BlueCross BlueShield of Texas

Summary of Benefits

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

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

January 1, 2022 – December 31, 2022

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

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Pre-Enrollment Checklist

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

Understanding the Benefits

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

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. **In addition, you will pay a higher copay for services received by non-contracted providers.**

INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2022 – December 31, 2022

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
You have choices about how to get your Medicare prescription drug benefits	• One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. • Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Cross Medicare Advantage Choice Premier (PPO)** or **Blue Cross Medicare Advantage Choice Plus (PPO)**.	
Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what **Blue Cross Medicare Advantage Choice Premier (PPO)** or **Blue Cross Medicare Advantage Choice Plus (PPO)** covers and what you pay. • If you want to compare our plans with other Medicare Health Plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on 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 Premier (PPO)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Prescription Drug Benefits	• Things to Know About **Blue Cross Medicare Advantage Choice Plus (PPO)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Prescription Drug Benefits
Blue Access for Members	Go to: getbluetx.com/mapd to access information about your plan selection, including: • Claims information • Benefits information • Pharmacy locator	
Hours of Operation	• From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. – 8:00 p.m. local time. • From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. – 8:00 p.m. local time.	

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
Phone Numbers and Website	• If you are a member of this plan, call toll-free 1-877-774-8592 (TTY users should call 711). • If you are not a member of this plan, call toll-free 1-877-583-8129 (TTY users should call 711). • Our website: getbluetx.com/mapd	
Who can join?	To join **Blue Cross Medicare Advantage Choice Premier (PPO)** or **Blue Cross Medicare Advantage Choice Plus (PPO)**, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, and live in our service area.	
	Our service area includes the following counties in Texas: Collin, Cooke, Dallas, Denton, Fannin, Hill, Hood, Johnson, Navarro, Rockwall, Tarrant, and Wise.	Our service area includes the following counties in Texas: Collin, Cooke, Dallas, Denton, Fannin, Hill, Hood, Johnson, Navarro, Rockwall, Tarrant, and Wise.
Which doctors, hospitals, and pharmacies can I use?	**Blue Cross Medicare Advantage Choice Premier (PPO)** 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. • You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. • You can see our plan's *Provider Finder* and *Pharmacy Directory* at our website getbluetx.com/mapd. • Or, call us and we will send you a copy of the *Provider Directory* and/or *Pharmacy Directory*.	**Blue Cross Medicare Advantage Choice Plus (PPO)** 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. • You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. • You can see our plan's *Provider Finder* and *Pharmacy Directory* at our website getbluetx.com/mapd. • Or, call us and we will send you a copy of the *Provider Directory* and/or *Pharmacy Directory*.
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.	

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
	You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, getbluetx.com/mapd. Or, call us and we will send you a copy of the formulary.	
How will I determine my drug costs?	Our plan groups each medication into one of five "tiers". You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, Coverage Gap, and Catastrophic Coverage.	

SUMMARY OF BENEFITS

January 1, 2022 – December 31, 2022

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	$62 per month. In addition, you must keep paying your Medicare Part B premium.	$0 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.	**In-Network:** $0 **Out-of-Network:** $750
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. **Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.**	
	Your yearly limit(s) in this plan: • $5,900 for services you receive from in-network providers. • $11,300 for services you receive from out-of-network providers. • $11,300 for services you receive from any provider. Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count toward this limit.	Your yearly limit(s) in this plan: • $7,550 for services you receive from in-network providers. • $11,300 for services you receive from out-of-network providers. • $11,300 for services you receive from any provider. Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count toward this limit.

