2022 Summary of Benefits

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PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

2022 Summary of Benefits

PREMERA BLUE CROSS MEDICARE ADVANTAGE (HMO) H7245-001
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This is a summary of drug and health services covered by 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, 2022 to December 31, 2022.

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 (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	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Thurston, Walla Walla, and Whatcom	Spokane, Stevens, and Walla Walla
Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
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	$160 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	No deductible.	No 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 $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 $350 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.
Outpatient Hospital Coverage	$350	$300	$275
Outpatient Hospital Observation Coverage	$90	$90	$90
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, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Thurston, Walla Walla, and Whatcom	Spokane, Stevens, and Walla Walla
Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Doctor Visits			
Primary care providers	You pay a $5 copay per office visit. You pay a $0 copay per telehealth visit.	You pay a $0 copay per office visit. You pay a $0 copay per telehealth visit.	You pay a $0 copay per office visit. You pay a $0 copay per telehealth visit.
Specialists	You pay a $40 copay per office visit (referral required). You pay a $35 copay per telehealth visit.	You pay a $30 copay per office visit (referral required). You pay a $25 copay per telehealth visit.	You pay a $30 copay 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.	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. Includes worldwide coverage.	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 $35 copay per visit. Includes worldwide coverage with a $50 copay.	You pay a $35 copay per visit. Includes worldwide coverage with a $50 copay.	You pay a $45 copay per visit. Includes worldwide coverage with a $50 copay.

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Diagnostic Services/Labs/ Imaging			
Diagnostic tests and procedures	You pay $60 of the total cost.	You pay $30 of the total cost.	You pay $30 of the total cost.
Lab services	You pay a $15 copay per order.	You pay a $0 copay per order.	You pay a $0 copay per order.
Outpatient x-rays	You pay a $15 copay per order.	You pay a $10 copay per order.	You pay a $10 copay per order.
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.
Diagnostic radiology services	$180	$160	$160
Hearing Services			
Medicare-covered hearing exam	You pay a $35 copay per visit.	You pay a $30 copay per visit.	You pay a $30 copay per visit.
Routine hearing exam	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 $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	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.	You pay a $0 copay. There is a $1,000 annual allowance per ear toward the purchase of hearing aids through Hearing Care Solutions.

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
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.
Annual maximum	$1,000	$1,500	$1,500
Dental services	You pay a $0 copay for preventive and comprehensive dental services.		
Preventive Services	• Prophylaxis (cleaning) - Two per calendar year OR Periodontal maintenance - Three per calendar year • Fluoride - Two per calendar year • Periodic oral exam - Up to two periodic oral evaluations per calendar year • Limited oral evaluation (problem focused) - One evaluation per 12 months • Comprehensive oral exam - One comprehensive exam per 36 months • Detailed and extensive oral evaluation - problem focused, by report - One per lifetime • Re-evaluation - limited, problem focused (established patient) - One per lifetime • Comprehensive periodontal exam - One per calendar year • Bitewing x-rays - One set per calendar year • Full-mouth complete set - One procedure every 60 months • Panoramic film x-ray for evaluation of the teeth and mouth - One procedure every 60 months		
Annual Comprehensive Deductible (in-network and out-of-network)	You pay a one-time annual Comprehensive Services deductible of $75. Deductible is waived for preventive and Medicare-covered dental services.		

Counties	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Thurston, Walla Walla, and Whatcom	Spokane, Stevens, and Walla Walla
Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Comprehensive services	• Periodontal scaling and root planning - One every two years, per quadrant • Scaling in presence of generalized moderate or severe gingival inflammation, full mouth - Once per two years • Occlusal adjustment performed with covered surgery – no limit • Gingivectomy or gingivoplasty - One surgical procedure per lifetime • Osseous surgery including flap entry and closure - One per lifetime • Pedicle or free soft tissue graft - One per set per lifetime • Full mouth debridement - One per lifetime • Intraoral x-rays: Periapical x-rays or Occlusal x-rays - One procedure code per calendar year • Restorations (fillings): amalgam (Silver) and/or Composite - One per tooth per 24 months • Recementing a crown that has fallen off - One per 12 months • Recementing bridges, inlays, onlays and crowns - After 12 months of insertion and per 12 months per tooth thereafter • Pins when preparing a tooth for a crown - Bundle with crown code and pins (when required) • Buildup of filling around a post to prepare the tooth for a crown - One combo per tooth every 5 years • Crowns - One per tooth every 5 years • Oral surgery, including postoperative care for coronectomy, intentional partial tooth removal - One per tooth per lifetime • Root canal – One initial root canal procedure and one retreatment procedure per tooth per lifetime • Pulpotomy – No Limit • Apicoectomy – No Limit • Retrograde fillings – Per root per lifetime • Medicine placed under fillings to promote pulp healing - Unlimited per plan year to plan annual maximum • Complete denture – maxillary (upper) or mandibular (lower) - One upper complete and/or one lower complete denture every seven years, including routine post-delivery care • Partial Dentures: Resin or metal, maxillary (upper) or mandibular (lower) or maxillary (upper) or mandibular (lower) - One upper and/or one lower partial denture every seven years		

