



**BlueCross BlueShield
of Texas**

Summary of Benefits

Blue Cross Medicare Advantage Basic (HMO)SM

Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM

Blue Cross Medicare Advantage Premier (HMO)SM

January 1, 2017 – December 31, 2017

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."

INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2017 - December 31, 2017

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
You have choices about how to get your Medicare benefits	<ul style="list-style-type: none"> • One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. • Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Blue Cross Medicare Advantage Basic (HMO)). 	<ul style="list-style-type: none"> • One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. • Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Blue Cross Medicare Advantage Basic Plus (HMO-POS)). 	<ul style="list-style-type: none"> • One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. • Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Blue Cross Medicare Advantage Premier (HMO)).
Tips for comparing your Medicare choices	<p>This Summary of Benefits booklet gives you a summary of what Blue Cross Medicare Advantage Basic (HMO) covers and what you pay.</p> <ul style="list-style-type: none"> • If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov. • 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 http://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. 	<p>This Summary of Benefits booklet gives you a summary of what Blue Cross Medicare Advantage Basic Plus (HMO-POS) covers and what you pay.</p> <ul style="list-style-type: none"> • If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov. • 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 http://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. 	<p>This Summary of Benefits booklet gives you a summary of what Blue Cross Medicare Advantage Premier (HMO) covers and what you pay.</p> <ul style="list-style-type: none"> • If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov. • 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 http://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.

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Sections in this booklet	<ul style="list-style-type: none"> • Things to Know About Blue Cross Medicare Advantage Basic (HMO) • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits 	<ul style="list-style-type: none"> • Things to Know About Blue Cross Medicare Advantage Basic Plus (HMO-POS) • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits 	<ul style="list-style-type: none"> • Things to Know About Blue Cross Medicare Advantage Premier (HMO) • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits
	<p>This document is available in other formats such as Braille and large print. This document may be available in a non-English language.</p> <p>For additional information, call us at 1-877-774-8592 (TTY/TDD users should call 711).</p> <p>Es posible que este documento esté disponible en un idioma distinto al inglés. Para obtener información adicional, llame a servicio al cliente al 1-877-774-8592 (los usuarios de TTY/TDD deben llamar al 711).</p>	<p>This document is available in other formats such as Braille and large print. This document may be available in a non-English language.</p> <p>For additional information, call us at 1-877-774-8592 (TTY/TDD users should call 711).</p> <p>Es posible que este documento esté disponible en un idioma distinto al inglés. Para obtener información adicional, llame a servicio al cliente al 1-877-774-8592 (los usuarios de TTY/TDD deben llamar al 711).</p>	<p>This document is available in other formats such as Braille and large print. This document may be available in a non-English language.</p> <p>For additional information, call us at 1-877-774-8592 (TTY/TDD users should call 711).</p> <p>Es posible que este documento esté disponible en un idioma distinto al inglés. Para obtener información adicional, llame a servicio al cliente al 1-877-774-8592 (los usuarios de TTY/TDD deben llamar al 711).</p>
Hours of Operation	<p>Things to Know About Blue Cross Medicare Advantage Basic (HMO)</p> <ul style="list-style-type: none"> • From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time. • From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time. 	<p>Things to Know About Blue Cross Medicare Advantage Basic Plus (HMO-POS)</p> <ul style="list-style-type: none"> • From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time. • From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time. 	<p>Things to Know About Blue Cross Medicare Advantage Premier (HMO)</p> <ul style="list-style-type: none"> • From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time. • From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time.

