



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, 2020 – December 31, 2020

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 between 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Understanding the Benefits

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

Understanding Important Rules

- ☐ In addition to your monthly plan premium, 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, 2021.
- ☐ If you are a member of Blue Cross Medicare Advantage Basic Plus (HMO-POS) or Blue Cross Medicare Advantage Premier Plus (HMO-POS), 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 situations, non-contracted providers may deny care. **In addition, you will pay a higher copay for services received by non-contracted providers.**
- ☐ If you are a member of Blue Cross Medicare Advantage Basic (HMO), we do not cover services by out-of-network providers (doctors who are not listed in the *Provider Directory*), except in emergency or urgent situations.

INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2020 – December 31, 2020

	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 www.bluememberil.com 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/TDD users should call 711). • If you are not a member of this plan, call toll-free 1-877-608-2698 (TTY/TDD users should call 711). • Our website: www.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, and Will.	Our service area includes the following counties in Illinois: Cook, DuPage, Kane, and Will.	Our service area includes the following counties in Illinois: Cook, DuPage, Kane, and Will.
Which doctors, hospitals, and pharmacies can I use?	Blue Cross Medicare Advantage has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. • You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. • Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. • You can see our plan's <i>Provider Directory</i> and <i>Pharmacy Directory</i> at our website (www.getblueil.com/mapd). • Or, call us and we will send you a copy of the <i>Provider Directory</i> and/or <i>Pharmacy Directory</i>.		

	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
What do we cover?	Like all Medicare health plans, we cover everything that Original Medicare covers—and <i>more</i>. Our plan members get <i>all</i> of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less. Our plan members also get <i>more than what is</i> covered by Original Medicare. Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, (www.getblueil.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: Initial Coverage, Coverage Gap, and Catastrophic Coverage.		

SUMMARY OF BENEFITS

January 1, 2020 - December 31, 2020

	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?	These plans do 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: \$3,400 for services you receive from in-network providers.	Your yearly limit(s) in this plan: \$4,500 for services you receive from in-network providers.	Your yearly limit(s) in this plan: \$4,500 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.	No. There are no limits on how much our plan will pay.	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*	Our plan covers an unlimited number of days for an inpatient hospital stay. 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	Our plan covers an unlimited number of days for an inpatient hospital stay. 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	Our plan covers an unlimited number of days for an inpatient hospital 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

	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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
OUTPATIENT CARE AND SERVICES			
Outpatient Hospital Care/Surgery*	<u>Outpatient hospital</u> In-network: • \$0-\$275 copay Out-of-network: • Not Covered <u>Ambulatory surgical center</u> In-network: • \$175 copay Out-of-network: • Not Covered	<u>Outpatient hospital</u> In-network: • \$0-\$275 copay Out-of-network: • 40% of the total cost <u>Ambulatory surgical center</u> In-network: • \$225 copay Out-of-network: • 40% of the total cost	<u>Outpatient hospital</u> In-network: • \$0-\$275 copay Out-of-network: • 40% of the total cost <u>Ambulatory surgical center</u> In-network: • \$225 copay Out-of-network: • 40% of the total cost
Doctor's Office Visits*	<u>Primary care physician visit</u> In-network: • \$0 copay Out-of-network: • Not Covered <u>Specialist visit</u> In-network: • \$30 copay Out-of-network: • Not Covered	<u>Primary care physician visit</u> In-network: • \$10 copay Out-of-network: • \$60 copay <u>Specialist visit</u> In-network: • \$40 copay Out-of-network: • \$75 copay	<u>Primary care physician visit</u> In-network: • \$5 copay Out-of-network: • \$60 copay <u>Specialist visit</u> In-network: • \$35 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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Preventive Care *	In-network: \$0 copay Out-of-network: - Not Covered Our plan covers many preventive services, including:	In-network: \$0 copay Out-of-network: \$60 copay Our plan covers many preventive services, including:	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	\$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.	\$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.	\$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.