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Comprehensive services	• Complete denture and partial denture adjustment - Two per denture per year • Complete or Partial Denture Reline or Rebase – One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth). • Recementation - One procedure per calendar year • Repair of dentures or fixed bridgework - One per denture/bridgework per 24 month • Teledentistry - Two per calendar year • Pain Management - Unlimited per plan year to plan annual maximum. Only if no services other than exam and x-rays were performed on the same date of service. • Deep sedation/general anesthesia - Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery. • Local anesthesia - Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery • Intravenous moderate (conscious) sedation/analgesia - Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery.		

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Vision Services			
Medicare-covered vision exam	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings 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 $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. You pay a $30 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. 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 $0 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 $0 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 $250 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.	There is a $200 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
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.	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 $35 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.	You pay a $30 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.	You pay a $30 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.
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.
Physical Therapy	You pay a $20 copay per visit.	You pay a $10 copay per visit.	You pay a $10 copay per visit.
Ambulance	You pay a $300 copay each way for Medicare-covered ambulance transport.	You pay a $330 copay each way for Medicare-covered ambulance transport.	You pay a $370 copay each way for Medicare-covered ambulance transport.

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
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.
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.
Chiropractic Services	Medicare-covered copay: $20. Routine Chiropractic Services: 6 visits/ $20 copay.	Medicare-covered copay: $20. Routine Chiropractic Services: 10 visits/ $20 copay.	Medicare-covered copay: $20. Routine Chiropractic Services: 10 visits/ $20 copay.
Acupuncture	Medicare-covered copay: $40. Routine Acupuncture: 6 visits/ $20 copay.	Medicare-covered copay: $30. Routine Acupuncture: 10 visits/ $20 copay.	Medicare-covered copay: $30. Routine Acupuncture: 10 visits/ $20 copay.
Routine Naturopathic Services	Not covered.	6 visits/ $30 copay	6 visits/ $30 copay

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Premera Blue Cross Medicare Advantage (HMO)			**Premera Blue Cross Medicare Advantage Classic (HMO)**			**Premera Blue Cross Medicare Advantage Total Health (HMO)**		
PRESCRIPTION DRUG BENEFITS (PART D)			**PRESCRIPTION DRUG BENEFITS (PART D)**			**PRESCRIPTION DRUG BENEFITS (PART D)**		
Deductible Phase	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. During this stage, your out-of-pocket costs for Select Insulins will be $35.		**Deductible Phase**	Because there is no deductible for the plan, this payment stage does not apply to you.		**Deductible Phase**	Because there is no deductible for the plan, this payment stage does not apply to you.	
Initial Coverage Phase - You begin in this stage when you fill your first prescription of the year. You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,430. During this stage, your out-of-pocket costs for Select Insulins will be $35.								
	Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost sharing (in network)(up to 30-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)		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 $4 copay.	You pay a $15 copay.	**Tier 1: Preferred Generic**	You pay a $2 copay.	You pay a $12 copay.	**Tier 1: Preferred Generic**	You pay a $2 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 $10 copay.	You pay a $20 copay.	**Tier 2: Generic**	You pay a $10 copay.	You pay a $20 copay.
Tier 3: Preferred Brand	You pay a $42 copay. $35 copay for Select Insulins.	You pay a $47 copay $35 copay for Select Insulins.	**Tier 3: Preferred Brand**	You pay a $40 copay. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.	**Tier 3: Preferred Brand**	You pay a $40 copay. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.
Tier 4: Non-Preferred Drugs	You pay a $100 copay.	You pay a $100 copay.	**Tier 4: Non-Preferred Drugs**	You pay a $100 copay.	You pay a $100 copay.	**Tier 4: Non-Preferred Drugs**	You pay a $100 copay.	You pay a $100 copay.
Tier 5: Specialty	You pay 30% of the total cost.	You pay 30% of the total cost.	**Tier 5: Specialty**	You pay 33% of the total cost.	You pay 33% of the total cost.	**Tier 5: Specialty**	You pay 33% of the total cost.	You pay 33% of the total cost.

