### 2021 Premera Medicare Advantage Plan Information

Thank you for your interest in applying for the Premera Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Premera within 7 days of the application receipt.

#### Enrollment Packet – click links below to view the information

Star Rating: <a href="Premera">Premera</a> / <a href="Soundpath">Soundpath</a>

<u>Download Application</u> <u>Summary of Benefits</u>

Provider Search
Pharmacy Search

Formulary

#### Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15<sup>th</sup> to December 7<sup>th</sup>. This will give you a January 1<sup>st</sup> effective date for your new plan.

#### Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15<sup>th</sup> and December 7<sup>th</sup>. *If they are signed*prior to October 15<sup>th</sup> they will be returned to you with a new application. If they are received after December 7<sup>th</sup>, you will not be able to change plans until the next AEP for January of the following year.

#### Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc...

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: Click here
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: https://medicare-washington.com

Y0062 MULTIPLAN CDA INSURANCE Washington 2021

# 2021 Summary of Benefits

PAGES 04-11 PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HMO)

PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HMO)

PAGES 12-22 PREMERA BLUE CROSS MEDICARE ADVANTAGE (HMO)

PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HMO)

PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HMO)

**PAGES 23-30** PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HMO)

PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HMO)

**PAGES 31-39** PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HMO)

PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HMO) PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HMO)



## 2021 Summary of Benefits

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PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HMO) H7245-006
PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HMO) H7245-008
PREMERA BLUE CROSS MEDICARE ADVANTAGE (HMO) H7245-001
PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HMO) H7245-002
PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HMO) H7245-005
PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HMO) H9302-011
PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HMO) H9302-007
PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HMO) H9302-004
PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HMO) H9302-003
PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HMO) H7245-003
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This is a summary of drug and health services covered by Premera Blue Cross Medicare Advantage Core (HMO), Premera Blue Cross Medicare Advantage Core Plus (HMO), Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO), Premera Blue Cross Medicare Advantage Total Health (HMO), Premera Blue Cross Medicare Advantage Peak + Rx (HMO), Premera Blue Cross Medicare Advantage Sound + Rx (HMO), Premera Blue Cross Medicare Advantage Alpine (HMO), Premera Blue Cross Medicare Advantage Charter + Rx (HMO), and Premera Blue Cross Medicare Advantage Classic Plus (HMO) January 1, 2021 to December 31, 2021.

Premera Blue Cross Medicare Advantage Core (HMO), Premera Blue Cross Medicare Advantage Core Plus (HMO), Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO), Premera Blue Cross Medicare Advantage Total Health (HMO), Premera Blue Cross Medicare Advantage Peak + Rx (HMO), Premera Blue Cross Medicare Advantage Sound + Rx (HMO), Premera Blue Cross Medicare Advantage Alpine (HMO), Premera Blue Cross Medicare Advantage Charter + Rx (HMO), and Premera Blue Cross Medicare Advantage Classic Plus (HMO) are plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" by calling customer service or accessing it on our website: premera.com/ma.

To join Premera Blue Cross Medicare Advantage Core (HMO), Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO), Premera Blue Cross Medicare Advantage Total Health (HMO), Premera Blue Cross Medicare Advantage Peak + Rx (HMO), Premera Blue Cross Medicare Advantage Sound + Rx (HMO), Premera Blue Cross Medicare Advantage Alpine (HMO), Premera Blue Cross Medicare Advantage Charter + Rx (HMO), or Premera Blue Cross Medicare Advantage Classic Plus (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Washington: Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, and Whatcom.

If you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

This document is available in other formats, including Braille and Spanish.

For more information, please call us at 888-850-8526 (TTY/TDD: 711), or visit us at **premera.com/ma**.

Representatives are available:

October 1 - March 31, 8 a.m. to 8 p.m., 7 days a week April 1 - Sept 30, 8 a.m. to 8 p.m., Monday through Friday.

	Counties: Island, San Juan, Skagit, Walla Walla, Whatcom	Counties: Island, San Juan, Skagit, Walla Walla
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HM0)
Monthly Plan Premium	You pay \$12 per month. You must continue to pay your Medicare Part B premium.	You pay \$75 per month. You must continue to pay your Medicare Part B premium.
Part C Deductible	No deductible.	No deductible.
Part D Deductible	\$180 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	\$180 per year for Part D prescription drugs except for drugs listed on Tier 1, Tier 2, and Tier 3, which are excluded from the deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than \$6,300 annually. Includes copays and other costs for medical services for the year.	You pay no more than \$5,000 annually. Includes copays and other costs for medical services for the year.
Inpatient Hospital Coverage	You pay \$450 copay per day for days 1-4. You pay \$0 copay per day for days 5 and beyond. <b>Prior Authorization rules may apply.</b>	You pay \$450 copay per day for days 1-4. You pay \$0 copay per day for days 5 and beyond. <b>Prior Authorization rules may apply.</b>
Outpatient Hospital Coverage	You pay 20% of the total cost for each Medicare-covered outpatient hospital surgery.	You pay a \$350 copay for each Medicare- covered outpatient hospital surgery.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Ambulatory Surgery Center	You pay a \$250 copay for each Medicare-covered ambulatory surgical center visit.	You pay a \$250 copay for each Medicare- covered ambulatory surgical center visit.
<b>Doctor Visits</b>		
Primary care providers	You pay \$15 copay per office visit. You pay a \$10 copay per telehealth visit.	You pay \$5 copay per office visit. You pay a \$0 copay per telehealth visit.
Specialists	You pay \$45 per office visit (referral required). You pay a \$40 copay per telehealth visit.	You pay \$30 per office visit (referral required). You pay a \$25 copay per telehealth visit.
Preventive Care (such as flu vaccine, diabetic screenings)	You pay nothing. Other preventive services are available. There are some covered services that have a cost.	You pay nothing. Other preventive services are available. There are some covered services that have a cost.

	Counties: Island, San Juan, Skagit, Walla Walla, Whatcom	Counties: Island, San Juan, Skagit, Walla Walla
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HM0)
Emergency Care	You pay a \$90 copay per visit. Waived, if you are admitted to the hospital within 24 hours. Includes worldwide coverage.	You pay a \$90 copay per visit. Waived, if you are admitted to the hospital within 24 hours. Includes worldwide coverage.
Urgently Needed Services	You pay a \$45 copay per visit.	You pay a \$45 copay per visit.
	Includes worldwide coverage with a \$50 copay.	Includes worldwide coverage with a \$50 copay.
Diagnostic Services/Labs/ Imaging		
Diagnostic tests and procedures	You pay 20% of the total cost.	You pay 20% of the total cost.
Lab services	You pay a \$20 copay per day.	You pay a \$10 copay per day.
Outpatient x-rays	You pay a \$20 copay per day.	You pay a \$10 copay per day.
Therapeutic radiology	You pay 20% of the total cost.	You pay 20% of the total cost.
services (such as radiation treatment for cancer)	If your doctor provides additional services, a separate cost sharing amount may apply.	If your doctor provides additional services, a separate cost sharing amount may apply.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Hearing Services		
Medicare-covered hearing exam	You pay a \$45 copay per visit.	You pay a \$0-\$30 copay per visit.
Routine hearing exam	Not covered.	You pay a \$0-\$30 copay for one routine hearing exam per calendar year.
Hearing aid	Not covered.	You pay a \$0 copay. There is a \$1,000 annual allowance per ear toward the purchase of hearing aids through Hearing Care Solutions.

