BlueCross BlueShield of Illinois

Summary of Benefits

Blue Cross Medicare Advantage Basic (HMO)SM

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

Blue Cross Medicare Advantage Premier Plus (HMO-POS)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 getblueil.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.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the *Provider Directory*).

INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2022 – December 31, 2022

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[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 Basic (HMO)**, **Blue Cross Medicare Advantage Basic Plus (HMO-POS)**, or **Blue Cross Medicare Advantage Premier Plus (HMO-POS)**.		
Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what **Blue Cross Medicare Advantage Basic (HMO)**, **Blue Cross Medicare Advantage Basic Plus (HMO-POS)**, or **Blue Cross Medicare Advantage Premier Plus (HMO-POS)** 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 Basic (HMO)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Prescription Drug Benefits	• 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 • Prescription Drug Benefits • Optional Benefits (you must pay an extra premium for these benefits)	• Things to Know About **Blue Cross Medicare Advantage Premier Plus (HMO-POS)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Prescription Drug Benefits

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Blue Access for Members	Go to: getblueil.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.		
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: getblueil.com/mapd		
Who can join?	To join **Blue Cross Medicare Advantage Basic (HMO)**, **Blue Cross Medicare Advantage Basic Plus (HMO-POS)**, or **Blue Cross Medicare Advantage Premier Plus (HMO-POS)**, 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 Illinois: Cook, DuPage, Kane, Kankakee, Kendall, McHenry, and Will.	Our service area includes the following counties in Illinois: Cook, DuPage, Kane, Kankakee, Kendall, McHenry, and Will.	Our service area includes the following counties in Illinois: Cook, DuPage, Kane, Kankakee, Kendall, McHenry, and Will.

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Which doctors, hospitals, and pharmacies can I use?	**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. • 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 getblueil.com/mapd. • Or, call us and we will send you a copy of the *Provider Directory* and/or *Pharmacy Directory*.	**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. • 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 getblueil.com/mapd. • Or, call us and we will send you a copy of the *Provider Directory* and/or *Pharmacy Directory*.	**Blue Cross Medicare Advantage Premier 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. • 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 getblueil.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. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, getblueil.com/mapd. Or, call us and we will send you a copy of the formulary.		

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

SUMMARY OF BENEFITS

January 1, 2022 – December 31, 2022

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[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.	$83 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.
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: • $2,950 for services you receive from in-network providers.	Your yearly limit(s) in this plan: • $3,450 for services you receive from in-network providers.	Your yearly limit(s) in this plan: • $2,900 for services you receive from in-network providers.
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.

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
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:** • $225 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:** • Not Covered	**In-network:** • $220 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:** • 40% of the total cost per stay	**In-network:** • $190 copay per day for days 1-8 and a $0 copay per day for days 9-90 • $0 copay per day for days 91 and beyond **Out-of-network:** • 40% of the total cost per stay
OUTPATIENT CARE AND SERVICES			
Outpatient Hospital Care/ Surgery*	**Outpatient hospital** **In-network:** • $250 copay **Out-of-network:** • Not Covered **Ambulatory surgical center** **In-network:** • $150 copay **Out-of-network:** • Not Covered	**Outpatient hospital** **In-network:** • $250 copay **Out-of-network:** • 40% of the total cost **Ambulatory surgical center** **In-network:** • $200 copay **Out-of-network:** • 40% of the total cost	**Outpatient hospital** **In-network:** • $225 copay **Out-of-network:** • 40% of the total cost **Ambulatory surgical center** **In-network:** • $175 copay **Out-of-network:** • 40% of the total cost

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Doctor's Office Visits*	**Primary care physician visit** **In-network:** • $0 copay **Out-of-network:** • Not Covered **Specialist visit** **In-network:** • $25 copay **Out-of-network:** • Not Covered	**Primary care physician visit** **In-network:** • $0 copay **Out-of-network:** • $60 copay **Specialist visit** **In-network:** • $35 copay **Out-of-network:** • $75 copay	**Primary care physician visit** **In-network:** • $0 copay **Out-of-network:** • $60 copay **Specialist visit** **In-network:** • $30 copay **Out-of-network:** • $75 copay

