BlueCross BlueShield of Texas

# Summary of Benefits

## Blue Cross Medicare Advantage Choice Premier (PPO)[SM]

## Blue Cross Medicare Advantage Choice Plus (PPO)[SM]

**January 1, 2021 – December 31, 2021**

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

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## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-774-8592 (TTY: 711). We are open from 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

## Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.getbluetx.com/mapd or call 1-877-774-8592 to view a copy of the EOC.
- ☐ Review the *Provider Directory* (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the *Pharmacy Directory* to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

## Understanding Important Rules

- ☐ In addition to your monthly plan premium, if applicable, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. **In addition, you will pay a higher copay for services received by non-contracted providers.**

# INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2021 – December 31, 2021

| | Blue Cross Medicare Advantage Choice Premier (PPO)[SM] | Blue Cross Medicare Advantage Choice Plus (PPO)[SM] |
|---|---|---|
| **You have choices about how to get your Medicare prescription drug benefits** | • One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.<br>• Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Cross Medicare Advantage Choice Premier (PPO)** or **Blue Cross Medicare Advantage Choice Plus (PPO)**). | |
| **Tips for comparing your Medicare choices** | This Summary of Benefits booklet gives you a summary of what **Blue Cross Medicare Advantage Choice Premier (PPO)** or **Blue Cross Medicare Advantage Choice Plus (PPO)** covers and what you pay.<br>• If you want to compare our plans with other Medicare Health Plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.<br>• If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. | |
| **Sections in this booklet** | • Things to Know About **Blue Cross Medicare Advantage Choice Premier (PPO)**<br>• Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services<br>• Prescription Drug Benefits | • Things to Know About **Blue Cross Medicare Advantage Choice Plus (PPO)**<br>• Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services<br>• Prescription Drug Benefits |
| **Blue Access for Members** | Go to www.bluembertx.com to access information about your plan selection, including:<br>• Claims information<br>• Benefits information<br>• Pharmacy locator | |

<table>
<tr><th></th><th>Blue Cross Medicare Advantage Choice Premier (PPO)SM</th><th>Blue Cross Medicare Advantage Choice Plus (PPO)SM</th></tr>
<tr><td>Hours of Operation</td><td colspan="2"><ul><li>From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. – 8:00 p.m. local time.</li><li>From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. – 8:00 p.m. local time.</li></ul></td></tr>
<tr><td>Phone Numbers and Website</td><td colspan="2"><ul><li>If you are a member of this plan, call toll-free 1-877-774-8592. (TTY users should call 711).</li><li>If you are not a member of this plan, call toll-free 1-877-608-2698 (TTY users should call 711).</li></ul>Our website: www.getbluetx.com/mapd</td></tr>
<tr><td rowspan="2">Who can join?</td><td colspan="2">To join Blue Cross Medicare Advantage Choice Premier (PPO) or Blue Cross Medicare Advantage Choice Plus (PPO), you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, and live in our service area.</td></tr>
<tr><td>Our service area includes the following counties in Texas: Collin, Cooke, Dallas, Denton, Fannin, Hill, Hood, Johnson, Navarro, Rockwall, Tarrant, and Wise.</td><td>Our service area includes the following counties in Texas: Collin, Cooke, Dallas, Denton, Fannin, Hill, Hood, Johnson, Navarro, Rockwall, Tarrant, and Wise.</td></tr>
<tr><td>Which doctors, hospitals, and pharmacies can I use?</td><td colspan="2">Blue Cross Medicare Advantage has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.<ul><li>You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.</li><li>Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.</li><li>You can see our plan’s Provider Directory and Pharmacy Directory at our website (www.getbluetx.com/mapd).</li><li>Or, call us and we will send you a copy of the Provider Directory and/or Pharmacy Directory.</li></ul></td></tr>
</table>

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| **What do we cover?** | Like all Medicare health plans, we cover everything that Original Medicare covers—and *more*.<br>**Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.<br>**Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.<br>We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.<br>You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, (www.getbluetx.com/mapd). Or, call us and we will send you a copy of the formulary. | |
| **How will I determine my drug costs?** | Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, Coverage Gap, and Catastrophic Coverage. | |

