BlueCross BlueShield of Texas

Summary of Benefits

Blue Cross Medicare Advantage Choice Plus (PPO)SM

Blue Cross Medicare Advantage Choice Premier (PPO)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."

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INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2017 - December 31, 2017

	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
You have choices about how to get your Medicare 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. • Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Cross Medicare Advantage Choice Plus (PPO)**.	• 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 Choice Premier (PPO)**.
Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what **Blue Cross Medicare Advantage Choice Plus (PPO)** covers and what you pay. • 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.	This Summary of Benefits booklet gives you a summary of what **Blue Cross Medicare Advantage Choice Premier (PPO)** covers and what you pay. • 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.
Sections in this booklet	• Things to Know About **Blue Cross Medicare Advantage Choice Plus (PPO)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits	• Things to Know About **Blue Cross Medicare Advantage Choice Premier (PPO)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits

	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
	This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-877-774-8592 (TTY/TDD users should call 711). 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).	This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-877-774-8592 (TTY/TDD users should call 711). 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).
Hours of Operation	Things to Know About **Blue Cross Medicare Advantage Choice Plus (PPO)** • 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.	Things to Know About **Blue Cross Medicare Advantage Choice Premier (PPO)** • 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.
Phone Numbers and Website	• 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 s hould call 711). • Our website: www.getbluetx.com/mapd	• 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?	To join **Blue Cross Medicare Advantage Choice Plus (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in ·Texas: · Austin Area: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson. · Dallas Area: Collin, Dallas, Denton, and Tarrant. · Houston Area: Chambers, Fort Bend, Hardin, Harris, Jefferson, Liberty and Montgomery. · San Antonio Area: Bexar.	To join **Blue Cross Medicare Advantage Choice Premier (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Texas: · Austin Area: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson. · Dallas Area: Collin, Dallas, Denton, and Tarrant. · Houston Area: Chambers, Fort Bend, Hardin, Harris, Jefferson, Liberty and Montgomery. · San Antonio Area: Bexar.

	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
Which doctors, hospitals, and pharmacies can I use?	**Blue Cross Medicare Advantage Choice Plus (PPO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's provider and pharmacy directory at our website (www.getbluetx.com/mapd). Or, call us and we will send you a copy of the provider and pharmacy directories.	**Blue Cross Medicare Advantage Choice Premier (PPO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's provider and pharmacy directory at our website (www.getbluetx.com/mapd). Or, call us and we will send you a copy of the provider and pharmacy directories.
What do we cover?	Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*. **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. **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. 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.	Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*. **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. **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. 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.

	Blue Cross Medicare Advantage Choice Plus (PPO)SM	Blue Cross Medicare Advantage Choice Premier (PPO)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.

SUMMARY OF BENEFITS

January 1, 2017 - December 31, 2017

	Blue Cross Medicare Advantage Choice Plus (PPO)SM	Blue Cross Medicare Advantage Choice Premier (PPO)SM
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	·Austin Area: $42 per month ·Dallas Area: $31.60 per month ·Houston Area: $31.60 per month ·San Antonio Area: $42 per month In addition, you must keep paying your Medicare Part B premium.	·Austin Area: $74 per month ·Dallas Area: $74 per month ·Houston Area: $74 per month ·San Antonio Area: $74 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.
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. Your yearly limit(s) in this plan: • $4,900 for services you receive from in-network providers • $10,000 for services you receive from out-of-network providers. • $10,000 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. 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	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. Your yearly limit(s) in this plan: • $4,900 for services you receive from in-network providers • $10,00 for services you receive from out-of-network providers. • $10,000 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. 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
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.
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]	Our plan covers an unlimited number of days for an inpatient hospital stay.
	• In-network:
	  • $275 copay per day for days 1 through 7
	  • You pay nothing per day for days 8 through 90
	  • You pay nothing per day for days 91 and beyond
	• Out-of-network: 50% of the cost per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.
		• In-network:
		  • $250 copay per day for days 1 through 7
		  • You pay nothing per day for days 8 through 90
		  • You pay nothing per day for days 91 and beyond
		• Out-of-network:
		  • 50% of the cost per stay