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
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 * may require prior authorization or a referral from your doctor.		
INPATIENT CARE		
Inpatient Hospital Care*	**In-network:** • $265 copay per day for days 1-7 and a $0 copay per day for days 8-90 • $0 copay per day for days 91 and beyond **Out-of-network:** • 50% of the total cost per stay	**In-network:** • $372 copay per day for days 1-5 and a $0 copay per day for days 6-90 • $0 copay per day for days 91 and beyond **Out-of-network:** • 50% of the total cost per stay
OUTPATIENT CARE AND SERVICES		
Outpatient Hospital Care/ Surgery*	**Outpatient hospital** **In-network:** • $325 copay **Out-of-network:** • 50% of the total cost **Ambulatory surgical center** **In-network:** • $225 copay **Out-of-network:** • 50% of the total cost	**Outpatient hospital** **In-network:** • $325 copay **Out-of-network:** • 50% of the total cost **Ambulatory surgical center** **In-network:** • $275 copay **Out-of-network:** • 50% of the total cost

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
Doctor's Office Visits*	**Primary care physician visit** **In-network:** • $5 copay **Out-of-network:** • 50% of the total cost **Specialist visit** **In-network:** • $35 copay **Out-of-network:** • 50% of the total cost	**Primary care physician visit** **In-network:** • $10 copay **Out-of-network:** • 50% of the total cost **Specialist visit** **In-network:** • $50 copay **Out-of-network:** • 50% of the total cost

<table>
<tr><th></th><th>Blue Cross Medicare Advantage Choice Premier (PPO)℠</th><th>Blue Cross Medicare Advantage Choice Plus (PPO)℠</th></tr>
<tr><td rowspan="3">Preventive Care*</td><td>In-network:
• $0 copay
Out-of-network:
• 50% of the total cost</td><td>In-network:
• $0 copay
Out-of-network:
• 50% of the total cost</td></tr>
<tr><td colspan="2">Our plan covers many preventive services, including:</td></tr>
<tr><td colspan="2">• 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.</td></tr>
<tr><td>Emergency Care</td><td>$90 copay
Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital Care" section of this booklet for other costs.</td><td>$90 copay
Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital Care" section of this booklet for other costs.</td></tr>
<tr><td>Urgently Needed Services</td><td>$40 copay</td><td>$40 copay</td></tr>
</table>

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
Diagnostic Tests, Lab and Radiology Services, and X-Rays ***(Costs for these services may vary based on place of service)****	**<u>Diagnostic radiology services (such as MRIs, CT scans)</u>** **In-network:** • $225 copay at a free-standing clinic and $300 copay for services in an outpatient hospital setting **Out-of-network:** • 50% of the total cost **<u>Diagnostic tests and procedures</u>** **In-network:** • $0 - $100 copay, depending on the service **Out-of-network:** • 50% of the total cost **<u>Lab services</u>** **In-network:** • $5 - $50 copay **Out-of-network:** • 50% of the total cost **<u>Outpatient X-rays</u>** **In-network:** • $5 - $100 copay **Out-of-network:** • 50% of the total cost	**<u>Diagnostic radiology services (such as MRIs, CT scans)</u>** **In-network:** • $300 copay at a free-standing clinic and $325 copay for services in an outpatient hospital setting **Out-of-network:** • 50% of the total cost **<u>Diagnostic tests and procedures</u>** **In-network:** • $0 - $100 copay, depending on the service **Out-of-network:** • 50% of the total cost **<u>Lab services</u>** **In-network:** • $5 - $50 copay **Out-of-network:** • 50% of the total cost **<u>Outpatient X-rays</u>** **In-network:** • $5 - $100 copay **Out-of-network:** • 50% of the total cost

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
	Therapeutic radiology services (such as radiation treatment for cancer) **In-network:** • 20% of the total cost **Out-of-network:** • 50% of the total cost	**Therapeutic radiology services (such as radiation treatment for cancer)** **In-network:** • 20% of the total cost **Out-of-network:** • 50% of the total cost

	Blue Cross Medicare Advantage Choice Premier (PPO)℠	Blue Cross Medicare Advantage Choice Plus (PPO)℠
Hearing Services	**Exam to diagnose and treat hearing and balance issues** **In-network:** • $45 copay **Out-of-network:** • 50% of the total cost **Routine hearing exam** **In-network:** • $0 copay for 1 routine hearing exam each year **Out-of-network:** • 50% of the total cost for 1 routine hearing exam each year **Hearing aid fitting/evaluation** **In-network:** • Purchase includes unlimited provider visits for fitting and adjustments within 12 months of purchase of hearing aids. **Out-of-Network:** • 50% of the total cost for 1 hearing aid fitting and evaluation visit every three years **Hearing Aids** • There is a $1,000 maximum plan coverage limit for hearing aids (both ears combined) purchased in- or out-of-network every three years.	**Exam to diagnose and treat hearing and balance issues** **In-network:** • $50 copay **Out-of-network:** • 50% of the total cost **Routine hearing exam** • Not Covered **Hearing aid fitting/evaluation** • Not Covered **Hearing aids** • Not Covered