	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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Urgently Needed Services	\$30 copay	\$30 copay	\$30 copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays <i>(Costs for these services may vary based on place of service)</i>	<u>Diagnostic radiology services (such as MRIs, CT scans)</u> In-network: \$150 copay for services at a free-standing clinic and a \$200 copay for services in an outpatient hospital setting Out-of-network: - Not Covered	<u>Diagnostic radiology services (such as MRIs, CT scans)</u> In-network: \$175 copay for services at a free-standing clinic and a \$225 copay for services in an outpatient hospital setting Out-of-network: 40% of the total cost	<u>Diagnostic radiology services (such as MRIs, CT scans)</u> In-network: \$150 copay for services at a free-standing clinic and a \$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: - Not Covered	<u>Diagnostic tests and procedures</u> In-network: \$0-\$50 copay depending on the service 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: - Not Covered	<u>Lab services</u> In-network: \$0 copay Out-of-network: 40% of the total cost	<u>Lab services</u> In-network: \$0 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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Diagnostic Tests, Lab and Radiology Services, and X-Rays (continued) <i>(Costs for these services may vary based on place of service)</i>	<u>Outpatient X-rays</u> In-network: • \$0 copay Out-of-network: • Not Covered <u>Therapeutic radiology services (such as radiation treatment for cancer)</u> In-network: • 20% of the total cost Out-of-network: • Not Covered	<u>Outpatient X-rays</u> In-network: • \$0 copay Out-of-network: • 40% of the total cost <u>Therapeutic radiology services (such as radiation treatment for cancer)</u> In-network: • 20% of the total cost Out-of-network: • 40% of the total cost	<u>Outpatient X-rays</u> In-network: • \$0 copay Out-of-network: • 40% of the total cost <u>Therapeutic radiology services (such as radiation treatment for cancer)</u> 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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Hearing Services *	<u>Exam to diagnose and treat hearing and balance issues</u> In-network: • \$35 copay Out-of-network: • Not Covered	<u>Exam to diagnose and treat hearing and balance issues</u> In-network: • \$5 copay Out-of-network: • 40% of the total cost	<u>Exam to diagnose and treat hearing and balance issues</u> In-network: • \$5 copay Out-of-network: • 40% of the total cost <u>Routine hearing exam</u> In-network: • \$5 copay (for up to 1 routine hearing exam every year) <u>Hearing aid fitting/evaluation</u> In-network: • \$0 copay for 1 fitting every 3 years <u>Hearing aids</u> In-network: • \$0 copay • \$1,000 maximum plan coverage limit for hearing aids (both ears combined) purchased in- or out-of-network every three years

	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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Dental Services *	<u>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)</u>		
	In-network: \$35 copay Out-of-network: - Not Covered <u>Comprehensive dental coverage</u> \$500 plan coverage limit for comprehensive dental benefits every year. For more details on benefits and benefit limitations regarding your dental coverage, please see your Evidence of Coverage.	In-network: \$35 copay Out-of-network: 40% of the total cost	In-network: \$45 copay Out-of-network: 40% of the total cost <u>Comprehensive dental coverage</u> \$500 maximum plan coverage amount for in and out-of-network comprehensive dental benefits per year. For more details on benefits and benefit limitations regarding your dental coverage, please see your Evidence of Coverage.