Counties: Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom		
Premera Blue Cross Medicare Advantage (HMO)		
	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 2: Generic	You pay a $36 copay.	You pay a $20 copay.
Tier 3: Preferred Brand	You pay a $126 copay. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.
Tier 4: Non-Preferred Drugs	You pay a $300 copay.	You pay a $100 copay.
Tier 5: Specialty	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.		

Counties: Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Thurston, Walla Walla, and Whatcom		
Premera Blue Cross Medicare Advantage Classic (HMO)		
	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 2: Generic	You pay a $30 copay.	You pay a $20 copay.
Tier 3: Preferred Brand	You pay a $120 copay. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.
Tier 4: Non-Preferred Drugs	You pay a $300 copay.	You pay a $100 copay.
Tier 5: Specialty	Not offered.	You pay 33% 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.		

Counties: Spokane, Stevens, and Walla Walla		
Premera Blue Cross Medicare Advantage Total Health (HMO)		
	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 2: Generic	You pay a $30 copay.	You pay a $20 copay.
Tier 3: Preferred Brand	You pay a $120 copay. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.
Tier 4: Non-Preferred Drugs	You pay a $300 copay.	You pay a $100 copay.
Tier 5: Specialty	Not offered.	You pay 33% 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.		

Counties	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Thurston, Walla Walla, and Whatcom	Spokane, Stevens, and Walla Walla
Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
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 $7,050, which is the end of the Coverage Gap. During this stage, your out-of-pocket costs for Select Insulins will be $35. Not everyone will reach the Coverage Gap.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay whichever of these is larger: • 5% of the cost of the drug, or • $3.95 copay for a generic drug, or a drug that is treated like a generic and $9.85 copay for all other drugs.		

Counties	King, Pierce, Snohomish, Thurston, and Whatcom	
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**
Monthly Plan Premium	You pay $0 per month. You must continue to pay your Medicare Part B premium.	You pay $35 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.	There is no deductible for Sound + Rx.
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 $450 per day for days 1-4. You pay a $0 copay per day for days 5 and beyond.	You pay a $450 per day for days 1-4. You pay a $0 copay per day for days 5 and beyond.
Outpatient Hospital Coverage	$350	$350
Outpatient Hospital Observation Coverage	$90	$90
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 $5 copay per office visit. You pay a $0 copay per telehealth visit.	You pay a $0 copay per office visit. You pay a $0 copay per telehealth visit.
Specialists	You pay a $40 copay per office visit (referral required). You pay a $35 copay per telehealth visit.	You pay a $45 copay per office visit (referral required). You pay a $40 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	King, Pierce, Snohomish, Thurston, and Whatcom	
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**
Emergency Care	You pay a $90 copay per visit. Waived, if admitted to the hospital within 24 hours. Includes worldwide coverage.	You pay a $90 copay per visit. Waived, if admitted to the hospital within 24 hours. Includes worldwide coverage.
Urgently Needed Services	You pay a $35 copay per visit. Includes worldwide coverage with a $50 copay.	You pay a $40 copay per visit. Includes worldwide coverage with a $50 copay.
Diagnostic Services/Labs/ Imaging		
Diagnostic tests and procedures	You pay $60 of the total cost.	You pay $25 of the total cost.
Lab services	You pay a $15 copay per order.	You pay a $5 copay per order.
Outpatient x-rays	You pay a $15 copay per order.	You pay a $10 copay per order.
Therapeutic radiology services (such as radiation treatment for cancer)	You pay 20% of the cost. If your doctor provides additional services, a separate cost sharing amount may apply.	You pay 20% of the cost. If your doctor provides additional services, a separate cost sharing amount may apply.
Diagnostic radiology services	$180	$170
Hearing Services		
Medicare-covered hearing exam	You pay a $35 copay per visit.	You pay a $45 copay per visit.
Routine hearing exam	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 performed by all other providers.	You pay a $0–$45 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.	