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Phone Numbers and Website	<ul style="list-style-type: none"> • If you are a member of this plan, call toll-free 1-877-774-8592 (TTY/TDD users should call 711). • If you are not a member of this plan, call toll-free 1-844-624-2546 (TTY/TDD users should call 711). • Our website: www.getbluetx.com/mapd 	<ul style="list-style-type: none"> • If you are a member of this plan, call toll-free 1-877-774-8592 (TTY/TDD users should call 711). • If you are not a member of this plan, call toll-free 1-844-624-2546 (TTY/TDD users should call 711). • Our website: www.getbluetx.com/mapd 	<ul style="list-style-type: none"> • If you are a member of this plan, call toll-free 1-877-774-8592 (TTY/TDD users should call 711). • If you are not a member of this plan, call toll-free 1-844-624-2546 (TTY/TDD users should call 711). • Our website: www.getbluetx.com/mapd
Who can join?	<p>To join Blue Cross Medicare Advantage Basic (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.</p> <p>Our service area includes the following counties in Texas: Chambers, Fort Bend, Hardin, Harris, Jefferson, Liberty, Montgomery, and Orange.</p>	<p>To join Blue Cross Medicare Advantage Basic Plus (HMO-POS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.</p> <p>Our service area includes the following counties in Texas: Chambers, Fort Bend, Hardin, Harris, Jefferson, Liberty, Montgomery, and Orange.</p>	<p>To join Blue Cross Medicare Advantage Premier (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.</p> <p>Our service area includes the following counties in Texas: Chambers, Fort Bend, Hardin, Harris, Jefferson, Liberty, Montgomery, and Orange.</p>

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Which doctors, hospitals, and pharmacies can I use?	<p>Blue Cross Medicare Advantage Basic (HMO) 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.</p> <p>You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.</p> <p>Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.</p> <p>You can see our plan’s provider and pharmacy directory at our website (www.getbluetx.com/mapd).</p> <p>Or, call us and we will send you a copy of the provider and pharmacy directories.</p>	<p>Blue Cross Medicare Advantage Basic Plus (HMO-POS) 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.</p> <p>You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.</p> <p>Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.</p> <p>You can see our plan’s provider and pharmacy directory at our website (www.getbluetx.com/mapd).</p> <p>Or, call us and we will send you a copy of the provider and pharmacy directories.</p>	<p>Blue Cross Medicare Advantage Premier (HMO) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network.</p> <p>You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.</p> <p>Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.</p> <p>You can see our plan’s provider and pharmacy directory at our website (www.getbluetx.com/mapd).</p> <p>Or, call us and we will send you a copy of the provider and pharmacy directories.</p>

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
What do we cover?	<p>Like all Medicare health plans, we cover everything that Original Medicare covers - and <i>more</i>.</p> <p>Our plan members get <i>all</i> 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.</p> <p>Our plan members also get <i>more than what is covered by Original Medicare</i>. Some of the extra benefits are outlined in this booklet.</p> <p>We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.</p> <p>You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, (www.getbluetx.com/mapd).</p> <p>Or, call us and we will send you a copy of the formulary.</p>	<p>Like all Medicare health plans, we cover everything that Original Medicare covers - and <i>more</i>.</p> <p>Our plan members get <i>all</i> 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.</p> <p>Our plan members also get <i>more than what is covered by Original Medicare</i>. Some of the extra benefits are outlined in this booklet.</p> <p>We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.</p> <p>You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, (www.getbluetx.com/mapd).</p> <p>Or, call us and we will send you a copy of the formulary.</p>	<p>Like all Medicare health plans, we cover everything that Original Medicare covers - and <i>more</i>.</p> <p>Our plan members get <i>all</i> 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.</p> <p>Our plan members also get <i>more than what is covered by Original Medicare</i>. Some of the extra benefits are outlined in this booklet.</p> <p>We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.</p> <p>You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, (www.getbluetx.com/mapd).</p> <p>Or, call us and we will send you a copy of the formulary.</p>

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
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: Initial Coverage, Coverage Gap, and Catastrophic Coverage.	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: Initial Coverage, Coverage Gap, and Catastrophic Coverage.	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: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