	Counties: Island, San Juan, Skagit, Walla Walla, Whatcom	Counties: Island, San Juan, Skagit, Walla Walla
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HM0)
Dental Services		
Medicare-covered dental services	You pay a \$45 copay per visit.	You pay a \$30 copay per visit.
Routine dental services	For Dental Services (routine), see "Optional	You pay a \$0 copay for routine dental services.
	supplemental dental benefit" section later in	Routine oral exams - two per calendar year.
	the booklet.	Comprehensive periodontal exam - one per calendar year.
		<ul> <li>Routine cleaning – limited up to two routine cleaning (prophylaxis) per calendar year OR</li> <li>Periodontal maintenance – limited up to three periodontal maintenance per calendar year.</li> </ul>
		Fluoride treatment – twice per calendar year.
		<ul> <li>Bitewing x-ray – up to one set of four bitewing x-rays every year.</li> </ul>
		<ul> <li>Panoramic or complete series x-ray – once every 60 months.</li> </ul>
		<ul> <li>Limited emergency exam – limited to once per calendar year.</li> </ul>
		Emergency palliative treatment of dental pain.
		Periapical x-rays.
		• \$200 toward additional diagnostic, preventive, basic, and major restorative services.

	Counties: Island, San Juan, Skagit, Walla Walla, Whatcom	Counties: Island, San Juan, Skagit, Walla Walla
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HM0)
Vision Services		
Medicare-covered vision exam	You pay a \$0 copay for each Medicare-covered diabetic retinopathy screening once per calendar year.	You pay a \$0 copay for each Medicare-covered diabetic retinopathy screening once per calendar year.
	You pay a \$45 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a \$30 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.
Medicare-covered vision hardware	You pay a \$0 copay for one pair of Medicare- covered eyeglasses or contact lenses after each cataract surgery.	You pay a \$0 copay for one pair of Medicare- covered eyeglasses or contact lenses after each cataract surgery.
Routine vision exam	You pay a \$45 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses. No referral is required for routine vision exam.	You pay a \$20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses. No referral is required for routine vision exam.
Routine vision hardware	Not covered.	There is a \$150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.
Mental Health Services		
Inpatient mental health care	You pay a \$390 copay per day for days 1-4. You pay a \$0 copay per day for days 5-90.	You pay a \$390 copay per day for days 1-4. You pay a \$0 copay per day for days 5-90.
Outpatient mental health care	You pay a \$40 copay for each Medicare-covered individual or group therapy visit.	You pay a \$40 copay for each Medicare-covered individual or group therapy visit.
	You pay a \$35 copay for each telemental health visit.	You pay a \$35 copay for each telemental health visit.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Skilled Nursing Facility	You pay a \$0 copay per day for days 1-20. You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for days 61-100.	You pay a \$0 copay per day for days 1-20. You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for days 61-100.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.

	Counties: Island, San Juan, Skagit, Walla Walla, Whatcom	Counties: Island, San Juan, Skagit, Walla Walla
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HM0)
Physical Therapy	You pay a \$40 copay per visit.	You pay a \$20 copay per visit.
Ambulance	You pay a \$300 copay each way for Medicare- covered ambulance transport.	You pay a \$310 copay each way for Medicare- covered ambulance transport.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Transportation	Not covered.	Not covered.
Medicare Part B Drugs	You pay 20% of the total cost for Medicare- covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the total cost for Medicare- covered Part B chemotherapy drugs and other Part B drugs.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.

Counties: Island, San Juan, Skagit, Walla Walla, Whatcom			Counties: Island, San Juan, Skagit, Walla Walla						
PREMERA BLUE CROSS MEDICARE ADVANTAGE			PREMERA BLUE CROSS MEDICARE ADVANTAGE						
CORE (HM0)					CORE PLUS	CORE PLUS (HM0)			
PRESCRIPTION	ON DRUG BEN	IEFITS (PART	D)		PRESCRIPTI	ON DRUG BEN	IEFITS FOR (F	PART D)	
Deductible	During this s	stage, you pay	the full cost o	of your Tier 3,	Deductible				
Phase	_	gs. You stay in		,	Phase				til you have
		or your Tier 3, 4	_	•			or your Tier 4 a		,
Initial Coverage	<b>ge Phase -</b> Yo	u stay in the Ir	nitial Coverage	e Stage until	Initial Coverage Phase - You stay in the Initial Coverage Stage until				
your total dru	•	•		3		ig costs for the	,		3
	Preferred	Standard	Mail Order	Long-Term	,	Preferred	Standard	Mail Order	Long-
	Retail Cost	Retail Cost	Cost	Care Cost		Retail Cost	Retail Cost	Cost	Term Cost
	Sharing	Sharing	Sharing	Sharing		Sharing	Sharing	Sharing	Sharing
	(in network)	(in network)	(90-day	(up to a 31-		(in network)	(in network)	(90-day	(up to a 31-
	(up to a 30-	(up to 30-	supply)	day supply)		(up to a 30-	(up to 30-	supply)	day supply)
	day supply)	day supply)	11 37	, , , , ,		day supply)	day supply)	11 7/	, , , , ,
Tier 1:			\/		Tier 1:				
Preferred	You pay a	You pay a	You pay a	You pay a	Preferred	You pay a	You pay a	You pay a	You pay a
Generic	\$4 copay.	\$15 copay.	\$0 copay.	\$15 copay.	Generic	\$2 copay.	\$12 copay.	\$0 copay.	\$12 copay.
Tier 2:	You pay a	You pay a	You pay a	You pay a	Tier 2:	You pay a	You pay a	You pay a	You pay a
Generic	\$12 copay.	\$20 copay.	\$36 copay.	\$20 copay.	Generic	\$10 copay.	\$20 copay.	\$30 copay.	\$20 copay.
Tier 3:		\/	You pay		Tier 3:	\/	\/	You pay	
Preferred	You pay a	You pay a	a \$126	You pay a	Preferred	You pay a	You pay a	a \$120	You pay a
Brand	\$42 copay.	\$47 copay.	copay.	\$47 copay.	Brand	\$40 copay.	\$47 copay.	copay.	\$47 copay.
Tier 4: Non-	You pay	You pay	You pay	You pay	Tier 4: Non-	You pay	You pay	You pay	You pay
Preferred	33% of	33% of	33% of	33% of	Preferred	33% of	33% of	33% of	33% of
Drugs	the cost.	the cost.	the cost.	the cost.	Drugs	the cost.	the cost.	the cost.	the cost.
Tion F:	You pay	You pay	Nat	You pay	T:	You pay	You pay	Net	You pay
Tier 5:	29% of	29% of	Not	29% of	Tier 5:	29% of	29% of	Not	29% of
Specialty	the cost.	the cost.	offered.	the cost.	Specialty	the cost.	the cost.	offered.	the cost.