Counties	King, Pierce, Snohomish, Thurston, and Whatcom	
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**
Dental Services		
Medicare-covered dental services	You pay a $50 copay per visit.	
Annual maximum	$1,000	$1,300
Dental services	You pay a $0 copay for routine dental services.	
Preventive Services	• Prophylaxis (cleaning) - Two per calendar year OR Periodontal maintenance - Three per calendar year • Fluoride - Two per calendar year • Periodic oral exam - Up to two periodic oral evaluations per calendar year • Limited oral evaluation (problem focused) - One evaluation per 12 months • Comprehensive oral exam - One comprehensive exam per 36 months • Detailed and extensive oral evaluation - problem focused, by report - One per lifetime • Re-evaluation - limited, problem focused (established patient) - One per lifetime • Comprehensive periodontal exam - One per calendar year • Bitewing x-rays - One set per calendar year • Full-mouth complete set - One procedure every 60 months • Panoramic film x-ray for evaluation of the teeth and mouth - One procedure every 60 months	
Annual Comprehensive Deductible (in-network and out-of-network)	You pay a one-time annual Comprehensive Services deductible of $75. Deductible is waived for preventive and Medicare-covered dental services.	

Counties	King, Pierce, Snohomish, Thurston, and Whatcom	
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**
Comprehensive services	• Periodontal scaling and root planning - One every two years, per quadrant • Scaling in presence of generalized moderate or severe gingival inflammation, full mouth - Once per two years • Occlusal adjustment performed with covered surgery – no limit • Gingivectomy or gingivoplasty - One surgical procedure per lifetime • Osseous surgery including flap entry and closure - One per lifetime • Pedicle or free soft tissue graft - One per set per lifetime • Full mouth debridement - One per lifetime • Intraoral x-rays: Periapical x-rays or Occlusal x-rays - One procedure code per calendar year • Restorations (fillings): amalgam (Silver) and/or Composite - One per tooth per 24 months • Recementing a crown that has fallen off - One per 12 months • Recementing bridges, inlays, onlays and crowns - After 12 months of insertion and per 12 months per tooth thereafter • Pins when preparing a tooth for a crown - Bundle with crown code and pins (when required) • Buildup of filling around a post to prepare the tooth for a crown - One combo per tooth every 5 years • Crowns - One per tooth every 5 years • Oral surgery, including postoperative care for coronectomy, intentional partial tooth removal - One per tooth per lifetime • Root canal – One initial root canal procedure and one retreatment procedure per tooth per lifetime • Pulpotomy – No Limit • Apicoectomy – No Limit • Retrograde fillings – Per root per lifetime • Medicine placed under fillings to promote pulp healing - Unlimited per plan year to plan annual maximum • Complete denture – maxillary (upper) or mandibular (lower) - One upper complete and/or one lower complete denture every seven years, including routine post-delivery care • Partial Dentures: Resin or metal, maxillary (upper) or mandibular (lower) or maxillary (upper) or mandibular (lower) - One upper and/or one lower partial denture every seven years • Complete denture and partial denture adjustment - Two per denture per year	

Counties	King, Pierce, Snohomish, Thurston, and Whatcom	
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**
Comprehensive services	• Complete or Partial Denture Reline or Rebase – One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth). • Recementation - One procedure per calendar year • Repair of dentures or fixed bridgework - One per denture/bridgework per 24 months • Teledentistry - Two per calendar year • Pain Management - Unlimited per plan year to plan annual maximum. Only if no services other than exam and x-rays were performed on the same date of service. • Deep sedation/general anesthesia - Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery. • Local anesthesia - Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery • Intravenous moderate (conscious) sedation/analgesia - Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery.	

Counties	King, Pierce, Snohomish, Thurston, and Whatcom	
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**
Vision Services		
Medicare-covered vision exam	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings 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 $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. You pay a $50 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.
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 $35 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.	You pay a $35 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.
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.
Physical Therapy	You pay a $20 copay per visit.	You pay a $35 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.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom	
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**
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.
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.
Chiropractic Services	Medicare-covered copay: $20. Routine Chiropractic Services: 6 visits/ $20 copay.	Medicare-covered copay: $20. Routine Chiropractic Services: 6 visits/ $20 copay.
Acupuncture	Medicare-covered copay: $40. Routine Acupuncture: 6 visits/ $20 copay.	Medicare-covered copay: $45. Routine Acupuncture: 6 visits/ $20 copay.
Routine Naturopathic Services	Not covered.	Not covered.