# SUMMARY OF BENEFITS

January 1, 2021 – December 31, 2021

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| **MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES** | | |
| **How much is the monthly premium?** | $62 per month. In addition, you must keep paying your Medicare Part B premium. | $0 per month. In addition, you must keep paying your Medicare Part B premium. |
| **How much is the deductible?** | This plan does not have a medical deductible. | In-network: $0<br>Out-of-network: $750 |
| **Is there any limit on how much I will pay for my covered services?** | Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>**Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.** | |
| | Your yearly limit(s) in this plan:<br>• $7,550 for services you receive from in-network providers.<br>• $11,300 for services you receive from out-of-network providers.<br>• $11,300 for services you receive from any provider. Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count toward this limit. | Your yearly limit(s) in this plan:<br>• $7,550 for services you receive from in-network providers.<br>• $11,300 for services you receive from out-of-network providers.<br>• $11,300 for services you receive from any provider. Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count toward this limit. |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| **MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES** | | |
| **Is there a limit on how much the plan will pay?** | Our plan has a coverage limit every year for certain benefits from any provider. Contact us for the services that apply. | Our plan has a coverage limit every year for certain benefits from any provider. Contact us for the services that apply. |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | |
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **INPATIENT CARE** | | |
| **Inpatient Hospital Care*** | Our plan covers an unlimited number of days for an inpatient hospital stay.<br>• In-network: $265 copay per day for days 1-7 and $0 copay per day for days 8-90; $0 copay per day for days 91 and beyond<br>• Out-of-network: 50% of the total cost per stay | Our plan covers an unlimited number of days for an inpatient hospital stay.<br>• In-network: $372 copay per day for days 1-5 and $0 copay per day for days 6-90; $0 copay per day for days 91 and beyond<br>• Out-of-network: 50% of the total cost per stay |
| **OUTPATIENT CARE AND SERVICES** | | |
| **Outpatient Hospital Care/Surgery*** | **Outpatient hospital**<br>• In-network: $0-$325 copay<br>• Out-of-network: 50% of the total cost<br>**Ambulatory surgical center**<br>• In-network: $225 copay<br>• Out-of-network: 50% of the total cost | **Outpatient hospital**<br>• In-network: $0-$325 copay<br>• Out-of-network: 50% of the total cost<br>**Ambulatory surgical center**<br>• In-network: $275 copay<br>• Out-of-network: 50% of the total cost |

<table>
<tr><th></th><th>Blue Cross Medicare Advantage Choice Premier (PPO)SM</th><th>Blue Cross Medicare Advantage Choice Plus (PPO)SM</th></tr>
<tr><td colspan="3">NOTE: Services with a * may require prior authorization from your doctor.</td></tr>
<tr><td>Doctor's Office Visits*</td><td><u>Primary care physician visit</u><br>• In-network: $5 copay<br>• Out-of-network: 50% of the total cost<br><u>Specialist visit</u><br>• In-network: $35 copay<br>• Out-of-network: 50% of the total cost</td><td><u>Primary care physician visit</u><br>• In-network: $10 copay<br>• Out-of-network: 50% of the total cost<br><u>Specialist visit</u><br>• In-network: $50 copay<br>• Out-of-network: 50% of the total cost</td></tr>
<tr><td rowspan="2">Preventive Care*</td><td>• In-network: $0 copay<br>• Out-of-network: 50% of the total cost</td><td>• In-network: $0 copay<br>• Out-of-network: 50% of the total cost</td></tr>
<tr><td colspan="2">Our plan covers many preventive services, including:<br>- Abdominal aortic aneurysm screening<br>- Alcohol misuse counseling<br>- Bone mass measurement<br>- Breast cancer screening (mammogram)<br>- Cardiovascular disease (behavioral therapy)<br>- Cardiovascular screenings<br>- Cervical and vaginal cancer screening<br>- Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)<br>- Depression screening<br>- Diabetes screenings<br>- HIV screening<br>- Medical nutrition therapy services<br>- Obesity screening and counseling<br>- Prostate cancer screenings (PSA)<br>- Sexually transmitted infections screening and counseling<br>- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots<br>- "Welcome to Medicare" preventive visit (one-time)<br>- Yearly "Wellness" visit<br>Any additional preventive services approved by Medicare during the contract year will be covered.</td></tr>
</table>