Counties: Island, San Juan, Skagit, Walla Walla, Whatcom	Counties: Island, San Juan, Skagit, Walla Walla
PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HM0)
Cost sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.	Cost sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.
Coverage Gap	Coverage Gap
After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach \$6,550, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.	After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach \$6,550, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.
Catastrophic Coverage	Catastrophic Coverage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:
• 5% of the cost of the drug, or	• 5% of the cost of the drug, or
• \$3.70 copay for a generic drug, or a drug that is treated like a generic, and \$9.20 copay for all other drugs.	• \$3.70 copay for a generic drug, or a drug that is treated like a generic, and \$9.20 copay for all other drugs.
Part D Senior Savings Plan	Part D Senior Savings Plan
Maximum copay of \$35 for 30-day supply for recommended diabetic insulins	Maximum copay of \$35 for 30-day supply for recommended diabetic insulins
Over the Counter (OTC)	Over the Counter (OTC)
Receive a \$25 quarterly benefit for over-the-counter health and wellness products available through OTC Health Solutions.	Receive a \$50 quarterly benefit for over-the-counter health and wellness products available through OTC Health Solutions.

	an, Skagit, Walla Walla, Whatcom	Counties: Island, San Juan, Skagit, Walla Walla
PREMERA BLUE CROSS	MEDICARE ADVANTAGE	PREMERA BLUE CROSS MEDICARE ADVANTAGE
CORE (HM0) OPTIONAL SUPPLEMENT	TAI DENEEITS	CORE PLUS (HM0) OPTIONAL SUPPLEMENTAL BENEFITS
Optional Supplemental	TAL DENEFITS	Not applicable
Dental Benefit		Not applicable
Monthly Premium	You pay additional \$22.50 per month.	
Deductible	There is no deductible.	
Annual Benefit Maximum	There is no annual maximum limit.	
You pay a \$0 copay for ro	outine dental services.	1
• Routine oral exams – tv	wo per calendar year.	
Comprehensive periodo	ontal exam – one per calendar year.	
<ul> <li>Routine cleaning – limit (prophylaxis) per calend</li> </ul>	ted up to two routine cleaning	
OR		
• Periodontal maintenand	ce – limited up to three periodontal	
maintenance per calend		
<ul> <li>Fluoride treatment – tw</li> </ul>	vice per calendar year.	
• Bitewing x-ray – up to c	one set of four bitewing x-rays every year.	
• Panoramic or complete series x-ray – once every 60 months.		
• Limited emergency exa	m – limited to once per calendar year.	
• Emergency palliative tre	eatment of dental pain.	
• Periapical x-rays.		

	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom	Counties: Spokane and Stevens
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)
Monthly Plan Premium	You pay \$0 per month. You must continue to pay your Medicare Part B premium.	You pay \$55 per month. You must continue to pay your Medicare Part B premium.	You pay \$24 per month. You must continue to pay your Medicare Part B premium.
Part C Deductible	No deductible.	No deductible.	No deductible.
Part D Deductible	\$180 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	\$180 per year for Part D prescription drugs except for drugs listed on Tier 1, Tier 2, and Tier 3, which are excluded from the deductible.	\$180 per year for Part D prescription drugs except for drugs listed on Tier 1, Tier 2, and Tier 3, which are excluded from the deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than \$6,300 annually. Includes copays and other costs for medical services for the year.	You pay no more than \$5,000 annually. Includes copays and other costs for medical services for the year.	You pay no more than \$5,000 annually. Includes copays and other costs for medical services for the year.
Inpatient Hospital Coverage	You pay a \$450 copay per day for days 1-4. You pay a \$0 copay per day for days 5 and beyond.	You pay a \$450 copay per day for days 1-4. You pay a \$0 copay per day for days 5 and beyond.	You pay a \$450 copay per day for days 1-4. You pay a \$0 copay per day for days 5 and beyond.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Outpatient Hospital Coverage	You pay 20% of the total cost for each Medicare-covered outpatient hospital surgery.	You pay a \$350 copay for each Medicare-covered outpatient hospital surgery.	You pay a \$350 copay for each Medicare-covered outpatient hospital surgery.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Ambulatory Surgery Center	You pay a \$250 copay for each Medicare-covered ambulatory surgical center visit.	You pay a \$250 copay for each Medicare-covered ambulatory surgical center visit.	You pay a \$250 copay for each Medicare-covered ambulatory surgical center visit.

	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom	Counties: Spokane and Stevens
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)
Doctor Visits			
Primary care providers	You pay a \$15 copay per office visit.	You pay a \$5 copay per office visit.	You pay a \$5 copay per office visit.
	You pay a \$10 copay per telehealth visit.	You pay a \$0 copay per telehealth visit.	You pay a \$0 copay per telehealth visit.
Specialists	You pay a \$45 copay per office visit (referral required).	You pay a \$30 copay per office visit (referral required).	You pay a \$30 copay per office visit (referral required).
	You pay a \$40 copay per telehealth visit.	You pay a \$25 copay per telehealth visit.	You pay a \$25 copay per telehealth visit.
Preventive Care (such as flu vaccine, diabetic screenings)	You pay nothing. Other preventive services are available. There are some covered services that have a cost.	You pay nothing. Other preventive services are available. There are some covered services that have a cost.	You pay nothing. Other preventive services are available. There are some covered services that have a cost.
Emergency Care	You pay a \$90 copay per visit. Waived, if you are admitted to the hospital within 24 hours.	You pay a \$90 copay per visit. Waived, if you are admitted to the hospital within 24 hours.	You pay a \$90 copay per visit. Waived, if you are admitted to the hospital within 24 hours.
	Includes worldwide coverage.	Includes worldwide coverage.	Includes worldwide coverage.
Urgently Needed Services	You pay a \$45 copay per visit.	You pay a \$45 copay per visit.	You pay a \$45 copay per visit.
	Includes worldwide coverage with a \$50 copay.	Includes worldwide coverage with a \$50 copay.	Includes worldwide coverage with a \$50 copay.

	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom	Counties: Spokane and Stevens
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)
Diagnostic Services/Labs/ Imaging			
Diagnostic tests and procedures	You pay 20% of the total cost.	You pay 20% of the total cost.	You pay 20% of the total cost.
Lab services	You pay a \$20 copay per day.	You pay a \$10 copay per day.	You pay a \$10 copay per day.
Outpatient x-rays	You pay a \$20 copay per day.	You pay a \$10 copay per day.	You pay a \$10 copay per day.
Therapeutic radiology	You pay 20% of the total cost.	You pay 20% of the total cost.	You pay 20% of the total cost.
services (such as radiation treatment for cancer)	If your doctor provides additional services, a separate cost sharing amount may apply.	If your doctor provides additional services, a separate cost sharing amount may apply.	If your doctor provides additional services, a separate cost sharing amount may apply.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Hearing Services			
Medicare-covered hearing exam	You pay a \$45 copay per visit.	You pay a \$0-\$30 copay per visit. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.	You pay a \$0-\$30 copay per visit. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.
Routine hearing exam	Not covered.	You pay a \$0-\$30 copay for one routine hearing exam per calendar year. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.	You pay a \$0-\$30 copay for one routine hearing exam per calendar year. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.
Hearing aid	Not covered.	You pay a \$0 copay. There is a \$1,000 annual allowance per ear toward the purchase of hearing aids through Hearing Care Solutions.	You pay a \$0 copay. There is a \$1,000 annual allowance per ear toward the purchase of hearing aids through Hearing Care Solutions.