	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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Dental Services[*] (continued)	<u>Preventive dental services</u> Cleaning In-network: \$0 copay for up to 2 cleanings per year Dental X-ray(s) In-network: \$0 copay for up to 1 bitewing X-ray per year Oral exam In-network: \$0 copay for up to 2 oral exams per year Out-of-network: - Not Covered		<u>Preventive dental services</u> Cleaning In-network: \$0 copay for up to 2 cleanings per year Dental X-ray(s) In-network: \$0 copay for up to 1 bitewing X-ray per year Oral exam In-network: \$0 copay for up to 2 oral exams per year Out-of-network: - Not Covered
Vision Services[*]	<u>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)</u>		
	In-network: \$0 copay for Medicare-covered eye exam; \$0 copay for one vision specialist exam Out-of-network: - Not Covered	In-network: \$0 copay for Medicare-covered eye exam; \$0 copay for one vision specialist exam Out-of-network: 40% of the total cost	In-network: \$0 copay for Medicare-covered eye exam; \$0 copay for one vision specialist exam 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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Vision Services[*] (continued)	<u>Routine eye exam</u> In-network: \$0 copay for 1 routine vision exam every year <u>Eyeglasses or contact lenses after cataract surgery</u> 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 <u>Routine eye wear</u> <u>Contact lenses</u> In-network: \$0 copay <u>Eyeglass frames</u> In-network: \$0 copay	<u>Routine eye exam</u> In-network: \$0 copay for 1 routine vision exam every year <u>Eyeglasses or contact lenses after cataract surgery</u> In-network: \$35 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery Out-of-network: 40% of the total cost for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lens after cataract surgery <u>Routine eye wear</u> - Not Covered	<u>Routine eye exam</u> In-network: \$0 copay for 1 routine vision exam every year <u>Eyeglasses or contact lenses after cataract surgery</u> In-network: \$0 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery Out-of-network: 40% of the total cost for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lens after cataract surgery <u>Routine eye wear</u> <u>Contact lenses</u> In-network: \$0 copay <u>Eyeglass frames</u> In-network: \$0 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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Vision Services[*] (continued)	<u>Eyeglass lenses</u> In-network: \$0 copay \$150 plan coverage limited in- and out-of-network for routine eye wear every 2 years (including eyeglass frames, lenses, and contact lenses)		<u>Eyeglass lenses</u> In-network: \$25 copay (Single-vision, lined bifocal, trifocal or lenticular lenses only) for up to 1 pair of lenses every 2 years \$100 plan coverage limited in- and out-of-network for routine eye wear every 2 years (including eyeglass frames, lenses, and contact lenses)
Mental Health Care[*]	<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. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.		

	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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Mental Health Care* (continued)	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 <u>Outpatient group therapy visit</u> In-network: \$30 copay Out-of-network: - Not Covered <u>Outpatient individual therapy visit</u> In-network: \$30 copay Out-of-network: - Not Covered	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 <u>Outpatient group therapy visit</u> In-network: \$30 copay Out-of-network: 40% of the total cost <u>Outpatient individual therapy visit</u> In-network: \$30 copay Out-of-network: 40% of the total cost	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 <u>Outpatient group therapy visit</u> In-network: \$30 copay Out-of-network: 40% of the total cost <u>Outpatient individual therapy visit</u> In-network: \$30 copay Out-of-network: 40% of the total cost

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NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Skilled Nursing Facility (SNF)*	Our plans cover up to 100 days in a SNF.		
	In-network: \$0 copay per day for days 1-20 and a \$178 copay per day for days 21-100 Out-of-network: - Not Covered	In-network: \$0 copay per day for days 1-20 and a \$178 copay per day for days 21-100 Out-of-network: 40% of the total cost per stay	In-network: \$0 copay per day for days 1-20 and a \$178 copay per day for days 21-100 Out-of-network: 40% of the total cost per stay
Outpatient Rehabilitation*	<u>Cardiac (heart) rehab services</u> (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 <u>Occupational therapy visit</u> In-network: \$35 copay Out-of-network: - Not Covered	In-network: \$50 copay Out-of-network: 40% of the total cost <u>Occupational therapy visit</u> In-network: \$35 copay Out-of-network: 40% of the total cost	In-network: \$50 copay Out-of-network: 40% of the total cost <u>Occupational therapy visit</u> In-network: \$35 copay Out-of-network: 40% of the total cost

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NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Outpatient Rehabilitation* (continued)	<u>Physical therapy and speech and language therapy visit</u> In-network: \$35 copay Out-of-network: - Not Covered	<u>Physical therapy and speech and language therapy visit</u> In-network: \$40 copay Out-of-network: 40% of the total cost	<u>Physical therapy and speech and language therapy visit</u> In-network: \$40 copay Out-of-network: 40% of the total cost
Ambulance* (Medicare-covered ground and air transportation services)	In-network: \$200 copay for each one-way trip Out-of-network: - Not Covered	In-network: \$200 copay for each one-way trip Out-of-network: \$200 copay for each one-way trip	In-network: \$225 copay for each one-way trip Out-of-network: \$225 copay for each one-way trip
Transportation*	In-network: \$0 copay for up to 12 one-way trips every year to plan-approved locations Out-of-network: - Not Covered	In-network: \$0 copay for up to 12 one-way trips every year to plan-approved locations Out-of-network: - Not Covered	In-network: \$0 copay for up to 12 one-way trips every year to plan-approved locations Out-of-network: - Not Covered