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Emergency Care** | $90 copay<br>Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital Care" section of this booklet for other costs. | $90 copay<br>Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital Care" section of this booklet for other costs. |
| **Urgently Needed Services** | $40 copay | $40 copay |
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays** ***(Costs for these services may vary based on place of service)**** | **Diagnostic radiology services (such as MRIs, CT scans)**<br>• In-network: $225 to $300 copay ($225 at free standing radiology clinic; $300 at outpatient hospital)<br>• Out-of-network: 50% of the total cost<br>**Diagnostic tests and procedures**<br>• In-network: $0-$100 copay, depending on the service<br>• Out-of-network: 50% of the total cost<br>**Lab services**<br>• In-network: $5 to $50 copay ($5 at free standing lab; $5 at PCP; $35 at Specialist; $50 at outpatient hospital)<br>• Out-of-network: 50% of the total cost<br>**Outpatient X-rays**<br>• In-network: $5 to $100 copay ($5 at free standing radiology clinic; $100 at outpatient hospital)<br>• Out-of-network: 50% of the total cost | **Diagnostic radiology services (such as MRIs, CT scans)**<br>• In-network: $300 to $325 copay ($300 at free standing radiology clinic; $325 at outpatient hospital)<br>• Out-of-network: 50% of the total cost<br>**Diagnostic tests and procedures**<br>• In-network: $0-$100 copay, depending on the service<br>• Out-of-network: 50% of the total cost<br>**Lab services**<br>• In-network: $5 to $50 copay ($5 at free standing lab; $10 at PCP; $50 at Specialist; $50 at outpatient hospital)<br>• Out-of-network: 50% of the total cost<br>**Outpatient X-rays**<br>• In-network: $5 to $100 copay ($5 at free standing radiology clinic; $100 at outpatient hospital)<br>• Out-of-network: 50% of the total cost |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays** ***(Costs for these services may vary based on place of service)**** **(continued)** | **Therapeutic radiology services (such as radiation treatment for cancer)**<br>• In-network: 20% of the total cost<br>• Out-of-network: 50% of the total cost | **Therapeutic radiology services (such as radiation treatment for cancer)**<br>• In-network: 20% of the total cost<br>• Out-of-network: 50% of the total cost |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Hearing Services** | **Exams to diagnose and treat hearing and balance issues**<br>• In-network: $45 copay<br>• Out-of-network: 50% of the total cost<br>**Routine hearing exam**<br>• In-network: $10 copay for up to 1 routine hearing exam every 3 years<br>• Out-of-network: 50% of the total cost for up to 1 routine hearing exam every 3 years<br>**Hearing aid fitting/evaluation**<br>• In-network: $0 copay for 1 hearing aid fitting and evaluation visit every 3 years<br>• Out-of-network: 50% of the total cost for 1 hearing aid fitting and evaluation visit every 3 years<br>**Hearing aids**<br>• In- or out-of-network: $0 copay<br>There is a $1,000 maximum plan coverage limit for hearing aids (both ears combined) purchased in- or out-of-network every 3 years. | **Exams to diagnose and treat hearing and balance issues**<br>• In-network: $50 copay<br>• Out-of-network: 50% of the total cost<br>**Routine hearing services are not covered.** |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Dental Services*** | **Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)** | |
| | • In-network: $45 copay<br>• Out-of-network: 50% of the total cost<br>**Preventive dental services**<br>**Cleanings**<br>• In- or out-of-network: $0 copay for up to 2 cleanings per year.<br>**Dental X-rays**<br>• In- or out-of-network: $0 copay for up to 1 bitewing X-ray per year.<br>**Oral exams**<br>• In- or out-of-network: $0 copay for up to 2 oral exams per year.<br>**Comprehensive dental coverage**<br>$1,000 maximum plan coverage amount for in- and out-of-network comprehensive dental benefits per year. For more details on benefits and benefit limitations regarding your dental coverage, please see your Evidence of Coverage. | • In-network: $50 copay<br>• Out-of-network: 50% of the total cost<br>**Preventive dental services**<br>**Cleanings**<br>• In- or out-of-network: $0 copay for up to 2 cleanings per year.<br>**Dental X-rays**<br>• In- or out-of-network: $0 copay for up to 1 bitewing X-ray per year.<br>**Oral exams**<br>• In- or out-of-network: $0 copay for up to 2 oral exams per year.<br>**Comprehensive dental coverage**<br>Not Covered |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Vision Services*** | **Exams to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)** | |
| | • In-network: $0 copay for Medicare-covered eye exam; $0 copay for one vision specialist exam<br>• Out-of-network: 50% of the total cost<br>**Routine eye exam**<br>• In- or out-of-network: $0 copay for 1 routine eye exam every year<br>$40 allowance for an in-network or out-of-network routine eye exam every year<br>**Eyeglasses or contact lenses after cataract surgery**<br>• In-network: $0 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery<br>• Out-of-network: 50% of the total cost for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery | • In-network: $0 copay for Medicare-covered eye exam; $0 copay for one vision specialist exam<br>• Out-of-network: 50% of the total cost<br>**Routine eye exam**<br>• In- or out-of-network: $0 copay for 1 routine eye exam every year<br>$40 allowance for an in-network or out-of-network routine eye exam every year<br>**Eyeglasses or contact lenses after cataract surgery**<br>• In-network: $0 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery<br>• Out-of-network: 50% of the total cost for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Vision Services* (continued)** | **Routine eye wear**<br>**Contact lenses**<br>• In- or out-of-network: $0 copay (unlimited quantity)<br>**Eyeglass frames**<br>• In- or out-of-network: $0 copay for 1 frame per year<br>**Eyeglass lenses**<br>• In- or out-of-network: $0 copay for 1 pair of eyeglass lenses every year (Standard lenses only. Progressive lenses excluded)<br>$100 plan coverage limited in- and out-of-network for routine eye wear every year (including eyeglass frames, lenses, and contact lenses) | **Routine eye wear**<br>Not Covered |