	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom	Counties: Spokane and Stevens
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)
Dental Services  Medicare-covered dental services	You pay a \$45 copay per visit.	You pay a \$30 copay per visit.	You pay a \$30 copay per visit.
Routine dental services	For dental services (routine), see "Optional supplemental	You pay a \$0 copay for routine dental services.	You pay a \$0 copay for routine dental services.
	dental benefit" section later in the booklet.	Routine oral exams - two per calendar year.	Routine oral exams - two per calendar year.
		Comprehensive periodontal exam - one per calendar year.	Comprehensive periodontal exam - one per calendar year.
		<ul> <li>Routine cleaning – limited up to two routine cleaning (prophylaxis) per calendar year.</li> </ul>	Routine cleaning – limited up to two routine cleaning (prophylaxis) per calendar year
		OR Periodontal maintenance – limited up to three periodontal maintenance per calendar year.	OR Periodontal maintenance – limited up to three periodontal maintenance per calendar year.
		<ul> <li>Fluoride treatment – twice per calendar year.</li> </ul>	Fluoride treatment— twice per calendar year.
		<ul> <li>Bitewing x-ray-up to one set of four bitewing x-rays every year.</li> </ul>	Bitewing x-ray-up to one set of four bitewing x-rays every year.
		<ul> <li>Panoramic or complete series x-ray-once every 60 months.</li> </ul>	<ul> <li>Panoramic or complete series x-ray-once every 60 months.</li> </ul>
		<ul> <li>Limited emergency exam- limited to once per calendar year.</li> </ul>	<ul> <li>Limited emergency exam- limited to once per calendar year.</li> </ul>
		Emergency palliative treatment of dental pain.	Emergency palliative treatment of dental pain.

	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom	Counties: Spokane and Stevens
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)
		Periapical x-rays.	Periapical x-rays.
		<ul> <li>\$200 toward additional diagnostic, preventive, basic and major restorative services.</li> </ul>	<ul> <li>\$200 toward additional diagnostic, preventive, basic and major restorative services.</li> </ul>
Vision Services			
Medicare-covered vision exam	You pay a \$0 copay for each Medicare-covered diabetic retinopathy screening once per calendar year.	You pay a \$0 copay for each Medicare-covered diabetic retinopathy screening once per calendar year.	You pay a \$0 copay for each Medicare-covered diabetic retinopathy screening once per calendar year.
	You pay a \$20 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a \$30 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a \$30 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.
Medicare-covered vision hardware	You pay a \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.	You pay a \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.	You pay \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.
Routine vision exam	You pay a \$20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses. No referral is required for routine vision exam.	You pay a \$20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses. No referral is required for routine vision exam.	You pay a \$20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses. No referral is required for routine vision exam.
Routine vision hardware	Not covered.	There is a \$150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.	There is a \$150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.

	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom	Counties: Spokane and Stevens
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)
Mental Health Services			
Inpatient mental health care	You pay a \$390 copay per day for days 1-4.	You pay a \$390 copay per day for days 1-4.	You pay a \$390 copay per day for days 1−4.
	You pay a \$0 copay per day for days 5-90.	You pay a \$0 copay per day for days 5-90.	You pay a \$0 copay per day for days 5–90.
Outpatient mental health care	You pay a \$40 copay for each Medicare-covered individual or group therapy visit.	You pay a \$40 copay for each Medicare-covered individual or group therapy visit.	You pay a \$40 copay for each Medicare-covered individual or group therapy visit.
	You pay a \$35 copay for each telemental health visit.	You pay a \$35 copay for each telemental health visit.	You pay a \$35 copay for each telemental health visit.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Skilled Nursing Facility	You pay a \$0 copay per day for days 1-20.	You pay a \$0 copay per day for days 1-20.	You pay a \$0 copay per day for days 1-20.
	You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for days 61-100.	You pay a \$160 copay per day for days 21–60. You pay a \$0 copay per day for days 61–100.	You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for days 61-100.
	for days 21-60. You pay a \$0 copay per day for	You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for	You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for
Physical Therapy	for days 21–60. You pay a \$0 copay per day for days 61–100.  Prior Authorization rules	You pay a \$160 copay per day for days 21–60. You pay a \$0 copay per day for days 61–100.  Prior Authorization rules	You pay a \$160 copay per day for days 21–60. You pay a \$0 copay per day for days 61–100.  Prior Authorization rules
Physical Therapy Ambulance	for days 21–60. You pay a \$0 copay per day for days 61–100.  Prior Authorization rules may apply.	You pay a \$160 copay per day for days 21–60. You pay a \$0 copay per day for days 61–100.  Prior Authorization rules may apply.	You pay a \$160 copay per day for days 21–60. You pay a \$0 copay per day for days 61–100.  Prior Authorization rules may apply.

	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom	Counties: Spokane and Stevens
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)
Transportation	Not covered.	Not covered.	Not covered.
Medicare Part B Drugs	You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.

Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston		Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom		Counties: Spokane and Stevens				
PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)		PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)			PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)			
PRESCRIPT	ION DRUG BENE	FITS (PART D)	PRESCRIPT	ION DRUG BENE	FITS (PART D)	PRESCRIPT	ION DRUG BENE	FITS (PART D)
Deductible	During this sta	ge, you pay the	Deductible	During this sta	ge, you pay the	Deductible	During this sta	ge, you pay the
Phase	full cost of you		Phase	full cost of you		Phase	full cost of you	
	_	tay in this stage		drugs. You stay			drugs. You stay	_
	until you have I	•		until you have I			until you have I	
	your Tier 3, 4, a			your Tier 4 and			your Tier 4 and	J
	age Phase - You			age Phase - You			age Phase - You	
	age Stage until yo			age Stage until yo e year reach \$4,1			age Stage until yo	
COSIS FOI THE	e year reach \$4,1 Preferred	Standard Retail	COSIS FOI THE	Preferred	Standard Retail	COSIS TOT LITE	e year reach \$4,1 Preferred	Standard Retail
	Retail Cost	Cost sharing		Retail Cost	Cost sharing		Retail Cost	Cost Sharing
	Sharing	(in network)		Sharing	(in network)		Sharing	(in network)
	(in network)	(up to 30-day		(in network)	(up to 30-day		(in network)	(up to 30-day
	(up to a 30-day	supply)		(up to a 30-day	supply)		(up to a 30-day	supply)
	supply)			supply)			supply)	
Tier 1:	You pay a	You pay a	Tier 1:	You pay a	You pay a	Tier 1:	You pay a	You pay a
Preferred	\$4 copay.	\$15 copay.	Preferred	\$2 copay.	\$12 copay.	Preferred	\$2 copay.	\$12 copay.
Generic	, ,		Generic	. ,		Generic	. ,	
Tier 2:	You pay a	You pay a	Tier 2:	You pay a	You pay a	Tier 2:	You pay a	You pay a
Generic	\$12 copay.	\$20 copay.	Generic	\$10 copay.	\$20 copay.	Generic	\$10 copay.	\$20 copay.
Tier 3: Preferred	You pay a	You pay a	Tier 3: Preferred	You pay a	You pay a	Tier 3: Preferred	You pay a	You pay a
Brand	\$42 copay.	\$47 copay.	Brand	\$40 copay.	\$47 copay.	Brand	\$40 copay.	\$47 copay.
Tier 4:			Tier 4:			Tier 4:		
Non-	You pay	You pay	Non-	You pay	You pay	Non-	You pay	You pay
Preferred	33% of the	33% of the	Preferred	33% of the	33% of the	Preferred	33% of the	33% of the
Drugs	total cost.	total cost.	Drugs	total cost.	total cost.	Drugs	total cost.	total cost.
Tier 5:	You pay	You pay	Tier 5:	You pay	You pay	Tier 5:	You pay	You pay
Specialty	29% of the	29% of the	Specialty	29% of the	29% of the	Specialty	29% of the	29% of the
	total cost.	total cost.		total cost.	total cost.		total cost.	total cost.

Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston				Counties: Spokane and Stevens				
PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)		DICARE	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)		PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)			
	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)		Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)		Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)
Tier 1: Preferred Generic	You pay a \$0 copay.	You pay a \$15 copay.	Tier 1: Preferred Generic	You pay a \$0 copay.	You pay a \$12 copay.	Tier 1: Preferred Generic	You pay a \$0 copay.	You pay a \$12 copay.
Tier 2: Generic	You pay a \$36 copay.	You pay a \$20 copay.	Tier 2: Generic	You pay a \$30 copay.	You pay a \$20 copay.	Tier 2: Generic	You pay a \$30 copay.	You pay a \$20 copay.
Tier 3: Preferred Brand	You pay a \$126 copay.	You pay a \$47 copay.	Tier 3: Preferred Brand	You pay a \$120 copay.	You pay a \$47 copay.	Tier 3: Preferred Brand	You pay a \$120 copay.	You pay a \$47 copay.
Tier 4: Non- Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.	Tier 4: Non- Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.	Tier 4: Non- Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.
Tier 5: Specialty	Not offered.	You pay 29% of the total cost.	Tier 5: Specialty	Not offered.	You pay 29% of the total cost.	Tier 5: Specialty	Not offered.	You pay 29% of the total cost.
Cost sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.		the pharmad	g may change de by you choose an er of the four pha fit.	nd when you	the pharmad	g may change de by you choose an er of the four pha fit.	id when you	
Coverage Gap		Coverage Ga	ар		Coverage Gap			
After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach \$6,550, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.		After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach \$6,550, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.		me drugs and Irugs until your ,550, which is				

Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom	Counties: Spokane and Stevens
PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)
Catastrophic Coverage	Catastrophic Coverage	Catastrophic Coverage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:
• 5% of the cost of the drug, or	• 5% of the cost of the drug, or	• 5% of the cost of the drug, or
• \$3.70 copay for a generic drug, or a drug that is treated like a generic and \$9.20 copay for all other drugs.	• \$3.70 copay for a generic drug, or a drug that is treated like a generic and \$9.20 copay for all other drugs.	• \$3.70 copay for a generic drug, or a drug that is treated like a generic and \$9.20 copay for all other drugs.
Part D Senior Savings Plan	Part D Senior Savings Plan	Part D Senior Savings Plan
Maximum copay of \$35 for 30-day supply for recommended diabetic insulins	Maximum copay of \$35 for 30-day supply for recommended diabetic insulins	Maximum copay of \$35 for 30-day supply for recommended diabetic insulins
Over the Counter (OTC)	Over the Counter (OTC)	Over the Counter (OTC)
Receive a \$25 quarterly benefit for over- the-counter health and wellness products available through OTC Health Solutions.	Receive a \$50 quarterly benefit for over- the-counter health and wellness products available through OTC Health Solutions.	Receive a \$50 quarterly benefit for over- the-counter health and wellness products available through OTC Health Solutions.

Pierce, Snohomish	King, Kitsap, Lewis, , Spokane, and Thurston	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom	Counties: Spokane and Stevens
PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)		PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)
`	EMENTAL BENEFITS	OPTIONAL SUPPLEMENTAL BENEFITS	OPTIONAL SUPPLEMENTAL BENEFITS
Optional Supplemental Dental Benefit		Not applicable.	Not applicable.
Monthly Premium	You pay an additional \$22.50 per month.		
Deductible	There is no deductible.		
Annual Benefit Maximum	There is no annual maximum limit.		
You pay a \$0 copay dental services.	/ for routine		
<ul> <li>Routine oral exar year.</li> </ul>	ns - two per calendar		
<ul> <li>Comprehensive per calendar year</li> </ul>	periodontal exam - one c.		
routine cleaning ( calendar year OR			
	tenance – limited up tal maintenance per		
Fluoride treatmer calendar year.	nt-twice per		
<ul> <li>Bitewing x-ray-up to one set of four bitewing x-rays every year.</li> </ul>			
<ul> <li>Panoramic or complete series x-ray—once every 60 months.</li> </ul>			
<ul> <li>Limited emergency exam-limited to once per calendar year.</li> </ul>			
<ul> <li>Emergency pallia dental pain.</li> </ul>	tive treatment of		
<ul> <li>Periapical x-rays.</li> </ul>			

	Available to residents of these counties: King, Pierce, Snohomish, Thurston, and Whatcom				
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HM0)			
Monthly Plan Premium	You pay \$0 per month. You must continue to pay your Medicare Part B premium.	You pay \$40 per month. You must continue to pay your Medicare Part B premium.			
Part C Deductible	No deductible.	No deductible.			
Part D Deductible	\$160 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	\$160 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.			
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than \$6,700 annually. Includes copays and other costs for medical services for the year.	You pay no more than \$6,500 annually. Includes copays and other costs for medical services for the year.			
Inpatient Hospital Coverage	You pay a \$595 copay per day for days 1-3. You pay a \$0 copay per day for days 4 and beyond.	You pay a \$595 copay per day for days 1-3. You pay a \$0 copay per day for days 4 and beyond.			
	Prior Authorization rules may apply.	Prior Authorization rules may apply.			
Outpatient Hospital Coverage	You pay 20% of the total cost for each Medicare- covered outpatient hospital surgery.	You pay a \$495 copay for each Medicare-covered outpatient hospital surgery.			
	Prior Authorization rules may apply.	Prior Authorization rules may apply.			
Ambulatory Surgery Center	You pay a \$250 copay for each Medicare-covered ambulatory surgical center visit.	You pay a \$395 copay for each Medicare-covered ambulatory surgical center visit.			
Doctor Visits					
Primary care providers	You pay a \$15 copay per office visit. You pay a \$10 copay per telehealth visit.	You pay a \$10 copay per office visit. You pay a \$5 copay per telehealth visit.			
Specialists	You pay a \$50 copay per office visit (referral required).	You pay a \$50 copay per office visit (referral required).			
	You pay a \$45 copay per telehealth visit.	You pay a \$45 copay per telehealth visit.			
Preventive Care (such as flu vaccine, diabetic screenings)	You pay nothing. Other preventive services are available. There are some covered services that have a cost.	You pay nothing. Other preventive services are available. There are some covered services that have a cost.			

	Available to residents of these counties: King, Pierce, Snohomish, Thurston, and Whatcom				
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HM0)			
Emergency Care	You pay a \$90 copay per visit. Waived, if admitted to the hospital within 24 hours.	You pay a \$90 copay per visit. Waived, if admitted to the hospital within 24 hours.			
	Includes worldwide coverage.	Includes worldwide coverage.			
<b>Urgently Needed Services</b>	You pay a \$45 copay per visit.	You pay a \$45 copay per visit.			
	Includes worldwide coverage with a \$50 copay.	Includes worldwide coverage with a \$50 copay.			
Diagnostic Services/Labs/ Imaging					
Diagnostic tests and procedures	You pay 20% of the total cost.	You pay 20% of the total cost.			
Lab services	You pay a \$15 copay per day.	You pay a \$15 copay per day.			
Outpatient x-rays	You pay a \$20 copay per day.	You pay a \$20 copay per day.			
Therapeutic radiology	You pay 20% of the cost.	You pay 20% of the cost.			
services (such as radiation treatment for cancer)	If your doctor provides additional services, a separate cost sharing amount may apply.	If your doctor provides additional services, a separate cost sharing amount may apply.			
	Prior Authorization rules may apply.	Prior Authorization rules may apply.			
Hearing Services					
Medicare-covered hearing exam	You pay a \$0-\$50 copay per visit. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams performed by all other providers.	You pay a \$0-\$50 copay per visit. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams performed by all other providers.			
Routine hearing exam	You pay a \$0-\$50 copay for one routine hearing exam per calendar year. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams performed by all other providers.	You pay a \$0-\$50 copay for one routine hearing exam per calendar year. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams performed by all other providers.			
Hearing aid	You pay a \$0 copay. There is a \$1,000 annual allowance per ear for hearing aids through Hearing Care Solutions provider.	You pay a \$0 copay. There is a \$1,000 annual allowance per ear for hearing aids through Hearing Care Solutions provider.			