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

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
Vision Services*	**Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)** **In-network:** • $0 copay for Medicare-covered eye exam; $0 copay for one vision specialist exam **Out-of-network:** • 50% of the total cost **Routine eye exam** **In-network and Out-of-network:** • $0 copay for 1 routine vision exam every year • $40 allowance for an in-network or out-of-network routine eye exam every year **Eyeglasses or contact lenses after cataract surgery** **In-network:** • $0 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **Out-of-Network:** • 50% of the total cost for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **Routine eye wear** **Contact lenses** **In-network and Out-of-network:**	**Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)** **In-network:** • $0 copay for Medicare-covered eye exam; $0 copay for one vision specialist exam **Out-of-network:** • 50% of the total cost **Routine eye exam** **In-network and Out-of-network:** • $0 copay for 1 routine vision exam every year • $40 allowance for an in-network or out-of-network routine eye exam every year **Eyeglasses or contact lenses after cataract surgery** **In-network:** • $0 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **Out-of-Network:** • 50% of the total cost for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **Routine eye wear** • Not Covered

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
	• $0 copay **Eyeglass frames** **In-network and Out-of-network:** • $0 copay for 1 pair of eyeglass frames every year **Eyeglass lenses** **In-network and Out-of-network:** • $0 copay for 1 pair of eyeglass lenses every year (Standard lenses only. Progressive lenses excluded) $100 plan coverage limited in-network and out-of-network for routine eye wear every year (including eyeglass frames, lenses, and contact lenses)	

<table>
<tr><th></th><th>Blue Cross Medicare Advantage Choice Premier (PPO)℠</th><th>Blue Cross Medicare Advantage Choice Plus (PPO)℠</th></tr>
<tr><td rowspan="2">Mental Health Care*</td><td colspan="2"><u>Inpatient visit</u>
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.</td></tr>
<tr><td>In-network:
• $270 copay per day for days 1-6 and a $0 copay per day for days 7-90
Out-of-network:
• 50% of the total cost per stay
<u>Outpatient group therapy visit</u>
In-network:
• $30 copay
Out-of-network:
• 50% of the total cost
<u>Outpatient individual therapy visit</u>
In-network:
• $30 copay
Out-of-network:
• 50% of the total cost</td><td>In-network:
• $270 copay per day for days 1-6 and a $0 copay per day for days 7-90
Out-of-network:
• 50% of the total cost per stay
<u>Outpatient group therapy visit</u>
In-network:
• $30 copay
Out-of-network:
• 50% of the total cost
<u>Outpatient individual therapy visit</u>
In-network:
• $30 copay
Out-of-network:
• 50% of the total cost</td></tr>
</table>

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
Skilled Nursing Facility (SNF)*	**Our plan covers up to 100 days in a SNF.** Inpatient hospital stay is not required prior to admission. **In-network:** • $0 copay per day for days 1-20 and a $188 copay per day for days 21-100 **Out-of-network:** • 50% of the total cost per stay	**Our plan covers up to 100 days in a SNF.** Inpatient hospital stay is not required prior to admission. **In-network:** • $0 copay per day for days 1-20 and a $188 copay per day for days 21-100 **Out-of-network:** • 50% of the total cost per stay

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
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:** • $30 copay **Out-of-network:** • 50% of the total cost **Occupational therapy visit** **In-network:** • $40 copay **Out-of-network:** • 50% of the total cost **Physical therapy and speech and language therapy visit** **In-network:** • $40 copay **Out-of-network:** • 50% of the total 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:** • $30 copay **Out-of-network:** • 50% of the total cost **Occupational therapy visit** **In-network:** • $40 copay **Out-of-network:** • 50% of the total cost **Physical therapy and speech and language therapy visit** **In-network:** • $40 copay **Out-of-network:** • 50% of the total cost