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Preventive Care*	**In-network:** • $0 copay **Out-of-network:** • Not Covered	**In-network:** • $0 copay **Out-of-network:** • $60 copay	**In-network:** • $0 copay **Out-of-network:** • $60 copay
	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	$120 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.	$120 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.	$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.
Urgently Needed Services	$25 copay	$30 copay	$30 copay

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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:** • $125 copay at a free-standing clinic and $175 copay for services in an outpatient hospital setting **Out-of-network:** • Not Covered **<u>Diagnostic tests and procedures</u>** **In-network:** • $0 - $50 copay, depending on the service **Out-of-network:** • Not Covered **<u>Lab services</u>** **In-network:** • $0 copay **Out-of-network:** • Not Covered **<u>Outpatient X-rays</u>** **In-network:** • $0 copay **Out-of-network:**	**<u>Diagnostic radiology services (such as MRIs, CT scans)</u>** **In-network:** • $175 copay at a free-standing clinic and $225 copay for services in an outpatient hospital setting **Out-of-network:** • 40% of the total cost **<u>Diagnostic tests and procedures</u>** **In-network:** • $0 - $50 copay, depending on the service **Out-of-network:** • 40% of the total cost **<u>Lab services</u>** **In-network:** • $0 copay **Out-of-network:** • 40% of the total cost **<u>Outpatient X-rays</u>** **In-network:** • $0 copay **Out-of-network:**	**<u>Diagnostic radiology services (such as MRIs, CT scans)</u>** **In-network:** • $150 copay at a free-standing clinic and $200 copay for services in an outpatient hospital setting **Out-of-network:** • 40% of the total cost **<u>Diagnostic tests and procedures</u>** **In-network:** • $0 - $50 copay, depending on the service **Out-of-network:** • 40% of the total cost **<u>Lab services</u>** **In-network:** • $0 copay **Out-of-network:** • 40% of the total cost **<u>Outpatient X-rays</u>** **In-network:** • $0 copay **Out-of-network:**

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM
	• Not Covered **Therapeutic radiology services (such as radiation treatment for cancer)** **In-network:** • 20% of the total cost **Out-of-network:** • Not Covered	• 40% of the total cost **Therapeutic radiology services (such as radiation treatment for cancer)** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost	• 40% of the total cost **Therapeutic radiology services (such as radiation treatment for cancer)** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Hearing Services	**Exam to diagnose and treat hearing and balance issues** **In-network:** • $35 copay **Out-of-network:** • Not Covered **Routine hearing exam** **In-network:** • $0 copay 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. **Hearing aids** **In-network:** • $699 to $999 copay for up to 1 per ear per year	**Exam to diagnose and treat hearing and balance issues** **In-network:** • $5 copay **Out-of-network:** • 40% of the total cost **Routine hearing exam** • Not Covered **Hearing aid fitting/evaluation** • Not Covered **Hearing aids** • Not Covered	**Exam to diagnose and treat hearing and balance issues** **In-network:** • $5 copay **Out-of-network:** • 40% of the total cost **Routine hearing exam** **In-network:** • $0 copay 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. **Hearing aids** **In-network:** • $699 to $999 copay for up to 1 per ear per year

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Dental Services*	**Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)** **In-network:** • $35 copay **Out-of-network:** • Not Covered **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:**	**Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)** **In-network:** • $35 copay **Out-of-network:** • 40% of the total cost **Preventive dental services** • Not Covered **Comprehensive dental services** • Not Covered	**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:** • 40% 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:**

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
	• $2,000 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.		• $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.