Counties: King, Pierce, Snohomish, Thurston, and Whatcom

Premera Blue Cross Medicare Advantage Peak + Rx (HMO)

PRESCRIPTION DRUG BENEFITS (PART D)

Deductible Phase 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. During this stage, your out-of-pocket costs for Select Insulins will be $35.

Premera Blue Cross Medicare Advantage Sound + Rx (HMO)

PRESCRIPTION DRUG BENEFITS (PART D)

Deductible Phase Because there is no deductible for the plan, this payment stage does not apply to you.

Initial Coverage Phase - You begin in this stage when you fill your first prescription of the year. You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,430. During this stage, your out-of-pocket costs for Select Insulins will be $35.

Peak + Rx (HMO)

	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 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. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.	You pay a $126 copay. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.
Tier 4: Non-Preferred Drugs	You pay $100.	You pay $100.	You pay $300.	You pay $100.
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.

Sound + Rx (HMO)

	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 $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 3: Preferred Brand	You pay a $42 copay. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.	You pay a $126 copay. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.
Tier 4: Non-Preferred Drugs	You pay $100.	You pay $100.	You pay $300.	You pay $100.
Tier 5: Specialty	You pay 33% of the total cost.	You pay 33% of the total cost.	Not offered.	You pay 33% 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.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom	
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**
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 $7,050, which is the end of the Coverage Gap. During this stage, your out-of-pocket costs for Select Insulins will be $35. Not everyone will reach the Coverage Gap.	
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay whichever of these is larger: • 5% of the cost of the drug, or • $3.95 copay for a generic drug, or a drug that is treated like a generic and $9.85 copay for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay whichever of these is larger: • 5% of the cost of the drug, or • $3.95 copay for a generic drug, or a drug that is treated like a generic and $9.85 copay for all other drugs.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		King, Pierce, Snohomish, and Thurston
Premium and Benefits	**Premera Blue Cross Medicare Advantage Alpine (HMO)**	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**
Monthly Plan Premium	You pay $24 per month. You must continue to pay your Medicare Part B premium.	You pay $110 per month. You must continue to pay your Medicare Part B premium.	You pay $170 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 $350 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 $350 copay per day for days 1–4. You pay a $0 copay per day for days 5 and beyond.
Outpatient Hospital Coverage	$350	$290	$250
Outpatient Hospital Observation Coverage	$90	$290	$250
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, Snohomish, Thurston, and Whatcom		King, Pierce, Snohomish, and Thurston
Premium and Benefits	**Premera Blue Cross Medicare Advantage Alpine (HMO)**	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**
Doctor Visits			
Primary care providers	You pay a $0 copay per office visit. You pay a $0 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 $45 copay per office visit (referral required). You pay a $40 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. Includes worldwide coverage.	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 $40 copay per visit. Includes worldwide coverage with a $50 copay.	You pay a $45 copay per visit. Includes worldwide coverage with a $50 copay.	You pay a $45 copay per visit. Includes worldwide coverage with a $50 copay.
Diagnostic Services/Labs/ Imaging			
Diagnostic tests and procedures	You pay $25 of the total cost.	You pay 20% of the total cost.	You pay 20% of the total cost.
Lab services	You pay a $5 copay per order.	You pay a $7 copay per order.	You pay a $0 copay per order.
Outpatient x-rays	You pay a $10 copay per order.	You pay a $20 copay per order.	You pay a $0 copay per order.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		King, Pierce, Snohomish, and Thurston
Premium and Benefits	**Premera Blue Cross Medicare Advantage Alpine (HMO)**	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**
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.
Diagnostic radiology services	$170	20%	20%
Hearing Services			
Medicare-covered hearing exam	You pay a $50 copay per visit.	You pay a $35 copay per visit.	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, Snohomish, Thurston, and Whatcom		King, Pierce, Snohomish, and Thurston
