2023 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 Online Application Summary of Benefits 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 15th to December 7th. This will give you a January 1st effective date for your new plan.
Annual Enrollment Period (AEP)
Applications must be signed and dated on, or between October 15th and December 7th. *If they are signed prior to October 15th they will be returned to you with a new application.* If they are received after December 7th, 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 2023 (Pending)

2023 Summary of Benefits

Y0134_PBC3429_M
037040 (10-05-2022)

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

2023 Summary of Benefits

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

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) and Premera Blue Cross Medicare Advantage Alpine (HMO) from January 1, 2023 to December 31, 2023.

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) and **Premera Blue Cross Medicare Advantage Alpine (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)** or **Premera Blue Cross Medicare Advantage Alpine (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 – September 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 $54 per month. You must continue to pay your Medicare Part B premium.	You pay $23 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.

^ PCP referral may be required.

* Prior authorization is required.

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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)**
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. You pay a $35 copay per telehealth visit.	You pay a $30 copay per office visit. You pay a $25 copay per telehealth visit.	You pay a $30 copay per office visit. You pay a $25 copay per telehealth visit.
Preventive Care (such as flu vaccine, diabetic screenings)	You pay $0. Other preventive services are available. There are some covered services that have a cost.	You pay $0. Other preventive services are available. There are some covered services that have a cost.	You pay $0. 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 $35 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 a $60 copay per service location per day.	You pay a $30 copay per service location per day.	You pay a $30 copay per service location per day.
Lab services	You pay a $10 copay per service location per day.	You pay a $0 copay per service location per day.	You pay a $0 copay per service location per day.
Outpatient X-rays	You pay a $15 copay per service location per day.	You pay a $10 copay per service location per day.	You pay a $10 copay per service location per day.
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.	You pay 20% of the cost. If your doctor provides additional services, a separate cost sharing amount may apply.
Diagnostic radiology services*	$180 copay per service location per day.	$160 copay per service location per day.	$160 copay per service location per day.
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.		

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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	• Periodontal scaling and root planing – 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 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 five years • Crowns – One per tooth every five 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 – One 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 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.		

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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.	You pay a $0 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.	You pay a $0 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 $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 $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.	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* No prior authorization required for emergencies	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 cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the 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, if eligible.	**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 $4,660. During this stage, your out-of-pocket costs for Select Insulins will be $35, if eligible.					
	Standard Retail Cost sharing (in-network)(up to 30-day supply)		Standard Retail Cost sharing (in-network)(up to 30-day supply)		Standard Retail Cost Sharing (in-network)(up to 30-day supply)
Tier 1: Preferred Generic	You pay a $4 copay.	**Tier 1: Preferred Generic**	You pay a $2 copay.	**Tier 1: Preferred Generic**	You pay a $2 copay.
Tier 2: Generic	You pay a $12 copay.	**Tier 2: Generic**	You pay a $10 copay.	**Tier 2: Generic**	You pay a $10 copay.
Tier 3: Preferred Brand	You pay a $42 copay $35 copay for Select Insulins, if eligible.	**Tier 3: Preferred Brand**	You pay a $40 copay. $35 copay for Select Insulins, if eligible.	**Tier 3: Preferred Brand**	You pay a $40 copay. $35 copay for Select Insulins, if eligible.
Tier 4: Non-Preferred Drugs	You pay a $100 copay.	**Tier 4: Non-Preferred Drugs**	You pay a $100 copay.	**Tier 4: Non-Preferred Drugs**	You pay a $100 copay.
Tier 5: Specialty	You pay 30% of the cost.	**Tier 5: Specialty**	You pay 33% of the cost.	**Tier 5: Specialty**	You pay 33% of the cost.