SUMMARY OF BENEFITS

January 1, 2017 - December 31, 2017

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
How much is the monthly premium?	\$0 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.	\$48.00 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Is there any limit on how much I will pay for my covered services?	<p>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.</p> <p>Your yearly limit(s) in this plan:</p> <p>\$2,900 for services you receive from in-network providers.</p> <p>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.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>	<p>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.</p> <p>Your yearly limit(s) in this plan:</p> <p>\$4,200 for services you receive from in-network providers.</p> <p>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.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>	<p>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.</p> <p>Your yearly limit(s) in this plan:</p> <p>\$2,700 for services you receive from in-network providers.</p> <p>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.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

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COVERED MEDICAL AND HOSPITAL BENEFITS			
NOTE: Services with a ¹ may require prior authorization. Services with a ² may require a referral from your doctor.			
INPATIENT CARE			
Inpatient Hospital Care^{1,2}	Our plan covers an unlimited number of days for an inpatient hospital stay. \$250 copay per stay \$500 annual maximum You pay nothing per day for days 91 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: \$245 copay for days 1 through 7 • Out-of-network: 40% of the cost	Our plan covers an unlimited number of days for an inpatient hospital stay. \$250 copay per stay \$500 annual maximum You pay nothing per day for days 91 and beyond
OUTPATIENT CARE AND SERVICES			
Doctor's Office Visits^{1,2}	Primary care physician visit: You pay nothing Specialist visit: \$35 copay	Primary care physician visit: • In-network: \$10 copay • Out-of-network: \$60 copay Specialist visit: • In-network: \$45 copay • Out-of-network: \$75 copay	Primary care physician visit: You pay nothing Specialist visit: \$35 copay

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Preventive Care^{1,2}	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: \$60 copay <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>

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Emergency Care	<p>\$75 copay</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.</p>	<p>\$75 copay</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.</p>	<p>\$75 copay</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.</p>
Urgently Needed Services	\$30 copay	\$30 copay	\$30 copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for these services may vary based on place of service)^{1,2}	<p>Diagnostic radiology services (such as MRIs, CT scans): \$250 copay</p> <p>Diagnostic tests and procedures: \$0-100 copay, depending on the service</p> <p>Lab services: You pay nothing</p> <p>Outpatient X-rays: You pay nothing</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost</p>	<p>Diagnostic radiology services (such as MRIs, CT scans):</p> <ul style="list-style-type: none"> • In-network: \$250 copay • Out-of-network: 40% of the cost <p>Diagnostic tests and procedures:</p> <ul style="list-style-type: none"> • In-network: \$0-50 copay, depending on the service • Out-of-network: 40% of the cost <p>Lab services:</p> <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 40% of the cost <p>Outpatient X-rays:</p> <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 40% of the cost <p>Therapeutic radiology services (such as radiation treatment for cancer):</p> <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 40% of the cost 	<p>Diagnostic radiology services (such as MRIs, CT scans): \$250 copay</p> <p>Diagnostic tests and procedures: \$0-50 copay, depending on the service</p> <p>Lab services: You pay nothing</p> <p>Outpatient X-rays: You pay nothing</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost</p>

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Hearing Services¹	<p>Exam to diagnose and treat hearing and balance issues: \$35 copay</p> <p>Routine hearing exam (for up to 1 every year): \$5 copay</p> <p>Hearing aid fitting/evaluation (for up to 1 every year): \$0 copay</p> <p>Hearing aid: \$0 copay</p> <p>Our plan pays up to \$1,500 every three years for hearing aids.</p>	<p>Exam to diagnose and treat hearing and balance issues:</p> <ul style="list-style-type: none"> • In-network: \$5 copay • Out-of-network: 40% of the cost 	<p>Exam to diagnose and treat hearing and balance issues: \$35 copay</p> <p>Routine hearing exam (for up to 1 every year): \$5 copay</p> <p>Hearing aid fitting/evaluation (for up to 1 every year): \$0 copay</p> <p>Hearing aid: \$0 copay</p> <p>Our plan pays up to \$1,500 every three years for hearing aids.</p>
Dental Services^{1,2}	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$35 copay</p>	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: 40% of the cost 	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$35 copay</p> <p>Preventive dental services:</p> <p>Cleaning (for up to 2 every year): \$0 copay</p> <p>Dental x-ray(s) (for up to 1 every year): \$0 copay</p> <p>Oral exam (for up to 2 every year): \$0 copay</p> <p>Comprehensive dental coverage:</p> <p>\$1,500 annual max; 50% member pay for Basic Restorative services (ex. Cavities, Non-surgical tooth extractions); 70% member pay for Endodontics, Major restorative services and prosthodontics (ex. Root canals, crowns and dentures)</p> <p>For more details on benefits and benefit limitations regarding your dental coverage, please see your Evidence of Coverage.</p>

