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
PRESCRIPTION DRUG BENEFITS Continued				
		Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Blue Medicare Advantage Classic (HMO). You can get out-of-network drugs the following way: **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,850: Tier 1: Preferred Generic - $4 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $14 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Preferred Brand - $45 copay for a one-month (30-day) supply of drugs in this tier Tier 4: Non-Preferred Brand -$95 copay for a one-month (30-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Coverage Gap** You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).	**Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Blue Medicare Advantage Plus (HMO). You can get out-of-network drugs the following way: **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $3,200: Tier 1: Preferred Generic - $3 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $13 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Preferred Brand - $40 copay for a one-month (30-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $90 day copay for a one-month (30-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Coverage Gap** You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).	**Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Blue Medicare Advantage Premier (HMO). You can get out-of-network drugs the following way: **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $3,200: Tier 1: Preferred Generic - $2 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $12 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Preferred Brand - $30 copay for a one-month (30-day) supply of drugs in this tier Tier 4: Non-Preferred Brand - $80 day copay for a one-month (30-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Coverage Gap** You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
PRESCRIPTION DRUG BENEFITS Continued				
		You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). **Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Preferred Generic - $4 copay for a one-month (30-day) supply of certain drugs covered within this tier **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: – 5% coinsurance, or – $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). **Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Preferred Generic - $3 copay for a one-month (30-day) supply of certain drugs covered within this tier **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: – 5% coinsurance, or – $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). **Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: Tier 1: Preferred Generic - $2 copay for a one-month (30-day) supply of certain drugs covered within this tier **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: – 5% coinsurance, or – $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
26 – Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. 20% of the cost for Medicare-covered dental benefits.	**In-Network** $0 copay for the following preventive dental benefits: - up to 1 oral exam(s) every year - up to 1 cleaning(s) every year - up to 1 dental x-ray(s) every year 20% of the cost for Medicare-covered dental benefits. $500 plan coverage limit for supplemental preventive dental benefits every year.	**In-Network** $50 annual service category deductible for Medicare-covered dental benefits. This plan covers some preventive dental benefits for an extra cost (see Optional Supplemental Benefits"). 20% of the cost for Medicare-covered dental benefits.

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES Continued				
27 – Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** In general, supplemental routine hearing exams and hearing aids not covered. $0 copay for Medicare-covered diagnostic hearing exams. **See page page 51 for additional information about Hearing Services.**	**In-Network** Hearing aids not covered. $0 copay for Medicare-covered diagnostic hearing exams. $20 copay for supplemental routine hearing exams. $20 copay for each hearing aid fitting evaluations. **See page page 51 for additional information about Hearing Services.**	**In-Network** Hearing aids not covered. $0 copay for Medicare-covered diagnostic hearing exams. $20 copay for supplemental routine hearing exams. $20 copay for each hearing aid fitting evaluations. **See page page 51 for additional information about Hearing Services.**
PREVENTIVE SERVICES				
28 – Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk. Supplemental routine eye exams and eyeglasses (lenses and frames) not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.	**In-Network** This plan offers only Medicare-covered eye care and eyewear $0 to $40 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. 20% of the cost for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. If the doctor provides you services in addition to eye exams, separate cost sharing of $0 to $50 may apply. **See page page 51 for additional information about Vision Services.**	**In-Network** $0 to $30 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $20 copay for up to 1 supplemental routine eye exam(s) every year 20% of the cost for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. If a doctor provides you services in addition to the eye exams, separate cost sharing of $20 to $35 may apply **See page page 51 for additional information about Vision Services.**	**In-Network** $0 to $15 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $10 copay for up to 1 supplemental routine eye exam(s) every year 20% of the cost for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. If a doctor provides you services in addition to the eye exams, separate cost sharing of $10 to $20 may apply **See page page 51 for additional information about Vision Services.**
Wellness/ Education and Other Supplemental Benefits & Services	Not covered.	**In-Network** The plan covers the following supplemental education/wellness programs: - Health Education - Nutritional Benefit - Health Club Membership/Fitness Classes	**General** The plan covers the following supplemental education/wellness programs: - Health Education - Nutritional Benefit - Health Club Membership/Fitness Classes	**General** The plan covers the following supplemental education/wellness programs: - Health Education - Nutritional Benefit - Health Club Membership/Fitness Classes
Over-the-Counter Items	Not covered.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.