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<tr><td rowspan="2">Mental Health Care*</td><td colspan="2"><u>Inpatient visit</u><br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period There's no limit to the number of benefit periods.<br>Our plan covers 90 days for an inpatient hospital stay.<br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</td></tr>
<tr><td>• In-network: $270 copay per day for days 1-6 and $0 copay per day for days 7-90<br>• Out-of-network: 50% of the total cost per stay<br><u>Outpatient group therapy visit</u><br>• In-network: $30 copay<br>• Out-of-network: 50% of the total cost<br><u>Outpatient individual therapy visit</u><br>• In-network: $30 copay<br>• Out-of-network: 50% of the total cost</td><td>• In-network: $270 copay per day for days 1-6 and $0 copay per day for days 7-90<br>• Out-of-network: 50% of the total cost per stay<br><u>Outpatient group therapy visit</u><br>• In-network: $30 copay<br>• Out-of-network: 50% of the total cost<br><u>Outpatient individual therapy visit</u><br>• In-network: $30 copay<br>• Out-of-network: 50% of the total cost</td></tr>
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|---|---|---|
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Skilled Nursing Facility (SNF)*** | **Our plans cover up to 100 days in a SNF.** | |
| | • In-network: $0 copay per day for days 1-20 and $184 copay per day for days 21-100<br>• Out-of-network: 50% of the total cost per stay | • In-network: $0 copay per day for days 1-20 and $184 copay per day for days 21-100<br>• Out-of-network: 50% of the total cost per stay |
| **Outpatient Rehabilitation*** | **Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks)** | |
| | • In-network: $50 copay<br>• Out-of-network: 50% of the total cost<br>**Occupational therapy visit**<br>• In-network: $40 copay<br>• Out-of-network: 50% of the total cost<br>**Physical therapy and speech and language therapy visit**<br>• In-network: $40 copay<br>• Out-of-network: 50% of the total cost | • In-network: $50 copay<br>• Out-of-network: 50% of the total cost<br>**Occupational therapy visit**<br>• In-network: $40 copay<br>• Out-of-network: 50% of the total cost<br>**Physical therapy and speech and language therapy visit**<br>• In-network: $40 copay<br>• Out-of-network: 50% of the total cost |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
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| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Ambulance*** ***(Medicare-covered ground and air transportation services)*** | **Ground services**<br>• In-network: $300 copay for each one-way trip<br>• Out-of-network: $300 copay for each one-way trip<br>**Air services**<br>• In-network: $300 copay for each one-way trip<br>• Out-of-network: $300 copay for each one-way trip | **Ground services**<br>• In-network: $300 copay for each one-way trip<br>• Out-of-network: $300 copay for each one-way trip<br>**Air services**<br>• In-network: $300 copay for each one-way trip<br>• Out-of-network: $300 copay for each one-way trip |
| **Transportation*** | Not Covered | Not Covered |
| **Medicare Part B Drugs*** | **Part B chemotherapy drugs and other Part B drugs**<br>• In-network: 20% of the total cost<br>• Out-of-network: 50% of the total cost | **Part B chemotherapy drugs and other Part B drugs**<br>• In-network: 20% of the total cost<br>• Out-of-network: 50% of the total cost |