OUTPATIENT CARE AND SERVICES		
Doctor's Office Visits	Primary care physician visit: • In-network: $20 copay • Out-of-network: 50% of the cost Specialist visit: • In-network: $50 copay • Out-of-network: 50% of the cost	Primary care physician visit: • In-network: $15 copay • Out-of-network: 50% of the cost Specialist visit: • In-network: $45 copay • Out-of-network: 50% of the cost

	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
Preventive Care	• In-network: You pay nothing • Out-of-network: 50% of the cost Our plan covers many preventive services, including: • 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 Any additional preventive services approved by Medicare during the contract year will be covered.	• In-network: You pay nothing • Out-of-network: 50% of the cost Our plan covers many preventive services, including: • 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 Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$75 copay 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.	$75 copay 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.

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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)*[1,2]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $325 copay • Out-of-network: 50% of the cost Diagnostic tests and procedures: • In-network: $0-100 copay, depending on the service • Out-of-network: 50% of the cost Lab services: • In-network: $5 copay • Out-of-network: 50% of the cost Outpatient x-rays: • In-network: $20-100 copay, depending on the service • Out-of-network: 50% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 20% of the cost • Out-of-network: 50% of the cost	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $325 copay • Out-of-network: 50% of the cost Diagnostic tests and procedures: • In-network: $0-100 copay, depending on the service • Out-of-network: 50% of the cost Lab services: • In-network: $5 copay • Out-of-network: 50% of the cost Outpatient x-rays: • In-network: $15-100 copay, depending on the service • Out-of-network: 50% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 20% of the cost • Out-of-network:50% of the cost

	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $50 copay • Out-of-network: 50% of the cost Routine hearing exam (for up to 1 every year): • In-network: $10 copay • Out-of-network: 50% of the cost Hearing aid fitting/evaluation (1 every 3 years): • In-network: $0 copay • Out-of-network: 50% of the cost Hearing aid: • In-network: $0 copay • Out-of-network: $0 copay Our plan pays up to $1,000 every three years for hearing aids from any provider.	Exam to diagnose and treat hearing and balance issues: • In-network: $45 copay • Out-of-network: 50% of the cost Routine hearing exam (for up to 1 every year): • In-network: $10 copay • Out-of-network: 50% of the cost Hearing aid fitting/evaluation (1 every 3 years): • In-network: $0 copay • Out-of-network: 50% of the cost Hearing aid: • In-network: $0 copay • Out-of-network: $0 copay Our plan pays up to $1,000 every three years for hearing aids from any provider.
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $50 copay • Out-of-network: 50% of the cost	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $45 copay • Out-of-network: 50% of the cost A single office visit that includes: •Cleaning (for up to 2 every year) •Dental x-ray(s) (for up to 1 every year) •Oral exam (for up to 2 every year) • In-network: $5 copay • Out-of-network: $5 copay

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Vision Services[1,2]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0 copay • Out-of-network: 50% of the cost Routine eye exam (for up to 1 every year): • In-network: $10 copay • Out-of-network: Our plan pays up to $40 every year Contact lenses: • In-network: $0 copay • Out-of-network: $0 copay Eyeglass frames: • In-network: $0 copay • Out-of-network: $0 copay Eyeglass lenses (for up to 1 every year): • In-network: $0 copay • Out-of-network: $0 copay Eyeglasses or contact lenses after cataract surgery: • In-network: $0 copay • Out-of-network: 50% of the cost Our plan pays up to $100 every two years for contact lenses, eyeglass lenses, and eyeglass frames from any provider. You pay a $10 copay for a routine eye exam in-network and you receive up to $40 every year for routine eye exams at any provider out-of-network.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0 copay • Out-of-network: 50% of the cost Routine eye exam (for up to 1 every year): • In-network: $10 copay • Out-of-network: Our plan pays up to $40 every year Contact lenses: • In-network: $0 copay • Out-of-network: $0 copay Eyeglass frames: • In-network: $0 copay • Out-of-network: $0 copay Eyeglass lenses (for up to 1 every year): • In-network: $0 copay • Out-of-network: $0 copay Eyeglasses or contact lenses after cataract surgery: • In-network: $40 copay • Out-of-network: 50% of the cost Our plan pays up to $100 every two years for contact lenses, eyeglass lenses, and eyeglass frames from any provider. You pay a $10 copay for a routine eye exam in-network and you receive up to $40 every year for routine eye exams at any provider out-of-network.