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[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:** • Not Covered **Routine eye exam** **In-network:** • $0 copay for 1 routine vision exam every year **Eyeglasses or contact lenses after cataract surgery** **In-network:** • $35 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **Out-of-Network:** • Not Covered	**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:** • 40% of the total cost **Routine eye exam** **In-network:** • $0 copay for 1 routine vision exam every year **Eyeglasses or contact lenses after cataract surgery** **In-network:** • $35 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **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:** • 40% of the total cost **Routine eye exam** **In-network:** • $0 copay for 1 routine vision 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:**

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
		• 40% of the total cost for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery	• 40% 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:** • $0 copay **Eyeglass frames** **In-network:** • $0 copay for 1 pair of eyeglass frames every year **Eyeglass lenses** **In-network:** • $0 copay for 1 pair of eyeglass lenses every year (Standard lenses only. Progressive lenses excluded) $200 plan coverage limited in-network for routine eye wear every year (including eyeglass frames, lenses, and contact lenses)	**Routine eye wear** • Not Covered	**Routine eye wear** **Contact lenses** **In-network:** • $0 copay **Eyeglass frames** **In-network:** • $0 copay for 1 pair of eyeglass frames every year **Eyeglass lenses** **In-network:** • $0 copay for 1 pair of eyeglass lenses every year (Standard lenses only. Progressive lenses excluded) $200 plan coverage limited in-network for routine eye wear every year (including eyeglass frames, lenses, and contact lenses)

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Mental Health Care*	**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.		
	In-network: • $260 copay per day for days 1-7 and a $0 copay per day for days 8-90 **Out-of-network:** • Not Covered **Outpatient group therapy visit** **In-network:** • $30 copay **Out-of-network:** • Not Covered **Outpatient individual therapy visit** **In-network:** • $30 copay **Out-of-network:**	**In-network:** • $215 copay per day for days 1-7 and a $0 copay per day for days 8-90 **Out-of-network:** • 40% of the total cost per stay **Outpatient group therapy visit** **In-network:** • $30 copay **Out-of-network:** • 40% of the total cost **Outpatient individual therapy visit** **In-network:** • $30 copay **Out-of-network:**	**In-network:** • $225 copay per day for days 1-7 and a $0 copay per day for days 8-90 **Out-of-network:** • 40% of the total cost per stay **Outpatient group therapy visit** **In-network:** • $30 copay **Out-of-network:** • 40% of the total cost **Outpatient individual therapy visit** **In-network:** • $30 copay **Out-of-network:**

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
	• Not Covered	• 40% of the total cost	• 40% of the total cost
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:** • Not Covered	**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:** • 40% 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:** • 40% of the total cost per stay

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[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:** • Not Covered **Occupational therapy visit** **In-network:** • $35 copay **Out-of-network:** • Not Covered **Physical therapy and speech and language therapy visit** **In-network:** • $35 copay **Out-of-network:** • Not Covered	**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:** • 40% of the total cost **Occupational therapy visit** **In-network:** • $35 copay **Out-of-network:** • 40% of the total cost **Physical therapy and speech and language therapy visit** **In-network:** • $40 copay **Out-of-network:** • 40% 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:** • 40% of the total cost **Occupational therapy visit** **In-network:** • $35 copay **Out-of-network:** • 40% of the total cost **Physical therapy and speech and language therapy visit** **In-network:** • $40 copay **Out-of-network:** • 40% of the total cost

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Ambulance* ***(Medicare-covered ground and air transportation services)***	**In-network:** • $250 copay for each one-way ground transportation trip • 20% of the total cost for each one-way air transportation trip **Out-of-network:** • Not Covered	**In-network:** • $250 copay for each one-way ground transportation trip • 20% of the total cost for each one-way air transportation trip **Out-of-network:** • $250 copay for each one-way ground transportation trip • 20% of the total cost for each one-way air transportation trip	**In-network:** • $225 copay for each one-way ground transportation trip • 20% of the total cost for each one-way air transportation trip **Out-of-network:** • $225 copay for each one-way ground transportation trip • 20% of the total cost for each one-way air transportation trip
Transportation*	• $0 copay for up to 12 one-way trips every year to plan-approved locations.	• $0 copay for up to 24 one-way trips every year to plan-approved locations.	• $0 copay for up to 12 one-way trips every year to plan-approved locations.