	Available to residents of these counties: King, Pierce, Snohomish, Thurston, and Whatcom				
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HM0)			
Dental Services					
Medicare-covered dental services	You pay a \$50 copay per visit.	You pay a \$50 copay per visit.			
Routine dental services	For dental services (routine), see "Optional supplemental dental benefit" section later in	You pay a \$0 copay for routine dental services.			
	the booklet.	Routine oral exams - two per calendar year.			
		Comprehensive periodontal exam - one per calendar year.			
		Routine cleaning – limited up to two routine cleaning (prophylaxis) per calendar year			
		OR			
		Periodontal maintenance – limited up to three periodontal maintenance per calendar year.			
		Fluoride treatment – twice per calendar year.			
		<ul> <li>Bitewing x-ray-up to one set of four bitewing x-rays every year.</li> </ul>			
		<ul> <li>Panoramic or complete series x-ray—once every 60 months.</li> </ul>			
		Limited emergency exam-limited to once per calendar year.			
		Emergency palliative treatment of dental pain.			
		Periapical x-rays.			
Vision Services					
Medicare-covered vision exam	You pay a \$0 copay for each Medicare-covered diabetic retinopathy screening once per calendar year.	You pay a \$0 copay for each Medicare-covered diabetic retinopathy screening once per calendar year.			
	You pay a \$50 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a \$50 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.			

	Available to residents of these counties: King, Pierce, Snohomish, Thurston, and Whatcom			
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HM0)		
Medicare-covered vision hardware	You pay \$0 copay for one pair of Medicare- covered eyeglasses or contact lenses after each cataract surgery.	You pay \$0 copay for one pair of Medicare- covered eyeglasses or contact lenses after each cataract surgery.		
Routine vision exam	You pay a \$20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses. No referral is required for Routine Vision Exam.	You pay a \$20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses. No referral is required for Routine Vision Exam.		
Routine vision hardware	There is a \$150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.	There is a \$150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.		
Mental Health Services				
Inpatient mental health care	You pay a \$595 copay per day for days 1-2. You pay \$0 copay per day for days 3-90.	You pay a \$595 copay per day for days 1-2. You pay \$0 copay per day for days 3-90.		
Outpatient mental health care	You pay a \$40 copay for each Medicare-covered individual or group therapy visit.	You pay a \$40 copay for each Medicare-covered individual or group therapy visit.		
	You pay a \$35 copay for each telemental health visit.	You pay a \$35 copay for each telemental health visit.		
	Prior Authorization rules may apply.	Prior Authorization rules may apply.		
Skilled Nursing Facility	You pay a \$0 copay per day for days 1-20. You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for days 61-100.	You pay a \$0 copay per day for days 1-20. You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for days 61-100.		
	Prior Authorization rules may apply.	Prior Authorization rules may apply.		
Physical Therapy	You pay a \$40 copay per visit.	You pay a \$40 copay per visit.		
Ambulance	You pay a \$280 copay each way for Medicare- covered ambulance transport.	You pay a \$285 copay each way for Medicare- covered ambulance transport.		
	Prior Authorization rules may apply.	Prior Authorization rules may apply.		

	Available to residents of these counties: King, Pierce, Snohomish, Thurston, and Whatcom			
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HM0)		
Transportation	Not covered.	Not covered.		
Medicare Part B Drugs	You pay 20% of the total cost for Medicare- covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the total cost for Medicare- covered Part B chemotherapy drugs and other Part B drugs.		
	Prior Authorization rules may apply.	Prior Authorization rules may apply.		

	Available to residents of these counties: King, Pierce, Snohomish, Thurston, and Whatcom								
PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HM0)			PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HM0)						
PRESCRIPTION		NEFITS (PART	D)		PRESCRIPTI	ON DRUG BEN	IEFITS (PART	D)	
Deductible Phase	4, and 5 drug	stage, you pay gs. You stay ir or your Tier 3, 4	this stage un	itil you have	<b>Deductible Phase</b> During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid \$160 for your Tier 3, 4, and 5 drugs.			itil you have	
		ou stay in the In e year reach \$		e Stage until		<b>ge Phase -</b> Youg costs for the	•	•	e Stage until
	Preferred Retail Cost Sharing (in network) (up to a 30- day supply)	Standard Retail Cost Sharing (in network) (up to 30- day supply)	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31- day supply)		Preferred Retail Cost Sharing (in network) (up to a 30- day supply)	Standard Retail Cost Sharing (in network) (up to 30- day supply)	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31- day supply)
Tier 1: Preferred Generic	You pay a \$3 copay.	You pay a \$12 copay.	You pay a \$0 copay.	You pay a \$12 copay.	Tier 1: Preferred Generic	You pay a \$2 copay.	You pay a \$12 copay.	You pay a \$0 copay.	You pay a \$12 copay.
Tier 2: Generic	You pay a \$12 copay.	You pay a \$20 copay.	You pay a \$36 copay.	You pay a \$20 copay.	Tier 2: Generic	You pay a \$12 copay.	You pay a \$20 copay.	You pay a \$36 copay.	You pay a \$20 copay.
Tier 3: Preferred Brand	You pay a \$42 copay.	You pay a \$47 copay.	You pay a \$126 copay.	You pay a \$47 copay.	Tier 3: Preferred Brand	You pay a \$42 copay.	You pay a \$47 copay.	You pay a \$126 copay.	You pay a \$47 copay.
Tier 4: Non- Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.	You pay 33% of the total cost.	You pay 33% of the total cost.	Tier 4: Non- Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.	You pay 33% of the total cost.	You pay 33% of the total cost.
Tier 5: Specialty	You pay 30% of the total cost.	You pay 30% of the total cost.	Not offered.	You pay 30% of the total cost.	Tier 5: Specialty	You pay 30% of the total cost.	You pay 30% of the total cost.	Not offered.	You pay 30% of the total cost.
Cost sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.			Cost sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.						

Available to residents of these counties: King, Pierce, Snohomish, Thurston, and Whatcom					
PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HM0)				
Coverage Gap	Coverage Gap				
After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach \$6,550, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.	After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach \$6,550, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.				
Catastrophic Coverage	Catastrophic Coverage				
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:				
• 5% of the cost of the drug, or	• 5% of the cost of the drug, or				
• \$3.70 copay for a generic drug, or a drug that is treated like a generic and \$9.20 copay for all other drugs.	• \$3.70 copay for a generic drug, or a drug that is treated like a generic and \$9.20 copay for all other drugs.				
Part D Senior Savings Plan	Part D Senior Savings Plan				
Maximum copay of \$35 for 30 day supply for recommended diabetic insulins	Maximum copay of \$35 for 30 day supply for recommended diabetic insulins				
Over the Counter (OTC)	Over the Counter (OTC)				
Receive a \$25 quarterly benefit for over-the-counter health and wellness products available through OTC Health Solutions.	Receive a \$50 quarterly benefit for over-the-counter health and wellness products available through OTC Health Solutions.				