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

Mental Health Care[1]	Inpatient visit:
	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.
	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.
	Our plan covers 90 days for an inpatient hospital stay.
	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.
	• In-network:
	  • $250 copay per day for days 1 through 6
	  • You pay nothing per day for days 7 through 90
	• Out-of-network:
	  • 50% of the cost
	Outpatient group therapy visit:
	• In-network: $40 copay
	• Out-of-network: 50% of the cost
	Outpatient individual therapy visit:
	• In-network: $40 copay
	• Out-of-network: 50% of the cost
		Inpatient visit:
		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.
		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.
		Our plan covers 90 days for an inpatient hospital stay.
		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.
		• In-network:
		  • $250 copay per day for days 1 through 6
		  • You pay nothing per day for days 7 through 90
		• Out-of-network:
		  • 50% of the cost
		Outpatient group therapy visit:
		• In-network: $40 copay
		• Out-of-network: 50% of the cost
		Outpatient individual therapy visit:
		• In-network: $40 copay
		• Out-of-network: 50% of the cost

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Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF.
	• In-network:
	  • You pay nothing per day for days 1 through 20
	  • $164.50 copay per day for days 21 through 100
	• Out-of-network: 50% of the cost per stay
		Our plan covers up to 100 days in a SNF.
		• In-network:
		  • You pay nothing per day for days 1 through 20
		  • $164.50 copay per day for days 21 through 100
		• Out-of-network: 50% of the 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 • Out-of-network: 50% of the cost Occupational therapy visit: • In-network: $40 copay • Out-of-network: 50% of the cost Physical therapy and speech and language therapy visit: • In-network: $40 copay • Out-of-network: 50% of the cost	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 • Out-of-network: 50% of the cost Occupational therapy visit: • In-network: $40 copay • Out-of-network: 50% of the cost Physical therapy and speech and language therapy visit: • In-network: $40 copay • Out-of-network: 50% of the cost
Ambulance	• In-network: $300 copay • Out-of-network: $300 copay	• In-network: $300 copay • Out-of-network: $300 copay
Transportation	Not covered	Not covered
Foot Care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $50 copay • Out-of-network: 50% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $45 copay • Out-of-network: 50% of the cost
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	• In-network: 20% of the cost • Out-of-network: 20% of the cost	• In-network: 20% of the cost • Out-of-network: 20% of the cost

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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. Included
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: • In-network: 20% of the cost • Out-of-network: 50% of the cost Other Part B drugs: • In-network: 20% of the cost • Out-of-network: 50% of the cost	For Part B drugs such as chemotherapy drugs: • In-network: 20% of the cost • Out-of-network: 50% of the cost Other Part B drugs: • In-network: 20% of the cost • Out-of-network: 50% of the cost
Acupuncture	Not covered	Not covered
Chiropractic Care[1]	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 • Out-of-network: 50% 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): • In-network: $20 copay • Out-of-network: 50% of the cost