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Medicare Part B Drugs*	**Part B chemotherapy drugs** **In-network:** • 20% of the total cost **Out-of-network:** • Not Covered **Other Part B drugs** **In-network:** • 20% of the total cost **Out-of-network:** • Not Covered	**Part B chemotherapy drugs** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost **Other Part B drugs** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost	**Part B chemotherapy drugs** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost **Other Part B drugs** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
PRESCRIPTION DRUG BENEFITS			
Part D Deductible Stage	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you. You begin in the Initial Coverage Stage when you fill your first prescription of the year.	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you. You begin in the Initial Coverage Stage when you fill your first prescription of the year.	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you. You begin in the Initial Coverage Stage when you fill your first prescription of the year.

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 Basic (HMO)℠**	**Blue Cross Medicare Advantage Basic Plus (HMO-POS)℠**	**Blue Cross Medicare Advantage Premier Plus (HMO-POS)℠**
Tier 1: Preferred Generic	**One-month supply:** $10 copay	**One-month supply:** $10 copay	**One-month supply:** $10 copay
	Three-month supply: $30 copay	**Three-month supply:** $30 copay	**Three-month supply:** $30 copay
Tier 2: Generic	**One-month supply:** $20 copay	**One-month supply:** $20 copay	**One-month supply:** $20 copay
	Three-month supply: $60 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	**One-month supply:** $47 copay
	Three-month supply: $141 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	**One-month supply:** $100 copay
	Three-month supply: $300 copay	**Three-month supply:** $300 copay	**Three-month supply:** $300 copay
Tier 5: Specialty Tier	**One-month supply:** 33% of the total cost	**One-month supply:** 33% of the total cost	**One-month supply:** 33% 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.	**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 Basic (HMO)SM**	**Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM**	**Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM**
Tier 1: Preferred Generic	**One-month supply:** $0 copay	**One-month supply:** $0 copay	**One-month supply:** $0 copay
	Three-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	**One-month supply:** $10 copay
	Three-month supply: $30 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	**One-month supply:** $47 copay
	Three-month supply: $141 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	**One-month supply:** $100 copay
	Three-month supply: $300 copay	**Three-month supply:** $300 copay	**Three-month supply:** $300 copay
Tier 5: Specialty Tier	**One-month supply:** 33% of the total cost	**One-month supply:** 33% of the total cost	**One-month supply:** 33% 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.	**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 Basic (HMO)SM**	**Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM**	**Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM**
Tier 1: Preferred Generic	$20 copay	$20 copay	$20 copay
Tier 2: Generic	$40 copay	$40 copay	$40 copay
Tier 3: Preferred Brand	$94 copay	$94 copay	$94 copay
Tier 4: Non-Preferred Drug	$300 copay	$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.	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 Basic (HMO)SM**	**Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM**	**Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM**
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay
Tier 2: Generic	$20 copay	$20 copay	$20 copay
Tier 3: Preferred Brand	$94 copay	$94 copay	$94 copay
Tier 4: Non-Preferred Drug	$300 copay	$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.	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 Basic (HMO)SM	**Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM**	**Blue Cross Medicare Advantage Premier Plus (HMO-POS)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 Basic (HMO)℠	**Blue Cross Medicare Advantage Basic Plus (HMO-POS)℠**	**Blue Cross Medicare Advantage Premier Plus (HMO-POS)℠**
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.	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 Basic (HMO)SM	**Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM**	**Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM**
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 Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[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:** • $25 copay **Out-of-network:** • Not Covered	**In-network:** • $35 copay **Out-of-network:** • $75 copay	**In-network:** • $30 copay **Out-of-network:** • $75 copay
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:** • Not Covered	**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:** • 40% 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:** • 40% of the total cost

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Diabetes Supplies and Services*	**Diabetes monitoring supplies** **In-network** • 0% or 35% of the total cost **Out-of-network:** • Not Covered 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). 35% 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:**	**Diabetes monitoring supplies** **In-network** • 0% or 20% of the total cost **Out-of-network:** • 40% 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:**	**Diabetes monitoring supplies** **In-network** • 0% or 20% of the total cost **Out-of-network:** • 40% 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:**

	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM
	• Not Covered **<u>Therapeutic shoes or inserts</u>** **In-network:** • 35% of the total cost **Out-of-network:** • Not Covered	• 40% of the total cost **<u>Therapeutic shoes or inserts</u>** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost	• 40% of the total cost **<u>Therapeutic shoes or inserts</u>** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost
Durable Medical Equipment *(wheelchairs, oxygen, etc.)**	**In-network:** • 20% of the total cost **Out-of-network:** • Not Covered	**In-network:** • 20% of the total cost **Out-of-network:** • 30% of the total cost	**In-network:** • 20% of the total cost **Out-of-network:** • 30% 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.		