Premium and Benefits	**Premera Blue Cross Medicare Advantage Alpine (HMO)**	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**
Dental Services			
Medicare-covered dental services	$50	$35	$40
Annual maximum	$1,500	$1,300	$1,300
Dental services	You pay a $0 copay for routine preventive and comprehensive dental services.		
Preventive Services	• Prophylaxis (cleaning) - Two per calendar year OR Periodontal maintenance - Three per calendar year • Fluoride - Two per calendar year • Periodic oral exam - Up to two periodic oral evaluations per calendar year • Limited oral evaluation (problem focused) - One evaluation per 12 months • Comprehensive oral exam - One comprehensive exam per 36 months • Detailed and extensive oral evaluation - problem focused, by report - One per lifetime • Re-evaluation - limited, problem focused (established patient) - One per lifetime • Comprehensive periodontal exam - One per calendar year • Bitewing x-rays - One set per calendar year • Full-mouth complete set - One procedure every 60 months • Panoramic film x-ray for evaluation of the teeth and mouth - One procedure every 60 months		
Annual Comprehensive Deductible (in-network and out-of-network)	You Pay a one-time annual Comprehensive Services deductible of $25. Deductible is waived for preventive and Medicare-covered dental services.	You Pay a one-time annual Comprehensive Services deductible of $75. Deductible is waived for preventive and Medicare-covered dental services.	You Pay a one-time annual Comprehensive Services deductible of $75. Deductible is waived for preventive and Medicare-covered dental services.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		King, Pierce, Snohomish, and Thurston
Premium and Benefits	**Premera Blue Cross Medicare Advantage Alpine (HMO)**	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**
Comprehensive services	• Periodontal scaling and root planning - One every two years, per quadrant • Scaling in presence of generalized moderate or severe gingival inflammation, full mouth - Once per two years • Occlusal adjustment performed with covered surgery – no limit • Gingivectomy or gingivoplasty - One surgical procedure per lifetime • Osseous surgery including flap entry and closure - One per lifetime • Pedicle or free soft tissue graft - One per set per lifetime • Full mouth debridement - One per lifetime • Intraoral x-rays: Periapical x-rays or Occlusal x-rays - One procedure code per calendar year • Restorations (fillings): amalgam (Silver) and/or Composite - One per tooth per 24 months • Recementing a crown that has fallen off - One per 12 months • Recementing bridges, inlays, onlays and crowns - After 12 months of insertion and per 12 months per tooth thereafter • Pins when preparing a tooth for a crown - Bundle with crown code and pins (when required) • Buildup of filling around a post to prepare the tooth for a crown - One combo per tooth every 5 years • Crowns - One per tooth every 5 years • Oral surgery, including postoperative care for coronectomy, intentional partial tooth removal - One per tooth per lifetime • Root canal – One initial root canal procedure and one retreatment procedure per tooth per lifetime • Pulpotomy – No Limit • Apicoectomy – No Limit • Retrograde fillings – Per root per lifetime • Medicine placed under fillings to promote pulp healing - Unlimited per plan year to plan annual maximum • Complete denture – maxillary (upper) or mandibular (lower) - One upper complete and/or one lower complete denture every seven years, including routine post-delivery care • Partial Dentures: Resin or metal, maxillary (upper) or mandibular (lower) or maxillary (upper) or mandibular (lower) - One upper and/or one lower partial denture every seven years		

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		King, Pierce, Snohomish, and Thurston
Premium and Benefits	**Premera Blue Cross Medicare Advantage Alpine (HMO)**	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**
Comprehensive services	• Complete denture and partial denture adjustment - Two per denture per year • Complete or Partial Denture Reline or Rebase – One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth). • Recementation - One procedure per calendar year • Repair of dentures or fixed bridgework - One per denture/bridgework per 24 months • Teledentistry - Two per calendar year • Pain Management - Unlimited per plan year to plan annual maximum. Only if no services other than exam and x-rays were performed on the same date of service. • Deep sedation/general anesthesia - Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery. • Local anesthesia - Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery • Intravenous moderate (conscious) sedation/analgesia - Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery.		