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
Ambulance* ***(Medicare-covered ground and air transportation services)***	**In-network:** • $300 copay for each one-way ground transportation trip • 20% of the total cost for each one-way air transportation trip **Out-of-network:** • $300 copay for each one-way ground transportation trip • 20% of the total cost for each one-way air transportation trip	**In-network:** • $300 copay for each one-way ground transportation trip • 20% of the total cost for each one-way air transportation trip **Out-of-network:** • $300 copay for each one-way ground transportation trip • 20% of the total cost for each one-way air transportation trip
Transportation*	Not Covered	Not Covered
Medicare Part B Drugs*	**Part B chemotherapy drugs** **In-network:** • 20% of the total cost **Out-of-network:** • 50% of the total cost **Other Part B drugs** **In-network:** • 20% of the total cost **Out-of-network:** • 50% of the total cost	**Part B chemotherapy drugs** **In-network:** • 20% of the total cost **Out-of-network:** • 50% of the total cost **Other Part B drugs** **In-network:** • 20% of the total cost **Out-of-network:** • 50% of the total cost

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
PRESCRIPTION DRUG BENEFITS		
Part D Deductible Stage	• $295 per year for Part D prescription drugs except for drugs listed on Tier 1 Preferred Generic and Tier 2 Generic which are excluded from the deductible. Once you have paid $295 for your Tiers 3, 4 and 5 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.	• $480 per year for Part D prescription drugs except for drugs listed on Tier 1 Preferred Generic and Tier 2 Generic which are excluded from the deductible. Once you have paid $480 for your Tiers 3, 4 and 5 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

Prescription Drug Cost Shares During the Initial Coverage Stage

You pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.

Initial Coverage Stage: Standard Retail Pharmacy		
Standard Retail	**Blue Cross Medicare Advantage Choice Premier (PPO)℠**	**Blue Cross Medicare Advantage Choice Plus (PPO)℠**
Tier 1: Preferred Generic	**One-month supply:** $10 copay	**One-month supply:** $10 copay
	Three-month supply: $30 copay	**Three-month supply:** $30 copay
Tier 2: Generic	**One-month supply:** $20 copay	**One-month supply:** $20 copay
	Three-month supply: $60 copay	**Three-month supply:** $60 copay
Tier 3: Preferred Brand	**One-month supply:** $47 copay	**One-month supply:** $47 copay
	Three-month supply: $141 copay	**Three-month supply:** $141 copay
Tier 4: Non-Preferred Drug	**One-month supply:** $100 copay	**One-month supply:** $100 copay
	Three-month supply: $300 copay	**Three-month supply:** $300 copay
Tier 5: Specialty Tier	**One-month supply:** 28% of the total cost	**One-month supply:** 25% of the total cost
	Three-month supply: A long-term supply is not available for drugs in Tier 5.	**Three-month supply:** A long-term supply is not available for drugs in Tier 5.

Initial Coverage Stage: Preferred Retail Pharmacy		
Preferred Retail	**Blue Cross Medicare Advantage Choice Premier (PPO)℠**	**Blue Cross Medicare Advantage Choice Plus (PPO)℠**
Tier 1: Preferred Generic	**One-month supply:** $0 copay	**One-month supply:** $0 copay
	Three-month supply: $0 copay	**Three-month supply:** $0 copay
Tier 2: Generic	**One-month supply:** $10 copay	**One-month supply:** $10 copay
	Three-month supply: $30 copay	**Three-month supply:** $30 copay
Tier 3: Preferred Brand	**One-month supply:** $47 copay	**One-month supply:** $47 copay
	Three-month supply: $141 copay	**Three-month supply:** $141 copay
Tier 4: Non-Preferred Drug	**One-month supply:** $100 copay	**One-month supply:** $100 copay
	Three-month supply: $300 copay	**Three-month supply:** $300 copay
Tier 5: Specialty Tier	**One-month supply:** 28% of the total cost	**One-month supply:** 25% of the total cost
	Three-month supply: A long-term supply is not available for drugs in Tier 5.	**Three-month supply:** A long-term supply is not available for drugs in Tier 5.