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

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Diabetes Supplies and Services	Diabetes monitoring supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 50% of the cost Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 50% of the cost 0% of the cost for diabetic test strips from a preferred manufacturer; 20% 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: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 50% of the cost Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 50% of the cost 0% of the cost for diabetic test strips from a preferred manufacturer; 20% for other diabetic supplies (testing monitors, lancets, diabetic therapeutic shoes); 20% of the cost for diabetic test strips from a non-preferred manufacturer.
Home Health Care[1]	• In-network: You pay nothing • Out-of-network: 50% of the cost	• In-network: You pay nothing • Out-of-network: 50% of the cost
Outpatient Substance Abuse	Group therapy visit: • In-network: $100 copay • Out-of-network: 50% of the cost Individual therapy visit: • In-network: $100 copay • Out-of-network: 50% of the cost	Group therapy visit: • In-network: $100 copay • Out-of-network: 50% of the cost Individual therapy visit: • In-network: $100 copay • Out-of-network: 50% of the cost
Outpatient Surgery	Ambulatory surgical center: • In-network: $225 copay • Out-of-network: 50% of the cost Outpatient hospital: • In-network: $0-275 copay • Out-of-network: 50% of the cost	Ambulatory surgical center: • In-network: $225 copay • Out-of-network: 50% of the cost Outpatient hospital: • In-network: $0-275 copay • Out-of-network: 50% of the cost

	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
Over-the-Counter Items	Not Covered	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)* [1]	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 50% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 50% of the cost	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 50% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 50% of the cost
Renal Dialysis	• In-network: 20% of the cost • Out-of-network: 20% of the cost	• In-network: 20% of the cost • Out-of-network: 20% of the cost
Hospice	$0 copay 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.	$0 copay 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.
PRESCRIPTION DRUG BENEFITS		

	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]			Blue Cross Medicare Advantage Choice Premier (PPO)[SM]		
Initial Coverage	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. You may get your drugs at network retail pharmacies and mail order pharmacies.			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. You may get your drugs at network retail pharmacies and mail order pharmacies.		
	Standard Retail Cost-Sharing			**Standard Retail Cost-Sharing**		
	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 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 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

	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]			Blue Cross Medicare Advantage Choice Premier (PPO)[SM]		
Initial Coverage (continued)	**Preferred Retail Cost-Sharing**			**Preferred Retail Cost-Sharing**		
	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 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 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
	Standard Mail Order Cost-Sharing			**Standard Mail Order Cost-Sharing**		
	Tier	**Three-month supply**		**Tier**	**Three-month supply**	
	Tier 1 (Preferred Generic)	$27 copay		**Tier 1 (Preferred Generic)**	$27 copay	
	Tier 2 (Generic)	$60 copay		**Tier 2 (Generic)**	$60 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 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.		

	Blue Cross Medicare Advantage Choice Plus (PPO)SM	Blue Cross Medicare Advantage Choice Premier (PPO)SM
Coverage Gap	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. 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. 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.	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. 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. 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.

	Blue Cross Medicare Advantage Choice Plus (PPO)SM				Blue Cross Medicare Advantage Choice Premier (PPO)SM			
Coverage Gap (Continued)	**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 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
	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 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
	Standard Mail Order Cost-Sharing				**Standard Mail Order Cost-Sharing**			
	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 2 (Generic)	All		$60 copay	**Tier 2 (Generic)**	All		$60 copay

	Blue Cross Medicare Advantage Choice Plus (PPO)SM	Blue Cross Medicare Advantage Choice Premier (PPO)SM
Catastrophic Coverage	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: • 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.	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: • 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.

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 1-877-774-8592 (TTY: 711). تماس بگیرید.

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 નઃશુલ્ક 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

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 lasemana. 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).

Out-of-network/non-contracted providers are under no obligation to treat Plan/Part D Sponsor members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

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 Bastrop, Bexar, Burnet, Caldwell, Chambers, Collin, Dallas, Denton, Fayette, Fort Bend, Hardin, Harris, Hays, Jefferson, Lee, Liberty, Montgomery, Tarrant, Travis and Williamson counties.

PPO plans provided by Blue Cross and Blue Shield of Texas, which refers to HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. HISC is a Medicare Advantage organization with a Medicare contract. Enrollment in HISC's plan depends on contract renewal.