PREMERA BLUE CROSS PEAK + Rx (HM0)		g, Pierce, Snohomish, Thurston, and Whatcom PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HM0)
OPTIONAL SUPPLEMEN	TAL BENEFITS	OPTIONAL SUPPLEMENTAL BENEFITS
Optional Supplemental Dental Benefit		Not applicable
Monthly Premium	You pay additional \$22.50 per month.	
Deductible	There is no deductible.	
Annual Benefit Maximum	There is no annual maximum limit.	
You pay a \$0 copay for ro	outine dental services.	
• Routine oral exams - tw	vo per calendar year.	
• Comprehensive periodo	ontal exam - one per calendar year.	
<ul> <li>Routine cleaning – limit (prophylaxis) per calend</li> <li>OR</li> </ul>	ted up to two routine cleaning dar year	
Periodontal maintenand maintenance per calend	ce – limited up to three periodontal dar year.	
• Fluoride treatment–twi	ce per calendar year.	
• Bitewing x-ray-up to or	ne set of four bitewing x-rays every year.	
• Panoramic or complete	e series x-ray—once every 60 months.	
• Limited emergency exa	m-limited to once per calendar year.	
• Emergency palliative tre	eatment of dental pain.	
• Periapical x-rays.		

	Counties: King, Pierce, Snohomis	Counties: King, Pierce, Snohomish, and Thurston	
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)
Monthly Plan Premium	You pay \$42 per month. You must continue to pay your Medicare Part B premium.	You pay \$151 per month. You must continue to pay your Medicare Part B premium.	You pay \$191 per month. You must continue to pay your Medicare Part B premium.
Part C Deductible	No deductible.	No deductible.	No deductible.
Part D Deductible	Not applicable.	\$160 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	\$180 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than \$6,500 annually. Includes copays and other costs for medical services for the year.	You pay no more than \$4,900 annually. Includes copays and other costs for medical services for the year.	You pay no more than \$5,000 annually. Includes copays and other costs for medical services for the year.
Inpatient Hospital Coverage	You pay a \$595 copay per day for days 1-3. You pay a \$0 copay per day for days 4 and beyond.	You pay a \$450 copay per day for days 1-4. You pay a \$0 copay per day for days 5 and beyond.	You pay a \$350 copay per day for days 1-4. You pay a \$0 copay per day for days 5 and beyond.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Outpatient Hospital Coverage	You pay a \$495 copay for each Medicare-covered outpatient hospital surgery.	You pay a \$290 copay for each Medicare-covered outpatient hospital surgery.	You pay a \$250 copay for each Medicare-covered outpatient hospital surgery.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Ambulatory Surgery Center	You pay a \$250 copay for each Medicare-covered ambulatory surgical center visit.	You pay a \$190 copay for each Medicare-covered ambulatory surgical center visit.	You pay a \$250 copay for each Medicare-covered ambulatory surgical center visit.

	Counties: King, Pierce, Snohomis	Counties: King, Pierce, Snohomish, and Thurston	
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)
<b>Doctor Visits</b>			
Primary care providers	You pay a \$10 copay per office visit. You pay a \$5 copay per telehealth visit.	You pay a \$10 copay per office visit. You pay a \$5 copay per telehealth visit.	You pay a \$10 copay per office visit. You pay a \$5 copay per telehealth visit.
Specialists	You pay a \$50 copay per office visit (referral required). You pay a \$45 copay per telehealth visit.	You pay a \$35 copay per office visit (referral required). You pay a \$30 copay per telehealth visit.	You pay a \$40 copay per office visit (referral required). You pay a \$35 copay per telehealth visit.
Preventive Care (such as flu vaccine, diabetic screenings)	You pay nothing. Other preventive services are available. There are some covered services that have a cost.	You pay nothing. Other preventive services are available. There are some covered services that have a cost.	You pay nothing. Other preventive services are available. There are some covered services that have a cost.
Emergency Care	You pay a \$90 copay per visit. Waived, if you are admitted to the hospital within 24 hours.	You pay a \$90 copay per visit. Waived, if you are admitted to the hospital within 24 hours.	You pay a \$90 copay per visit. Waived, if you are admitted to the hospital within 24 hours.
	Includes worldwide coverage.	Includes worldwide coverage.	Includes worldwide coverage.
Urgently Needed Services	You pay a \$45 copay per visit.	You pay a \$45 copay per visit.	You pay a \$45 copay per visit.
	Includes worldwide coverage with a \$50 copay.	Includes worldwide coverage with a \$50 copay.	Includes worldwide coverage with a \$50 copay.
Diagnostic Services/Labs/ Imaging			
Diagnostic tests and procedures	You pay 20% of the total cost.	You pay 20% of the total cost.	You pay 20% of the total cost.
Lab services	You pay a \$15 copay per day.	You pay a \$7 copay per day.	You pay a \$0 copay per day.
Outpatient x-rays	You pay a \$20 copay per day.	You pay a \$20 copay per day.	You pay a \$0 copay per day.

	Counties: King, Pierce, Snohomis	h, Thurston, and Whatcom	Counties: King, Pierce, Snohomish, and Thurston
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)
Therapeutic radiology services (such as radiation treatment for cancer)	You pay 20% of the total cost.  If your doctor provides additional services, a separate cost sharing amount may apply.	You pay 20% of the total cost.  If your doctor provides additional services, a separate cost sharing amount may apply.	You pay 20% of the total cost.  If your doctor provides additional services, a separate cost sharing amount may apply.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Hearing Services			
Medicare-covered hearing exam	You pay a \$0-\$50 copay per visit. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.	You pay a \$0-\$35 copay per visit. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.	You pay a \$40 copay per visit.
Routine hearing exam	You pay a \$0-\$50 copay for one routine hearing exam per calendar year. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.	You pay a \$0-\$35 copay for one routine hearing exam per calendar year. \$0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.	You pay a \$40 copay for one routine hearing exam per calendar year.
Hearing aid	You pay a \$0 copay. There is a \$1,000 annual allowance per ear toward the purchase of hearing aids through Hearing Care Solutions provider.	You pay a \$0 copay. There is a \$1,000 annual allowance per ear toward the purchase of hearing aids through Hearing Care Solutions provider.	Not covered.

	Counties: King, Pierce, Snohomis	Counties: King, Pierce,	
	doubles. Ring, Fierce, Chonomic	on, marston, and whateom	Snohomish, and Thurston
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)
Dental Services			
Medicare-covered dental services	You pay a \$50 copay per visit.	You pay a \$35 copay per visit.	You pay a \$40 copay per visit.
Routine dental services	Not covered.	You pay a \$0 copay for routine dental services.	You pay a \$0 copay for routine dental services.
		Routine oral exams - two per calendar year.	Routine oral exams - two per calendar year.
		Comprehensive periodontal exam - one per calendar year	Comprehensive periodontal exam - one per calendar year.
		<ul> <li>Routine cleaning – limited up to two routine cleaning (prophylaxis) per calendar year OR Periodontal maintenance – limited up to three periodontal maintenance per calendar year.</li> </ul>	Routine cleaning – limited up to two routine cleaning (prophylaxis) per calendar year     OR     Periodontal maintenance – limited up to three periodontal maintenance per calendar year.
		<ul> <li>Fluoride treatment– twice per calendar year.</li> </ul>	<ul> <li>Fluoride treatment – twice per calendar year.</li> </ul>
		<ul> <li>Bitewing x-ray-up to one set of four bitewing x-rays every year.</li> </ul>	<ul> <li>Bitewing x-ray-up to one set of four bitewing x-rays every year.</li> </ul>
		<ul> <li>Panoramic or complete series x-ray—once every 60 months.</li> </ul>	<ul> <li>Panoramic or complete series x-ray—once every 60 months.</li> </ul>
		<ul> <li>Limited emergency exam- limited to once per calendar year.</li> </ul>	<ul> <li>Limited emergency exam- limited to once per calendar year.</li> </ul>
		<ul> <li>Emergency palliative treatment of dental pain.</li> </ul>	Emergency palliative treatment of dental pain.
		Periapical x-rays.	• Periapical x-rays.