| PRESCRIPTION DRUG BENEFITS | | |
|---|---|---|
| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
| **Part D Deductible Stage** | • $295 per year for Part D prescription drugs except for drugs listed on Tiers 1 and 2 which are excluded from the deductible.<br><br>Once you have paid $295 for your Tiers 3, 4 and 5 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage. | • $445 per year for Part D prescription drugs except for drugs listed on Tiers 1 and 2 which are excluded from the deductible.<br><br>Once you have paid $445 for yourTiers 3, 4 and 5 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage. |

## Prescription Drug Cost Shares During the Initial Coverage Stage

After you pay your yearly deductible, if applicable, you pay the following until your total yearly drug costs reach $4,130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail-order pharmacies.

| Initial Coverage Stage: Standard Retail Pharmacy | | |
|---|---|---|
| | **Blue Cross Medicare Advantage Choice Premier (PPO)SM** | **Blue Cross Medicare Advantage Choice Plus (PPO)SM** |
| **Tier 1: Preferred Generic** | **One-month supply:** $7 copay | **One-month supply:** $7 copay |
| | **Three-month supply:** $21 copay | **Three-month supply:** $21 copay |
| **Tier 2: Generic** | **One-month supply:** $20 copay | **One-month supply:** $20 copay |
| | **Three-month supply:** $60 copay | **Three-month supply:** $60 copay |
| **Tier 3: Preferred Brand** | **One-month supply:** $47 copay | **One-month supply:** $47 copay |
| | **Three-month supply:** $141 copay | **Three-month supply:** $141 copay |
| **Tier 4: Non-Preferred Drug** | **One-month supply:** $100 copay | **One-month supply:** $100 copay |
| | **Three-month supply:** $300 copay | **Three-month supply:** $300 copay |
| **Tier 5: Specialty Tier** | **One-month supply:** 27% of the total cost | **One-month supply:** 25% of the total cost |
| | **Three-month supply:** 27% of the total cost | **Three-month supply:** 25% of the total cost |

| Initial Coverage Stage: Preferred Retail Pharmacy | | |
|---|---|---|
| | **Blue Cross Medicare Advantage Choice Premier (PPO)SM** | **Blue Cross Medicare Advantage Choice Plus (PPO)SM** |
| **Tier 1: Preferred Generic** | **One-month supply:** $0 copay | **One-month supply:** $0 copay |
| | **Three-month supply:** $0 copay | **Three-month supply:** $0 copay |
| **Tier 2: Generic** | **One-month supply:** $13 copay | **One-month supply:** $13 copay |
| | **Three-month supply:** $39 copay | **Three-month supply:** $39 copay |
| **Tier 3: Preferred Brand** | **One-month supply:** $40 copay | **One-month supply:** $40 copay |
| | **Three-month supply:** $120 copay | **Three-month supply:** $120 copay |
| **Tier 4: Non-Preferred Drug** | **One-month supply:** $93 copay | **One-month supply:** $93 copay |
| | **Three-month supply:** $279 copay | **Three-month supply:** $279 copay |
| **Tier 5: Specialty Tier** | **One-month supply:** 27% of the total cost | **One-month supply:** 25% of the total cost |
| | **Three-month supply:** 27% of the total cost | **Three-month supply:** 25% of the total cost |

| Initial Coverage Stage: Standard Mail-Order Pharmacy (3-month supply) | | |
|---|---|---|
| | **Blue Cross Medicare Advantage Choice Premier (PPO)SM** | **Blue Cross Medicare Advantage Choice Plus (PPO)SM** |
| **Tier 1: Preferred Generic** | $14 copay | $14 copay |
| **Tier 2: Generic** | $40 copay | $40 copay |
| **Tier 3: Preferred Brand** | $94 copay | $94 copay |
| **Tier 4: Non-Preferred Drug** | $300 copay | $300 copay |
| **Tier 5: Specialty Tier** | 27% of the total cost | 25% of the total cost |