Initial Coverage Stage: Standard Mail Order Pharmacy (3-month supply)		
Standard Mail Order	**Blue Cross Medicare Advantage Choice Premier (PPO)℠**	**Blue Cross Medicare Advantage Choice Plus (PPO)℠**
Tier 1: Preferred Generic	$20 copay	$20 copay
Tier 2: Generic	$40 copay	$40 copay
Tier 3: Preferred Brand	$94 copay	$94 copay
Tier 4: Non-Preferred Drug	$300 copay	$300 copay
Tier 5: Specialty Tier	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

Initial Coverage Stage: Preferred Mail Order Pharmacy (3-month supply)		
Preferred Mail Order	**Blue Cross Medicare Advantage Choice Premier (PPO)℠**	**Blue Cross Medicare Advantage Choice Plus (PPO)℠**
Tier 1: Preferred Generic	$0 copay	$0 copay
Tier 2: Generic	$20 copay	$20 copay
Tier 3: Preferred Brand	$94 copay	$94 copay
Tier 4: Non-Preferred Drug	$300 copay	$300 copay
Tier 5: Specialty Tier	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

Initial Coverage Stage: Long-term Care and Out-of-network Pharmacies (one-month supply)		
	Blue Cross Medicare Advantage Choice Premier (PPO)SM	**Blue Cross Medicare Advantage Choice Plus (PPO)SM**
Long-term Care Tiers 1-5	If you reside in a long-term facility, you pay the same as at a standard retail pharmacy.	
Out-of-network Tiers 1-5	You may get drugs from an out-of-network pharmacy only when you are not able to use a network pharmacy. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.	

Coverage Gap Stage: Standard Retail Pharmacy		
	Blue Cross Medicare Advantage Choice Premier (PPO)℠	**Blue Cross Medicare Advantage Choice Plus (PPO)℠**
Coverage Gap Stage	Your plan provides additional coverage through the gap. For Tier 1, you continue to pay the similar amounts as you did in the Initial Coverage Stage. Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under your plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.	Your plan provides additional coverage through the gap. For Tier 1, you continue to pay the similar amounts as you did in the Initial Coverage Stage. Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under your plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.

Catastrophic Coverage Stage		
	Blue Cross Medicare Advantage Choice Premier (PPO)℠	**Blue Cross Medicare Advantage Choice Plus (PPO)℠**
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $7,050, you pay the greater of: • 5% of the total cost, or • $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs	

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
ADDITIONAL MEMBER BENEFITS		
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Acupuncture for Chronic Low Back Pain*	**In-network:** • $35 copay **Out-of-network:** • 50% of the total cost	**In-network:** • $50 copay **Out-of-network:** • 50% of the total cost
Chiropractic Care*	**Medicare-covered 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 total cost	**Medicare-covered 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 total cost

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
Diabetes Supplies and Services*	**Diabetes monitoring supplies** **In-network** • 0% or 20% of the total cost **Out-of-network:** • 20% of the total cost 0% cost sharing limited to diabetic testing supplies (meters, strips and lancets) obtained through the pharmacy for a LifeScan branded product (OneTouch Verio Flex, OneTouch Verio Reflect, OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2). 20% cost sharing for all other diabetic supplies including approved exceptions. All test strips will also be subject to a quantity limit of 204 per 30 days. Continuous Glucose Monitoring (CGM) products obtained through the pharmacy are subject to Prior Authorization and quantity limit. **Diabetes self-management training** **In-network:** • $0 copay **Out-of-network:** • 50% of the total cost **Therapeutic shoes or inserts** **In-network:** • 20% of the total cost	**Diabetes monitoring supplies** **In-network** • 0% or 20% of the total cost **Out-of-network:** • 20% of the total cost 0% cost sharing limited to diabetic testing supplies (meters, strips and lancets) obtained through the pharmacy for a LifeScan branded product (OneTouch Verio Flex, OneTouch Verio Reflect, OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2). 20% cost sharing for all other diabetic supplies including approved exceptions. All test strips will also be subject to a quantity limit of 204 per 30 days. Continuous Glucose Monitoring (CGM) products obtained through the pharmacy are subject to Prior Authorization and quantity limit. **Diabetes self-management training** **In-network:** • $0 copay **Out-of-network:** • 50% of the total cost **Therapeutic shoes or inserts** **In-network:** • 20% of the total cost