	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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Medicare Part B Drugs*	<u>Part B chemotherapy drugs</u> In-network: • 20% of the total cost Out-of-network: • Not Covered <u>Other Part B drugs</u> In-network: • 20% of the total cost Out-of-network: • Not Covered	<u>Part B chemotherapy drugs</u> In-network: • 20% of the total cost Out-of-network: • 40% of the total cost <u>Other Part B drugs</u> In-network: • 20% of the total cost Out-of-network: • 40% of the total cost	<u>Part B chemotherapy drugs</u> In-network: • 20% of the total cost Out-of-network: • 40% of the total cost <u>Other Part B drugs</u> In-network: • 20% of the total cost Out-of-network: • 40% of the total cost

	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
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 \$4,020. 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: Preferred Retail Pharmacy			
	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: \$8 copay	One-month supply: \$8 copay	One-month supply: \$8 copay
	Three-month supply: \$24 copay	Three-month supply: \$24 copay	Three-month supply: \$24 copay
Tier 3: Preferred Brand	One-month supply: \$39 copay	One-month supply: \$39 copay	One-month supply: \$39 copay
	Three-month supply: \$117 copay	Three-month supply: \$117 copay	Three-month supply: \$117 copay
Tier 4: Non-Preferred Brand	One-month supply: \$95 copay	One-month supply: \$95 copay	One-month supply: \$95 copay
	Three-month supply: \$285 copay	Three-month supply: \$285 copay	Three-month supply: \$285 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: 33% of the total cost	Three-month supply: 33% of the total cost	Three-month supply: 33% of the total cost

Initial Coverage Stage: Standard Mail-Order Pharmacy (up to a 90-day 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
Tier 1: Preferred Generic	\$15 copay	\$15 copay	\$15 copay
Tier 2: Generic	\$57 copay	\$57 copay	\$57 copay
Tier 3: Preferred Brand	\$141 copay	\$141 copay	\$141 copay
Tier 4: Non-Preferred Brand	\$300 copay	\$300 copay	\$300 copay
Tier 5: Specialty Tier	33% of the total cost	33% of the total cost	33% of the total cost

Initial Coverage Stage: Preferred Mail-Order Pharmacy (up to a 90-day 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
Tier 1: Preferred Generic	\$0 copay	\$0 copay	\$0 copay
Tier 2: Generic	\$24 copay	\$24 copay	\$24 copay
Tier 3: Preferred Brand	\$117 copay	\$117 copay	\$117 copay
Tier 4: Non-Preferred Brand	\$285 copay	\$285 copay	\$285 copay
Tier 5: Specialty Tier	33% of the total cost	33% of the total cost	33% of the total cost

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 retail pharmacy.		
Out-of-network Tiers 1-5	You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.		

Coverage Gap Stage: Standard Retail Pharmacy

	Blue Cross Medicare Advantage Basic (HMO) SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS) SM	Blue Cross Medicare Advantage Premier Plus (HMO-POS) SM
Coverage Gap 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 \$4,020. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total \$6,350, 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 \$6,350, you pay the greater of: • 5% of the total cost, or • \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copay 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	Not Covered		
Chiropractic Care *	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)		
	In-network: \$20 copay Out-of-network: - Not Covered	In-network: \$20 copay Out-of-network: 40% of the total cost	In-network: \$20 copay Out-of-network: 40% of the total cost
Diabetes Supplies and Services *	<u>Diabetes monitoring supplies</u> In-network: 0%-35% 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, OneTouch Ultra Mini and OneTouch Ultra 2). 35% cost sharing for plan approved non-preferred diabetic testing supplies (meters, strips and lancets). 35% cost sharing for all other diabetic supplies in this category.	<u>Diabetes monitoring supplies</u> In-network: 0%-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, OneTouch Ultra Mini and OneTouch Ultra 2). 20% cost sharing for plan approved non-preferred diabetic testing supplies (meters, strips and lancets). 20% cost sharing for all other diabetic supplies in this category.	<u>Diabetes monitoring supplies</u> In-network: 0%-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, OneTouch Ultra Mini and OneTouch Ultra 2). 20% cost sharing for plan approved non-preferred diabetic testing supplies (meters, strips and lancets). 20% cost sharing for all other diabetic supplies in this category.