| Initial Coverage Stage: Preferred Mail-Order Pharmacy (3-month supply) | | |
|---|---|---|
| | **Blue Cross Medicare Advantage Choice Premier (PPO)SM** | **Blue Cross Medicare Advantage Choice Plus (PPO)SM** |
| **Tier 1: Preferred Generic** | $0 copay | $0 copay |
| **Tier 2: Generic** | $26 copay | $26 copay |
| **Tier 3: Preferred Brand** | $80 copay | $80 copay |
| **Tier 4: Non-Preferred Drug** | $279 copay | $279 copay |
| **Tier 5: Specialty Tier** | 27% of the total cost | 25% of the total cost |

| Initial Coverage Stage: Long-term Care and Out-of-network Pharmacies (one-month supply) | | |
|---|---|---|
| | **Blue Cross Medicare Advantage Choice Premier (PPO)SM** | **Blue Cross Medicare Advantage Choice Plus (PPO)SM** |
| **Long-term Care Tiers 1-5** | If you reside in a long-term facility, you pay the same as at a retail pharmacy. | |
| **Out-of-network Tiers 1-5** | You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. | |

| Coverage Gap Stage: Standard Retail Pharmacy | | |
|---|---|---|
| | **Blue Cross Medicare Advantage Choice Premier (PPO)SM** | **Blue Cross Medicare Advantage Choice Plus (PPO)SM** |
| **Coverage Gap Stage** | Your plan provides additional coverage through the gap. For Tier 1, you continue to pay the similar amounts as you did in the Initial Coverage Stage.<br>Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130.<br>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.<br>Under your plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. | |

| Catastrophic Coverage Stage | | |
|---|---|---|
| | **Blue Cross Medicare Advantage Choice Premier (PPO)SM** | **Blue Cross Medicare Advantage Choice Plus (PPO)SM** |
| **Catastrophic Coverage Stage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $6,550, you pay the greater of:<br>• 5% of the total cost, or<br>• $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copay for all other drugs. | |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| **ADDITIONAL MEMBER BENEFITS** | | |
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Acupuncture for Chronic Low Back Pain*** | • In-network: $35 copay<br>• Out-of-network: 50% of the total cost | • In-network: $50 copay<br>• Out-of-network: 50% of the total cost |
| **Chiropractic Care*** | **Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)** | |
| | • In-network: $20 copay<br>• Out-of-network: 50% of the total cost | • In-network: $20 copay<br>• Out-of-network: 50% of the total cost |
| **Diabetes Supplies and Services*** | **Diabetes monitoring supplies**<br>• In-network: 0% to 20% of the total cost<br>• Out-of-network: 20% of the total cost<br>0% cost sharing limited to diabetic testing supplies (meters, strips, and lancets) obtained through the pharmacy for a LifeScan branded product (OneTouch Verio Flex, OneTouch Verio Reflect, OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2).<br>20% cost sharing for all other diabetic supplies including approved exceptions. | **Diabetes monitoring supplies**<br>• In-network: 0% to 20% of the total cost<br>• Out-of-network: 20% of the total cost<br>0% cost sharing limited to diabetic testing supplies (meters, strips, and lancets) obtained through the pharmacy for a LifeScan branded product (OneTouch Verio Flex, OneTouch Verio Reflect, OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2).<br>20% cost sharing for all other diabetic supplies including approved exceptions. |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Diabetes Supplies and Services* (continued)** | **Diabetes self-management training**<br>• In-network: $0 copay<br>• Out-of-network: 50% of the total cost<br>**Therapeutic shoes or inserts**<br>• In-network: 20% of the total cost<br>• Out-of-network: 20% of the total cost | **Diabetes self-management training**<br>• In-network: $0 copay<br>• Out-of-network: 50% of the total cost<br>**Therapeutic shoes or inserts**<br>• In-network: 20% of the total cost<br>• Out-of-network: 20% of the total cost |
| **Durable Medical Equipment *(wheelchairs, oxygen, etc.)**** | • In-network: 20% of the total cost<br>• Out-of-network: 20% of the total cost | • In-network: 20% of the total cost<br>• Out-of-network: 20% of the total cost |
| **Wellness Programs** | SilverSneakers† Fitness Program: $0 copay in-network only<br>This benefit includes SilverSneakers instructor-led group fitness classes. At participating locations, you can take classes plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms. SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and a mobile app, SilverSneakers GO™.<br>†SilverSneakers, SilverSneakers FLEX, SilverSneakers On-Demand, and SilverSneakers GO are registered trademarks or trademarks of Tivity Health, Inc. | |
| **Foot Care *(podiatry services)**** | **Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions** | |
| | • In-network: $45 copay<br>• Out-of-network: 50% of the total cost | • In-network: $45 copay<br>• Out-of-network: 50% of the total cost |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Home Health Care*** | • In-network: $0 copay<br>• Out-of-network: 50% of the total cost | • In-network: $0 copay<br>• Out-of-network: 50% of the total cost |
| **Opioid Treatment Program Services** | • In-network: $0 copay<br>• Out-of-network: 50% of the total cost | • In-network: $0 copay<br>• Out-of-network: 50% of the total cost |
| **Outpatient Substance Abuse Services*** | **Group therapy visit**<br>• In-network: $75 copay<br>• Out-of-network: 50% of the total cost<br>**Individual therapy visit**<br>• In-network: $75 copay<br>• Out-of-network: 50% of the total cost | **Group therapy visit**<br>• In-network: $75 copay<br>• Out-of-network: 50% of the total cost<br>**Individual therapy visit**<br>• In-network: $75 copay<br>• Out-of-network: 50% of the total cost |
| **Over-the-Counter Items** | Not Covered | Not Covered |
| **Prosthetic Devices *(braces, artificial limbs, etc.)**** | **Prosthetic devices**<br>• In-network: 20% of the total cost<br>• Out-of-network: 20% of the total cost<br>**Related medical supplies**<br>• In-network: 20% of the total cost<br>• Out-of-network: 20% of the total cost | **Prosthetic devices**<br>• In-network: 20% of the total cost<br>• Out-of-network: 20% of the total cost<br>**Related medical supplies**<br>• In-network: 20% of the total cost<br>• Out-of-network: 20% of the total cost |
| **Meals*** | Not Covered | Not Covered |