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Vision Services^{1,2}	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0 copay</p> <p>Routine eye exam (for up to 1 every year): \$10 copay</p> <p>Contact lenses: \$0 copay</p> <p>Eyeglass frames: \$0 copay</p> <p>Eyeglass lenses (for up to 1 every year): \$25 copay</p> <p>Eyeglasses or contact lenses after cataract surgery: \$0 copay</p> <p>Our plan pays up to \$250 every two years for contact lenses, eyeglass lenses, and eyeglass frames.</p>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):</p> <ul style="list-style-type: none"> • In-network: \$0 copay • Out-of-network: 40% of the cost <p>Eyeglasses or contact lenses after cataract surgery:</p> <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: 40% of the cost 	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0 copay</p> <p>Routine eye exam (for up to 1 every year): \$10 copay</p> <p>Contact lenses: \$0 copay</p> <p>Eyeglass frames: \$0 copay</p> <p>Eyeglass lenses (for up to 1 every year): \$25 copay</p> <p>Eyeglasses or contact lenses after cataract surgery: \$0 copay</p> <p>Our plan pays up to \$250 every two years for contact lenses, eyeglass lenses, and eyeglass frames.</p>

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Mental Health Care^{1,2}	<p>Inpatient visit:</p> <p>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.</p> <p>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.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>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.</p> <p>\$250 copay per stay \$500 annual maximum</p>	<p>Inpatient visit:</p> <p>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.</p> <p>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.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>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.</p> <ul style="list-style-type: none"> • In-network: \$215 copay for days 1 through 7 • Out-of-network: 40% of the cost 	<p>Inpatient visit:</p> <p>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.</p> <p>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.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>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.</p> <p>\$225 copay per stay \$450 annual maximum</p>

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Mental Health Care^{1,2} (continued)	<p>Outpatient group therapy visit: \$35 copay</p> <p>Outpatient individual therapy visit: \$35 copay</p>	<p>Outpatient group therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: 40% of the cost <p>Outpatient individual therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: 40% of the cost 	<p>Outpatient group therapy visit: \$30 copay</p> <p>Outpatient individual therapy visit: \$30 copay</p>
Skilled Nursing Facility (SNF)^{1,2}	<p>Our plan covers up to 100 days in a SNF.</p> <p>You pay nothing per day for days 1 through 20</p> <p>\$164.50 copay per day for days 21 through 100</p>	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> • In-network: You pay nothing per day for days 1 through 20 <p>\$150 copay per day for days 21 through 100</p> <ul style="list-style-type: none"> • Out-of-network: 40% of the cost 	<p>Our plan covers up to 100 days in a SNF. You pay nothing per day for days 1 through 20</p> <p>\$164.50 copay per day for days 21 through 100</p>
Outpatient Rehabilitation^{1,2}	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): \$30 copay</p> <p>Occupational therapy visit: \$35 copay</p> <p>Physical therapy and speech and language therapy visit: \$35 copay</p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):</p> <ul style="list-style-type: none"> • In-network: \$50 copay • Out-of-network: 40% of the cost <p>Occupational therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: 40% of the cost <p>Physical therapy and speech and language therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 40% of the cost 	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): \$30 copay</p> <p>Occupational therapy visit: \$35 copay</p> <p>Physical therapy and speech and language therapy visit: \$30 copay</p>
Ambulance¹	\$200 copay	\$225 copay	\$200 copay