Benefit	Original Medicare	Blue Medicare Advantage Classic (HMO) (H0302006)	Blue Medicare Advantage Plus (HMO) (H0302001)	Blue Medicare Advantage Premier (HMO) (H0302007)
WELLNESS/EDUCATION AND OTHER SUPPLEMENTAL BENEFITS & SERVICES				
Transportation (Routine)	Not covered.	**In-Network** This plan does not cover supplemental routine transportation.	**In-Network** This plan does not cover supplemental routine transportation.	**In-Network** This plan does not cover supplemental routine transportation.
Acupuncture and Other Alternative Therapies	Not covered.	**In-Network** This plan does not cover Acupuncture and other alternative therapies.	**In-Network** This plan does not cover Acupuncture and other alternative therapies.	**In-Network** This plan does not cover Acupuncture and other alternative therapies.
OPTIONAL SUPPLEMENTAL PACKAGE #1				
Premium and Other Important Information	Not covered.	Not covered.	Not covered.	Package 1 – Dental Plan: $32 monthly premium, in addition to your $55 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Preventive Dental - Comprehensive Dental $1,500 plan coverage limit every year for these benefits. **General** Plan offers additional comprehensive dental benefits. **In-Network** $0 copay for the following preventive dental benefits: - up to 2 oral cleaning(s) every year - up to 2 cleaning(s) every year - up to 2 dental x-ray(s) every year $1,500 plan coverage limit for comprehensive dental benefits every year. **See page page 52 for additional information about Optional Supplemental Benefit: Dental Services.**

OUTPATIENT SERVICES

FOR ALL PLANS:

- Pain Management Assessment (evaluation and management ONLY): **$30 co-payment per visit**
- Pain Management Treatment (i.e. epidurals, pain blockers and injections): **$75 co-payment per treatment**
- Outpatient Facility Chemotherapy*: **$0 co-payment**
- Outpatient IV Therapy* (including transfusions) and Hyperbaric Oxygen Treatment: **$25 co-payment per visit**
- Coumadin/Lipid/CHF Clinic: **$10 co-payment for per visit**
- Wound Clinic and Continence Clinic: **$20 co-payment per visit**
- You pay a **20% coinsurance** amount based on the Medicare-fee-for-service rate for the following Medicare-covered treatments or procedures: **Enhanced External Counterpulsation (EECP) treatment, TTT procedure, Dental care/ oral surgery and each treatment, virtual capsule enteroscopy, device and procedure for Medicare-covered Temporomandibular Joint (TMJ).**

* Part B or Part D drug copayment or coinsurance will apply for medication administered.

EACH PLAN:	Blue Medicare Advantage Classic (HMO)	Blue Medicare Advantage Plus (HMO)	Blue Medicare Advantage Premier (HMO)
Ambulatory Surgical Center (ASC), Outpatient Hospital Facility for Surgery or Other Procedures (i.e. endoscopy and cardiac catheterization)	$250 co-payment for each visit	$200 co-payment for each visit	$125 co-payment for each visit
Radiation Therapy	$20 co-payment for each visit	$15 co-payment for each visit	$10 co-payment for each visit

EMERGENCY SERVICES

FOR ALL PLANS:

- You may obtain emergency medical care, even if you are outside of the Plan's service area. You are covered anywhere in the United States or U.S. territories.

URGENT CARE

FOR ALL PLANS:

- If you are outside the Plan's service area and cannot get care from a network provider, the Plan will cover urgent care services provided by an out-of network provider.