| | Blue Cross Medicare Advantage Choice Premier (PPO)SM | Blue Cross Medicare Advantage Choice Plus (PPO)SM |
|---|---|---|
| NOTE: Services with a * may require prior authorization from your doctor. | | |
| **Renal Dialysis*** | • In-network: 20% of the total cost<br>• Out-of-network: 50% of the total cost | • In-network: 20% of the total cost<br>• Out-of-network: 50% of the total cost |
| **Telehealth Services** | • In- or out-of-network: $0 copay for urgent care visits through MDLive | • In- or out-of-network: $0 copay for urgent care visits through MDLive |
| **Hospice** | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. | |

BlueCross BlueShield of Texas

Blue Cross and Blue Shield of Texas complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Texas does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Texas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator

If you believe that Blue Cross and Blue Shield of Texas has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-774-8592 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-774-8592 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-774-8592 (TTY: 711).

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-877-774-8592 (TTY: 711) 。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-774-8592 (TTY: 711) 번으로 전화해 주십시오.

ملحوظ: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل رقم 1-877-774-8592 (رقم هاتف الصم والبكم: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-774-8592 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-774-8592 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-774-8592 (ATS: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-774-8592 (TTY: 711) पर कॉल करें।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی به صورت رایگان برای شما فراهم می باشد. با تماس بگیرید. 1-877-774-8592 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-774-8592 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-774-8592 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-774-8592 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-877-774-8592 (TTY: 711) まで、お電話にてご連絡ください。

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-774-8592 (TTY: 711).

BlueCross BlueShield of Texas

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Medicare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services

This information is not a complete description of benefits. Call 1-877-774-8592 (TTY: 711) for more information.

PPO plans are provided by HCSC Insurance Services Company (HISC). PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC and HISC are Independent Licensees of the Blue Cross and Blue Shield Association. HISC is a Medicare Advantage organization with a Medicare contract. Enrollment in HISC's plans depends on contract renewal.