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Transportation^{1,2}	You pay nothing 12 one way trips from plan approved transportation services only	<ul style="list-style-type: none"> • In-network: You pay nothing. 12 one way trips from plan approved transportation services only • Out-of-network: Not covered 	You pay nothing 12 one way trips from plan approved transportation services only
Foot Care (podiatry services)^{1,2}	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$35 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: 40% of the cost 	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$30 copay
Durable Medical Equipment (wheelchairs, oxygen, etc.)¹	20% of the cost	<ul style="list-style-type: none"> • In network: 20% of the cost • Out-of-network: 20% of the cost 	20% of the cost
Wellness Program	SilverSneakers^{®†} Fitness Program SilverSneakers is the nation’s leading exercise program designed exclusively for Medicare beneficiaries. Eligible members receive a standard fitness center membership where they can enjoy specialized low-impact SilverSneakers classes focusing on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination. Included	SilverSneakers^{®†} Fitness Program SilverSneakers is the nation’s leading exercise program designed exclusively for Medicare beneficiaries. Eligible members receive a standard fitness center membership where they can enjoy specialized low-impact SilverSneakers classes focusing on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination. <ul style="list-style-type: none"> • In-network: Included • Out-of-network: Not included 	SilverSneakers^{®†} Fitness Program SilverSneakers is the nation’s leading exercise program designed exclusively for Medicare beneficiaries. Eligible members receive a standard fitness center membership where they can enjoy specialized low-impact SilverSneakers classes focusing on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination. Included

† The SilverSneakers^{®†} Fitness program is a wellness program owned and operated by Healthways, Inc., an independent company.

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	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs ¹ : 20% of the cost Other Part B drugs ¹ : 20% of the cost	For Part B drugs such as chemotherapy drugs ¹ : <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 40% of the cost Other Part B drugs ¹ : <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 40% of the cost 	For Part B drugs such as chemotherapy drugs ¹ : 20% of the cost Other Part B drugs ¹ : 20% of the cost
Acupuncture	Not covered	Not covered	Not covered
Chiropractic Care^{1,2}	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): <ul style="list-style-type: none"> • In-network: \$20 copay • Out-of-network: 40% of the cost 	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay
Diabetes Supplies and Services^{1,2}	Diabetes monitoring supplies: 0-35% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing 0% of the cost for diabetic test strips from a preferred manufacturer; 0% for other diabetic supplies (testing monitors, lancets, diabetic therapeutic shoes); 35% of the cost for diabetic test strips from a non-preferred manufacturer.	Diabetes monitoring supplies: <ul style="list-style-type: none"> • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 40% of the cost Diabetes self-management training: <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 40% of the cost Therapeutic shoes or inserts: <ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 40% of the cost 0% of the cost for diabetic test strips from a preferred manufacturer; 0% for other diabetic supplies (testing monitors, lancets, diabetic therapeutic shoes); 20% of the cost for diabetic test strips from a non-preferred manufacturer.	Diabetes monitoring supplies: 0-35% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing 0% of the cost for diabetic test strips from a preferred manufacturer; 0% for other diabetic supplies (testing monitors, lancets, diabetic therapeutic shoes); 35% of the cost for diabetic test strips from a non-preferred manufacturer.