	Counties: King, Pierce, Snohomis	Counties: King, Pierce, Snohomish, and Thurston	
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)
Vision Services			
Medicare-covered vision exam	You pay a \$0 copay for each Medicare-covered diabetic retinopathy screening once per calendar year.	You pay a \$0 copay for each Medicare-covered diabetic retinopathy screening once per calendar year.	You pay a \$0 copay for each Medicare-covered diabetic retinopathy screening once per calendar year.
	You pay a \$50 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a \$35 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a \$40 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.
Medicare-covered vision hardware	You pay a \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.	You pay a \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.	You pay \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.
Routine vision exam	You pay a \$20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.	You pay a \$20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.	You pay a \$40 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.
Routine vision hardware	There is a \$150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.	There is a \$150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.	There is a \$150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.
Mental Health Services			
Inpatient mental health care	You pay a \$595 copay per day for days 1-2. You pay a \$0 copay per day for days 3-90.	You pay a \$450 copay per day for days 1-3. You pay a \$0 copay per day for days 4-90.	You pay a \$350 copay per day for days 1-4. You pay a \$0 copay per day for days 5-90.

	Counties: King, Pierce, Snohomis	Counties: King, Pierce, Snohomish, and Thurston	
PREMIUM AND BENEFITS	PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)
Outpatient mental health care	You pay a \$40 copay for each Medicare-covered individual or group therapy visit.	You pay a \$40 copay for each Medicare-covered individual or group therapy visit.	You pay a \$40 copay for each Medicare-covered individual or group therapy visit.
	You pay a \$35 copay for each telemental health visit.	You pay a \$35 copay for each telemental health visit.	You pay a \$35 copay for each telemental health visit.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Skilled Nursing Facility	You pay a \$0 copay per day for days 1-20. You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for days 61-100.	You pay a \$0 copay per day for days 1-20. You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for days 61-100.	You pay a \$0 copay per day for days 1-20. You pay a \$160 copay per day for days 21-60. You pay a \$0 copay per day for days 61-100.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Physical Therapy	You pay a \$40 copay per visit.	You pay a \$35 copay per visit.	You pay a \$40 copay per visit.
Ambulance	You pay a \$255 copay each way for Medicare-covered ambulance transport.	You pay a \$315 copay each way for Medicare-covered ambulance transport.	You pay a \$200 copay each way for Medicare-covered ambulance transport.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.
Transportation	Not covered.	Not covered.	Not covered.
Medicare Part B Drugs	You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.
	Prior Authorization rules may apply.	Prior Authorization rules may apply.	Prior Authorization rules may apply.

				Counties: King, Pierce, Snohomish, and Thurston		
PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)			PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)		
PRESCRIPTION DRUG BENEFITS (PART D)	PRESCRIPT	ION DRUG BENE	FITS (PART D)	PRESCRIPTION DRUG BENEFITS (PART D)		
Not applicable.	Deductible Phase			Deductible Phase	During this star full cost of you 5 drugs. You st until you have p your Tier 3, 4, a	r Tier 3, 4, and ay in this stage baid \$180 for
	Coverage Stage until your total drug costs			Initial Coverage Phase - You stay in the Initial Coverage Stage until your total drug costs for the year reach \$4,130.		
		Preferred Standard Retail Retail Cost Cost Sharing Sharing (in network) (in network) (up to 30-day (up to a 30-day supply) supply)			Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost Sharing (in network) (up to 30-day supply)
	Tier 1: Preferred Generic	You pay a \$2 copay.	You pay a \$12 copay.	Tier 1: Preferred Generic	You pay a \$4 copay.	You pay a \$12 copay.
	Tier 2: Generic	You pay a \$12 copay.	You pay a \$20 copay.	Tier 2: Generic	You pay a \$12 copay.	You pay a \$20 copay.
	Tier 3: Preferred Brand	You pay a \$42 copay.	You pay a \$47 copay.	Tier 3: Preferred Brand	You pay a \$42 copay.	You pay a \$47 copay.
	Tier 4: Non- Preferred Drugs	red You pay You pay 33% of the total cost		Tier 4: Non- Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.
	Tier 5: Specialty	You pay 30% of the total cost.	You pay 30% of the total cost.	Tier 5: Specialty	You pay 29% of the total cost.	You pay 29% of the total cost.

				Counties: King, Pierce, Snohomish, and Thurston		
PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)			PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)		
Not applicable.		Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)		Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)
	Tier 1: Preferred Generic	You pay a \$0 copay.	You pay a \$12 copay.	Tier 1: Preferred Generic	You pay a \$0 copay.	You pay a \$12 copay.
	Tier 2: Generic	You pay a \$36 copay.	You pay a \$20 copay.	Tier 2: Generic	You pay a \$36 copay.	You pay a \$20 copay.
	Tier 3: Preferred Brand	You pay a \$126 copay.	You pay a \$47 copay.	Tier 3: Preferred Brand	You pay a \$126 copay.	You pay a \$47 copay.
	Tier 4: Non- Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.	Tier 4: Non- Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.
	Tier 5: Specialty	Not offered.	You pay 30% of the total cost.	Tier 5: Specialty	Not offered.	You pay 29% of the total cost.
	the pharmad	g may change de cy you choose ar er of the four pha fit.	nd when you	the pharmad	g may change de by you choose an er of the four pha fit.	d when you

Counties: King, Pierce, Snohomish, Thursto	Counties: King, Pierce, Snohomish, and Thurston	
PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)
Not applicable.	Coverage Gap	Coverage Gap
	After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach \$6,550, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.	After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach \$6,550, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.
	Catastrophic Coverage	Catastrophic Coverage
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:
	• 5% of the cost of the drug, or	• 5% of the cost of the drug, or
	• \$3.70 copay for a generic drug, or a drug that is treated like a generic and \$9.20 copay for all other drugs.	• \$3.70 copay for a generic drug, or a drug that is treated like a generic and \$9.20 copay for all other drugs.
	Part D Senior Savings Plan	Part D Senior Savings Plan
	Maximum copay of \$35 for 30 day supply for recommended diabetic insulins	Maximum copay of \$35 for 30 day supply for recommended diabetic insulins
Over the Counter (OTC)	Over the Counter (OTC)	Over the Counter (OTC)
Receive a \$50 quarterly benefit for over- the-counter health and wellness products available through OTC Health Solutions.	Receive a \$50 quarterly benefit for over- the-counter health and wellness products available through OTC Health Solutions.	Receive a \$50 quarterly benefit for over- the-counter health and wellness products available through OTC Health Solutions.