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		King, Pierce, Snohomish, and Thurston
Premium and Benefits	**Premera Blue Cross Medicare Advantage Alpine (HMO)**	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**
Vision Services			
Medicare-covered vision exam	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings 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 $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. You pay a $35 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. 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 $300 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.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		King, Pierce, Snohomish, and Thurston
Premium and Benefits	**Premera Blue Cross Medicare Advantage Alpine (HMO)**	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**
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.
Outpatient mental health care	You pay a $35 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.	You pay a $40 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.	You pay a $40 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.
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.
Physical Therapy	You pay a $35 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.
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.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		King, Pierce, Snohomish, and Thurston
Premium and Benefits	**Premera Blue Cross Medicare Advantage Alpine (HMO)**	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**
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.
Chiropractic Services	Medicare-covered copay: $20. Routine Chiropractic Services: 12 visits/ $20 copay.	Medicare-covered copay: $20. Routine Chiropractic Services: Not covered.	Medicare-covered copay: $20. Routine Chiropractic Services: Not covered.
Acupuncture	Medicare-covered copay: $45. Routine Acupuncture: 12 visits/ $20.	Medicare-covered copay: $35. Routine Acupuncture: Not covered.	Medicare-covered copay: $40. Routine Acupuncture: Not covered.
Routine Naturopathic Services	25 visits/ $30 copay.	Not covered.	Not covered.

King, Pierce, Snohomish, Thurston, and Whatcom				King, Pierce, Snohomish, and Thurston		
Premera Blue Cross Medicare Advantage Alpine (HMO)	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**			**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**		
PRESCRIPTION DRUG BENEFITS (PART D)	PRESCRIPTION DRUG BENEFITS (PART D)			PRESCRIPTION DRUG BENEFITS (PART D)		
Not applicable.	**Deductible Phase**	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. During this stage, your out-of-pocket costs for Select Insulins will be $35.		**Deductible Phase**	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 $180 for your Tier 3, 4, and 5 drugs. During this stage, your out-of-pocket costs for Select Insulins will be $35.	
	Initial Coverage Phase - You begin in this stage when you fill your first prescription of the year. You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,430. During this stage, your out-of-pocket costs for Select Insulins will be $35.					
		Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost Sharing (in network)(up to 30-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)
	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. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.	**Tier 3: Preferred Brand**	You pay a $42 copay. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.
	Tier 4: Non-Preferred Drugs	You pay $100 of the total cost.	You pay $100 of the total cost.	**Tier 4: Non-Preferred Drugs**	You pay $100 of the total cost.	You pay $100 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 30% of the total cost.	You pay 30% of the total cost.

King, Pierce, Snohomish, Thurston, and Whatcom				King, Pierce, Snohomish, and Thurston		
Premera Blue Cross Medicare Advantage Alpine (HMO)	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**			**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**		
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. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.	**Tier 3: Preferred Brand**	You pay a $126 copay. $35 copay for Select Insulins.	You pay a $47 copay. $35 copay for Select Insulins.
	Tier 4: Non-Preferred Drugs	You pay $300 of the total cost.	You pay $100 of the total cost.	**Tier 4: Non-Preferred Drugs**	You pay $300 of the total cost.	You pay $100 of the total cost.
	Tier 5: Specialty	Not offered.	You pay 30% of the total cost.	**Tier 5: Specialty**	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.		

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		King, Pierce, Snohomish, and Thurston
Premium and Benefits	**Premera Blue Cross Medicare Advantage Alpine (HMO)**	**Premera Blue Cross Medicare Advantage Charter + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Classic Plus (HMO)**
Coverage Gap	not applicable	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 $7,050, which is the end of the Coverage Gap. During this stage, your out-of-pocket costs for Select Insulins will be $35. Not everyone will reach the Coverage Gap.	
Catastrophic Coverage	not applicable	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay whichever of these is larger: • 5% of the cost of the drug, or • $3.95 copay for a generic drug, or a drug that is treated like a generic and $9.85 copay for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay whichever of these is larger: • 5% of the cost of the drug, or • $3.95 copay for a generic drug, or a drug that is treated like a generic and $9.85 copay for all other drugs.

PREMERA
BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, Premera Blue Cross Medicare Advantage Plans - Complaints & Appeals, PO Box 262527, Plano, TX 75026, Phone: 888-850-8526, Fax: 800-889-1076, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-850-8526 (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 888-850-8526（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 888-850-8526 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-850-8526 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-850-8526 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-850-8526 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 888-850-8526 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 888-850-8526 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。888-850-8526（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 888-850-8526 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 888-850-8526 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-850-8526 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 888-850-8526 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-850-8526 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 888-850-8526 (TTY: 711).

Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera Blue Cross depends on renewal.