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Home Health Care^{1,2}	You pay nothing	<ul style="list-style-type: none"> • In-network: You pay nothing • Out-of-network: 40% of the cost 	You pay nothing
Outpatient Substance Abuse^{1,2}	Group therapy visit: \$100 copay Individual therapy visit: \$100 copay	Group therapy visit: <ul style="list-style-type: none"> • In-network: \$100 copay • Out-of-network: 40% of the cost Individual therapy visit: <ul style="list-style-type: none"> • In-network: \$100 copay • Out-of-network: 40% of the cost 	Group therapy visit: \$100 copay Individual therapy visit: \$100 copay
Outpatient Surgery^{1,2}	Ambulatory surgical center: \$150 copay, depending on the service Outpatient hospital: \$0-150 copay, depending on the service	Ambulatory surgical center: <ul style="list-style-type: none"> • In-network: \$325 copay • Out-of-network: 40% of the cost Outpatient hospital: <ul style="list-style-type: none"> • In-network: \$0-325 copay • Out-of-network: 40% of the cost 	Ambulatory surgical center: \$150 copay, depending on the service Outpatient hospital: \$0-250 copay, depending on the service
Over-the-Counter Items	Please visit our website to see our list of covered over-the-counter items. \$40 per month over-the-counter (OTC) purchase allowance: You will receive a card with a pre-funded monthly benefit allowance. With this allowance, you may purchase eligible OTC and health-related items (i.e. aspirin, cold & flu relief medications, and adhesive bandages) at any participating pharmacy.	Not covered	Please visit our website to see our list of covered over-the-counter items. \$50 per month over-the-counter (OTC) purchase allowance: You will receive a card with a pre-funded monthly benefit allowance. With this allowance, you may purchase eligible OTC and health-related items (i.e. aspirin, cold & flu relief medications, and adhesive bandages) at any participating pharmacy.

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Prosthetic Devices (braces, artificial limbs, etc.)¹	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost	Prosthetic devices: <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 40% of the cost Related medical supplies: <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 40% of the cost 	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost
Renal Dialysis^{1,2}	20% of the cost	20% of the cost	20% of the cost
Hospice	You pay nothing for hospice care from a Medicare certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	<ul style="list-style-type: none"> • In-network: You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. 	You pay nothing for hospice care from a Medicare certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
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PRESCRIPTION DRUG BENEFITS

Initial Coverage	<p>You pay the following until your total yearly drug costs reach \$3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p>			<p>You pay the following until your total yearly drug costs reach \$3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p>			<p>You pay the following until your total yearly drug costs reach \$3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p>		
	Standard Retail Cost-Sharing			Standard Retail Cost-Sharing			Standard Retail Cost-Sharing		
	Tier	One-month supply	Three-month supply	Tier	One-month supply	Three-month supply	Tier	One-month supply	Three-month supply
	Tier 1 (Preferred Generic)	\$9 copay	\$27 copay	Tier 1 (Preferred Generic)	\$9 copay	\$27 copay	Tier 1 (Preferred Generic)	\$9 copay	\$27 copay
	Tier 2 (Generic)	\$20 copay	\$60 copay	Tier 2 (Generic)	\$20 copay	\$60 copay	Tier 2 (Generic)	\$20 copay	\$60 copay
	Tier 3 (Preferred Brand)	\$47 copay	\$141 copay	Tier 3 (Preferred Brand)	\$47 copay	\$141 copay	Tier 3 (Preferred Brand)	\$47 copay	\$141 copay
	Tier 4 (Non-Preferred Brand)	\$100 copay	\$300 copay	Tier 4 (Non-Preferred Brand)	\$100 copay	\$300 copay	Tier 4 (Non-Preferred Brand)	\$100 copay	\$300 copay
	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost

	Blue Cross Medicare Advantage Basic (HMO) SM			Blue Cross Medicare Advantage Basic Plus (HMO-POS) SM			Blue Cross Medicare Advantage Premier (HMO) SM		
Initial Coverage (continued)	Preferred Retail Cost-Sharing			Preferred Retail Cost-Sharing			Preferred Retail Cost-Sharing		
	Tier	One-month supply	Three-month supply	Tier	One-month supply	Three-month supply	Tier	One-month supply	Three-month supply
	Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	Tier 1 (Preferred Generic)	\$0 copay	\$0 copay
	Tier 2 (Generic)	\$9 copay	\$27 copay	Tier 2 (Generic)	\$9 copay	\$27 copay	Tier 2 (Generic)	\$9 copay	\$27 copay
	Tier 3 (Preferred Brand)	\$39 copay	\$117 copay	Tier 3 (Preferred Brand)	\$39 copay	\$117 copay	Tier 3 (Preferred Brand)	\$39 copay	\$117 copay
	Tier 4 (Non-Preferred Brand)	\$95 copay	\$285 copay	Tier 4 (Non-Preferred Brand)	\$95 copay	\$285 copay	Tier 4 (Non-Preferred Brand)	\$95 copay	\$285 copay
	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost

	Blue Cross Medicare Advantage Basic (HMO)SM		Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM		Blue Cross Medicare Advantage Premier (HMO)SM	
Initial Coverage (continued)	Standard Mail Order Cost-Sharing		Standard Mail Order Cost-Sharing		Standard Mail Order Cost Sharing	
	Tier	Three-month supply	Tier	Three-month supply	Tier	Three-month supply
	Tier 1 (Preferred Generic)	\$27 copay	Tier 1 (Preferred Generic)	\$27 copay	Tier 1 (Preferred Generic)	\$27 copay
	Tier 2 (Generic)	\$60 copay	Tier 2 (Generic)	\$60 copay	Tier 2 (Generic)	\$60 copay
	Tier 3 (Preferred Brand)	\$141 copay	Tier 3 (Preferred Brand)	\$141 copay	Tier 3 (Preferred Brand)	\$141 copay
	Tier 4 (Non-Preferred Brand)	\$300 copay	Tier 4 (Non-Preferred Brand)	\$300 copay	Tier 4 (Non-Preferred Brand)	\$300 copay
	Tier 5 (Specialty Tier)	33% of the cost	Tier 5 (Specialty Tier)	33% of the cost	Tier 5 (Specialty Tier)	33% of the cost
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.		If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.		If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.	

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Coverage Gap	<p>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 \$3,700.</p> <p>After you enter the coverage gap, you pay 40% of the plan’s cost for covered brand name drugs and 51% of the plan’s cost for covered generic drugs until your costs total \$4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> <p>Under this 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. See the chart that follows to find out how much it will cost you.</p>	<p>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 \$3,700.</p> <p>After you enter the coverage gap, you pay 40% of the plan’s cost for covered brand name drugs and 51% of the plan’s cost for covered generic drugs until your costs total \$4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> <p>Under this 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. See the chart that follows to find out how much it will cost you.</p>	<p>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 \$3,700.</p> <p>After you enter the coverage gap, you pay 40% of the plan’s cost for covered brand name drugs and 51% of the plan’s cost for covered generic drugs until your costs total \$4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> <p>Under this 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. See the chart that follows to find out how much it will cost you.</p>