AMBULANCE SERVICES

FOR ALL PLANS:

- Emergency Air and Water Ambulance Transport: **20% coinsurance per transport (one-way)**

EACH PLAN:	Blue Medicare Advantage Classic (HMO)	Blue Medicare Advantage Plus (HMO)	Blue Medicare Advantage Premier (HMO)
Ground Ambulance	$150 co-payment per transport (one-way)	$125 co-payment per transport (one-way)	$50 co-payment per transport (one-way)

DIAGNOSTIC TESTS, X-RAYS, LAB SERVICES, AND RADIOLOGY SERVICES

FOR ALL PLANS:

- Carotid and Peripheral Vascular Ultrasound: **$25 co-payment**
- Sleep Study: **$75 co-payment per treatment**
- Genetic Testing: **20% coinsurance**

EACH PLAN:	Blue Medicare Advantage Classic (HMO)	Blue Medicare Advantage Plus (HMO)	Blue Medicare Advantage Premier (HMO)
X-ray with or without contrast (i.e chest, aortagram, IVP, BE, diagnostic mammogram), **EXCEPT as specified below**	$5 co-payment	$0 co-payment	$0 co-payment
Medicare-covered X-rays: **CT, MRI, MRA, SPECT**	$175 co-payment	$150 co-payment	$125 co-payment
Medicare-covered PET scan	$300 per study (requires prior authorization)	$275 per study (requires prior authorization)	$250 per study (requires prior authorization)

HEARING AND VISION SERVICES

FOR ALL PLANS:

- Medicare-covered Diagnostic Hearing Exam (performed by a network specialty care physician): A PCP referral **IS** required. Separate office visit copay may apply.
- Only routine hearing tests, annual vision examinations and eyewear obtained from a plan provider are a covered benefit. However, in cases where you obtain these services from a non-plan/out-of-network provider a request from your PCP along with a Prior Authorization from the plan is required.

EACH PLAN:	Blue Medicare Advantage Classic (HMO)	Blue Medicare Advantage Plus (HMO)	Blue Medicare Advantage Premier (HMO)
Non-Medicare covered routine annual vision exam for eye refraction, performed by an **Optometrist** PCP referral **IS NOT** required	Not covered	$20 co-payment per visit	$10 co-payment per visit
Medicare covered vision service for a disease or condition of the eye, performed by an **Optometrist**	$20 co-payment per visit	$20 co-payment per visit	$15 co-payment per visit
Medicare covered vision service for a disease or condition of the eye, performed by an **Ophthalmologist**	$50 co-payment per visit	$35 co-payment per visit	$20 co-payment per visit

OPTIONAL SUPPLEMENTAL BENEFIT: DENTAL SERVICES (IN-NETWORK ONLY)

FOR BLUE MEDICARE ADVANTAGE PREMIER (HMO) PLAN ONLY:

The maximum plan benefit coverage is $1,500 per year.

Preventive and Diagnostic Dental Procedures

No coinsurance, copayment or deductibles for Preventive and Diagnostic Dental Procedures.

Covered services include:

- Routine oral exams (this includes the scaling and polishing procedure to remove coronal plaque, calculus and stains). It does not include periodontal scaling and root planning). Limited to two exams per calendar year
- Two bitewing x-ray series per calendar year
- One full mouth x-ray or one panoramic x-ray every 36 months
- Emergency palliative treatment for pain
- Other dental x-rays if required for diagnosis and treatment of specific conditions or consultations for preventive or basic dental procedures

Basic Dental Procedures

$50 Deductible per year. After deductible, member pays 25% coinsurance (of the contracted amount)

Covered services include:

- Oral surgery (limited to the removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch)
- Periodontics (gum treatments)
- Endodontics (root canals)
- Extractions (this includes local anesthesia and routine post-operative care)
- Recementing bridges, crowns or inlays
- Crowns
- Fillings, other than gold
- General anesthetics (upon demonstration of Medical Necessity)
- Antibiotic drugs
- Rebasing or relining of removable dentures

Medicare Health Plan

(800) 446-8331 / TTY 711

October 1 – February 14:
7 days a week, 8 a.m. – 8 p.m.

February 15 – September 30:
Monday – Friday, 8 a.m. – 8 p.m.

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