	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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Diabetes Supplies and Services* (continued)	Approval will be required for all other Diabetic testing supplies (meters, strips and lancets). 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. Out-of-network: • Not Covered <u>Diabetes self-management training</u> In-network: • \$0 copay Out-of-network: • Not Covered <u>Therapeutic shoes or inserts</u> In-network: • 35% of the total cost Out-of-network: • Not Covered	Approval will be required for all other Diabetic testing supplies (meters, strips and lancets). 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. Out-of-network: • 40% of the total cost <u>Diabetes self-management training</u> In-network: • \$0 copay Out-of-network: • 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	Approval will be required for all other Diabetic testing supplies (meters, strips and lancets). 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. Out-of-network: • 40% of the total cost <u>Diabetes self-management training</u> In-network: • \$0 copay Out-of-network: • 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

	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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Durable Medical Equipment <i>(wheelchairs, oxygen, etc.)*</i>	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 SilverSneakers [®] is the nation's leading exercise program designed exclusively for Medicare beneficiaries. Eligible members receive a standard fitness center membership where they can enjoy specialized low-impact SilverSneakers [®] classes focusing on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination. † SilverSneakers [®] is a wellness program owned and operated by Tivity Health, Inc., an independent company. Tivity Health and SilverSneakers [®] are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries.		
Foot Care <i>(podiatry services)*</i>	<u>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions</u>		
	In-network: \$35 copay Out-of-network: - Not Covered	In-network: \$40 copay Out-of-network: 40% of the total cost	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

	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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Outpatient Substance Abuse Services*	<u>Group therapy visit</u> In-network: \$75 copay Out-of-network: - Not Covered <u>Individual therapy visit</u> In-network: \$75 copay Out-of-network: - Not Covered	<u>Group therapy visit</u> In-network: \$75 copay Out-of-network: 40% of the total cost <u>Individual therapy visit</u> In-network: \$75 copay Out-of-network: 40% of the total cost	<u>Group therapy visit</u> In-network: \$75 copay Out-of-network: 40% of the total cost <u>Individual therapy visit</u> In-network: \$75 copay Out-of-network: 40% of the total cost
Over-the-Counter Items	\$75 allowance every three (3) months for specific over-the-counter drugs and other health-related pharmacy products. Unused OTC amounts do not roll over to the next calendar year.	Not Covered	Not Covered

	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
NOTE: Services with a * may require prior authorization or a referral from your doctor.			
Prosthetic Devices <i>(braces, artificial limbs, etc.)*</i>	<u>Prosthetic devices</u> In-network: 20% of the total cost Out-of-network: - Not Covered <u>Related medical supplies</u> In-network: 20% of the total cost Out-of-network: - Not Covered	<u>Prosthetic devices</u> In-network: 20% of the total cost Out-of-network: 40% of the total cost <u>Related medical supplies</u> In-network: 20% of the total cost Out-of-network: 40% of the total cost	<u>Prosthetic devices</u> In-network: 20% of the total cost Out-of-network: 40% of the total cost <u>Related medical supplies</u> In-network: 20% of the total cost Out-of-network: 40% of the total cost
Renal Dialysis*	In-network: 20% of the total cost Out-of-network: - Not Covered	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
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.		

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	<u>Benefits include:</u> - Preventive Dental - Comprehensive Dental - Eyewear - Hearing Exams - Hearing Aids	Not Included
How much is the monthly premium?	Not Included	Additional \$27.10 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



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 file a grievance, Civil Rights Coordinator is available to help you.

You can also find 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/fix.html>.

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

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

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

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: 711)。

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

ملحوظ: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل رقم 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 નિઃશુલ્ક 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: 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: 711).

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

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: 711).



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/TDD:711) for more information.

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