	Blue Cross Medicare Advantage Basic (HMO) SM				Blue Cross Medicare Advantage Basic Plus (HMO-POS) SM				Blue Cross Medicare Advantage Premier (HMO) SM			
Coverage Gap (continued)	Standard Retail Cost-Sharing				Standard Retail Cost-Sharing				Standard Retail Cost-Sharing			
	Tier	Drugs Covered	One-month supply	Three-month supply	Tier	Drugs Covered	One-month supply	Three-month supply	Tier	Drugs Covered	One-month supply	Three-month supply
	Tier 1 (Preferred Generic)	All	\$9 copay	\$27 copay	Tier 1 (Preferred Generic)	All	\$9 copay	\$27 copay	Tier 1 (Preferred Generic)	All	\$9 copay	\$27 copay
	Tier 2 (Generic)	All	\$20 copay	\$60 copay	Tier 2 (Generic)	All	\$20 copay	\$60 copay	Tier 2 (Generic)	All	\$20 copay	\$60 copay
	Preferred Retail Cost-Sharing				Preferred Retail Cost-Sharing				Preferred Retail Cost-Sharing			
	Tier	Drugs Covered	One-month supply	Three-month supply	Tier	Drugs Covered	One-month supply	Three-month supply	Tier	Drugs Covered	One-month supply	Three-month supply
	Tier 1 (Preferred Generic)	All	\$0 copay	\$0 copay	Tier 1 (Preferred Generic)	All	\$0 copay	\$0 copay	Tier 1 (Preferred Generic)	All	\$0 copay	\$0 copay
	Tier 2 (Generic)	All	\$9 copay	\$27 copay	Tier 2 (Generic)	All	\$9 copay	\$27 copay	Tier 2 (Generic)	All	\$9 copay	\$27 copay
	Standard Mail Order Cost-Sharing				Standard Mail Order Cost-Sharing				Standard Mail Order Cost-Sharing			
	Tier	Drugs Covered	Three-month supply		Tier	Drugs Covered	Three-month supply		Tier	Drugs Covered	Three-month supply	
	Tier 1 (Preferred Generic)	All	\$27 copay		Tier 1 (Preferred Generic)	All	\$27 copay		Tier 1 (Preferred Generic)	All	\$27 copay	
	Tier 2 (Generic)	All	\$60 copay		Tier 2 (Generic)	All	\$60 copay		Tier 2 (Generic)	All	\$60 copay	

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier (HMO)SM
Catastrophic Coverage	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,950, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$3.30 copay for generic (including brand drugs treated as generic) and a \$8.25 copayment for all other drugs. 	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,950, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$3.30 copay for generic (including brand drugs treated as generic) and a \$8.25 copayment for all other drugs. 	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,950, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$3.30 copay for generic (including brand drugs treated as generic) and a \$8.25 copayment for all other drugs.
OPTIONAL BENEFITS (you must pay an extra premium each month for these benefits)			
Package 1: Optional Supplemental	Not Included	<p>Benefits include:</p> <ul style="list-style-type: none"> • Preventive Dental • Comprehensive Dental • Eye Exams • Eyewear • Hearing Exams • Hearing Aids 	Not Included
How much is the monthly premium?	Not Included	Additional \$34.00 per month. You must keep paying your Medicare Part B premium and your \$0 monthly plan premium.	Not Included
How much is the deductible?	Not Included	This package does not have a deductible.	Not Included
Is there a limit on how much the plan will pay?	Not Included	Our plan pays up to \$2,150. Our plan has additional coverage limits for certain benefits.	Not Included



**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 નિઃશુલ્ક 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, ໂດຍບໍ່ແຈ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຮ 1-877-774-8592 (TTY: 711).



**BlueCross BlueShield
of Texas**

This information is available for free in other languages. Please call our Customer Service number at 1-877-774-8592 (TTY/TDD users should call 711). We are open between 8:00 a.m. and 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Esta información está disponible en otros idiomas de forma gratuita. Comuníquese a nuestro número de Servicio al cliente al 1-877-774-8592 (los usuarios de TTY/TDD deben llamar al 711). Nuestro horario es de 8:00 a.m. a 8:00 p.m., hora local, los 7 días de la semana. Si usted llama del 15 de febrero al 30 de septiembre, durante los fines de semana y feriados, se usarán tecnologías alternas (por ejemplo, correo de voz).

You must continue to pay your Medicare Part B premium.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Plans available in Chambers, Fort Bend, Hardin, Harris, Jefferson, Liberty, Montgomery, and Orange counties.

Blue Cross Medicare Advantage HMO and HMO-POS plans provided by GHS Insurance Company (GHS), an Independent Licensee of the Blue Cross and Blue Shield Association. GHS is a Medicare Advantage organization with a Medicare contract. Enrollment in GHS' plans depends on contract renewal.