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Foot Care *(podiatry services)**	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions** **In-network:** • $35 copay **Out-of-network:** • Not Covered	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions** **In-network:** • $40 copay **Out-of-network:** • 40% of the total cost	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions** **In-network:** • $40 copay **Out-of-network:** • 40% of the total cost
Home Health Care*	**In-network:** • $0 copay **Out-of-network:** • Not Covered	**In-network:** • $0 copay **Out-of-network:** • 40% of the total cost	**In-network:** • $0 copay **Out-of-network:** • 40% of the total cost
Opioid Treatment Program Services*	**In-network:** • $25 copay **Out-of-network:** • Not Covered	**In-network:** • $35 copay **Out-of-network:** • $75 copay	**In-network:** • $30 copay **Out-of-network:** • $75 copay

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Outpatient Substance Abuse Services*	**Group therapy visit** **In-network:** • $75 copay **Out-of-network:** • Not Covered **Individual therapy visit** **In-network:** • $75 copay **Out-of-network:** • Not Covered	**Group therapy visit** **In-network:** • $75 copay **Out-of-network:** • 40% of the total cost **Individual therapy visit** **In-network:** • $75 copay **Out-of-network:** • 40% of the total cost	**Group therapy visit** **In-network:** • $75 copay **Out-of-network:** • 40% of the total cost **Individual therapy visit** **In-network:** • $75 copay **Out-of-network:** • 40% of the total cost
Over-the-Counter Items	• $50 allowance every three months for specific over-the-counter drugs and other health-related products. Unused OTC amounts do not roll over to the next calendar year.	• $75 allowance every three months for specific over-the-counter drugs and other health-related products. Unused OTC amounts do not roll over to the next calendar year.	• $75 allowance every three months for specific over-the-counter drugs and other health-related products. Unused OTC amounts do not roll over to the next calendar year.

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Prosthetic Devices *(braces, artificial limbs, etc.)**	**Prosthetic devices** **In-network:** • 20% of the total cost **Out-of-network:** • Not Covered **Related medical supplies** **In-network:** • 20% of the total cost **Out-of-network:** • Not Covered	**Prosthetic devices** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost **Related medical supplies** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost	**Prosthetic devices** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost **Related medical supplies** **In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost
Meals*	• 2 meals per day for 7 days. Limited to one time per year.	• 2 meals per day for 7 days. Limited to one time per year.	• 2 meals per day for 7 days. Limited to one time per year.
Renal Dialysis*	**In-network:** • 20% of the total cost **Out-of-network:** • Not Covered	**In-network:** • 20% of the total cost **Out-of-network:** • 40% of the total cost	**In-network:** • 20% of the total cost **Out-of-network:** • 40% 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	**In-network:** • $0 copay for urgent care visits through MDLive

	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
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.	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.

OPTIONAL SUPPLEMENTAL BENEFITS (you must pay an extra premium each month for these benefits)			
	Blue Cross Medicare Advantage Basic (HMO)SM	**Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM**	**Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM**
Package 1: Optional Supplemental	• Not Included	**Benefits include:** • Preventive Dental • Comprehensive Dental • Eyewear • Hearing Exams • Hearing Aids	• Not Included
How much is the monthly premium?	• Not Included	• Additional $23.90 per month. You must keep paying your Medicare Part B 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 Illinois

Blue Cross and Blue Shield of Illinois 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 Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

- 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 Illinois 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/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 Illinois

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.

HMO and HMO-POS plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HMO plans provided by Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC). HCSC and ILBCBSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and ILBCBSIC are Medicare Advantage organizations with a Medicare contract. Enrollment in HCSC's and ILBCBSIC's plans depends on contract renewal.