	Blue Cross Medicare Advantage Choice Premier (PPO)℠	Blue Cross Medicare Advantage Choice Plus (PPO)℠
	Out-of-network: • 20% of the total cost	**Out-of-network:** • 20% of the total cost
Durable Medical Equipment *(wheelchairs, oxygen, etc.)**	**In-network:** • 20% of the total cost **Out-of-network:** • 20% of the total cost	**In-network:** • 20% of the total cost **Out-of-network:** • 20% of the total cost
Wellness Programs	$0 copay for SilverSneakers® † Fitness Program This benefit includes SilverSneakers instructor-led group fitness classes. At participating locations, you can take classes plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms. SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and a mobile app, SilverSneakers GO™. †SilverSneakers, SilverSneakers FLEX, SilverSneakers On-Demand, and SilverSneakers GO are registered trademarks or trademarks of Tivity Health, Inc.	
Foot Care *(podiatry services)**	**Medicare-covered 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 total cost	**Medicare-covered 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 total cost

	Blue Cross Medicare Advantage Choice Premier (PPO)℠	Blue Cross Medicare Advantage Choice Plus (PPO)℠
Home Health Care*	**In-network:** • $0 copay **Out-of-network:** • 50% of the total cost	**In-network:** • $0 copay **Out-of-network:** • 50% of the total cost
Opioid Treatment Program Services*	**In-network:** • $35 copay **Out-of-network:** • 50% of the total cost	**In-network:** • $50 copay **Out-of-network:** • 50% of the total cost
Outpatient Substance Abuse Services*	**Group therapy visit** **In-network:** • $75 copay **Out-of-network:** • 50% of the total cost **Individual therapy visit** **In-network:** • $75 copay **Out-of-network:** • 50% of the total cost	**Group therapy visit** **In-network:** • $75 copay **Out-of-network:** • 50% of the total cost **Individual therapy visit** **In-network:** • $75 copay **Out-of-network:** • 50% of the total cost
Over-the-Counter Items	Not Covered	Not Covered

	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]	Blue Cross Medicare Advantage Choice Plus (PPO)[SM]
Prosthetic Devices *(braces, artificial limbs, etc.)**	**Prosthetic devices** **In-network:** • 20% of the total cost **Out-of-network:** • 20% of the total cost **Related medical supplies** **In-network:** • 20% of the total cost **Out-of-network:** • 20% of the total cost	**Prosthetic devices** **In-network:** • 20% of the total cost **Out-of-network:** • 20% of the total cost **Related medical supplies** **In-network:** • 20% of the total cost **Out-of-network:** • 20% of the total cost
Meals*	Not Covered	Not Covered
Renal Dialysis*	**In-network:** • 20% of the total cost **Out-of-network:** • 50% of the total cost	**In-network:** • 20% of the total cost **Out-of-network:** • 50% of the total cost
Telehealth Services	**In-network:** • $0 copay for urgent care visits through MDLive	**In-network:** • $0 copay for urgent care visits through MDLive
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

BlueCross BlueShield of Texas

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

Blue Cross and Blue Shield of Texas:

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

If you need these services, contact Civil Rights Coordinator.

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

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

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

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

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

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

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

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **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/TDD：**711**）。

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

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/TDD: **711**).

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

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

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

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/TDD: **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-774-8592** (TTY/TDD: **711**).

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

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

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-774-8592** (TTY: **711**).

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

BlueCross BlueShield of Texas

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

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

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