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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)**		
	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 $4 copay.	**Tier 1: Preferred Generic**	You pay a $0 copay.	You pay a $2 copay.	**Tier 1: Preferred Generic**	You pay a $0 copay.	You pay a $2 copay.
Tier 2: Generic	You pay a $36 copay.	You pay a $12 copay.	**Tier 2: Generic**	You pay a $30 copay.	You pay a $10 copay.	**Tier 2: Generic**	You pay a $30 copay.	You pay a $10 copay.
Tier 3: Preferred Brand	You pay a $126 copay. $105 copay for Select Insulins, if eligible.	You pay a $42 copay. $35 copay for Select Insulins, if eligible.	**Tier 3: Preferred Brand**	You pay a $120 copay. $105 copay for Select Insulins, if eligible.	You pay a $40 copay. $35 copay for Select Insulins, if eligible.	**Tier 3: Preferred Brand**	You pay a $120 copay. $105 copay for Select Insulins, if eligible.	You pay a $40 copay. $35 copay for Select Insulins, if eligible.
Tier 4: Non-Preferred Drugs	You pay a $300 copay.	You pay a $100 copay.	**Tier 4: Non-Preferred Drugs**	You pay a $300 copay.	You pay a $100 copay.	**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 cost.	**Tier 5: Specialty**	Not offered.	You pay 33% of the cost.	**Tier 5: Specialty**	Not offered.	You pay 33% of the cost.
Cost sharing may change when you enter another of the four phases of the Part D benefit.			Cost sharing may change when you enter another of the four phases of the Part D benefit.			Cost sharing may change 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 $7,400, which is the end of the Coverage Gap. During this stage, your out-of-pocket costs for Select Insulins will be $35, if eligible. 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 $7,400, you pay whichever of these is larger: • 5% of the cost of the drug, or • $4.15 copay for a generic drug, or a drug that is treated like a generic and $10.35 copay for all other drugs.		

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

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)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Monthly Plan Premium	You pay $0 per month. You must continue to pay your Medicare Part B premium.	You pay $34 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.	Not applicable.
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.	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 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	$350	$350
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 $275 copay for each Medicare-covered ambulatory surgical center visit.	You pay a $250 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.	You pay a $0 copay per office visit. You pay a $0 copay per telehealth visit.

^ PCP referral may be required.

* Prior authorization is required.

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)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Specialists^	You pay a $40 copay per office visit. You pay a $35 copay per telehealth visit.	You pay a $45 copay per office visit. You pay a $40 copay per telehealth visit.	You pay a $45 copay per office visit. You pay a $40 copay per telehealth visit.
Preventive Care (such as flu vaccine, diabetic screenings)	You pay $0. Other preventive services are available. There are some covered services that have a cost.	You pay $0. Other preventive services are available. There are some covered services that have a cost.	You pay $0. 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 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.	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 $40 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 a $60 copay per service location per day.	You pay a $25 copay per service location per day.	You pay a $25 copay per service location per day.
Lab services	You pay a $10 copay per service location per day.	You pay a $5 copay per service location per day.	You pay a $5 copay per service location per day.
Outpatient X-rays	You pay a $15 copay per service location per day.	You pay a $10 copay per service location per day.	You pay a $10 copay per service location per day.
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.	You pay 20% of the cost. If your doctor provides additional services, a separate cost sharing amount may apply.
Diagnostic radiology services*	$180 copay per service location per day.	$170 copay per service location per day.	$170 copay per service location per day.

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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)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Hearing Services			
Medicare-covered hearing exam	You pay a $35 copay per visit.	You pay a $45 copay per visit.	You pay a $50 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.	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.
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.		
Dental Services			
Medicare-covered dental services	You pay a $50 copay per visit.		
Annual maximum	$1,000	$1,300	$1,500
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		

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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)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
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.		You pay a one-time annual Comprehensive Services deductible of $25. Deductible is waived for preventive and Medicare-covered dental services.
Comprehensive services	• Periodontal scaling and root planing – 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 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 five years • Crowns – One per tooth every five 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 – One per root per lifetime		

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* Prior authorization is required.

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)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Comprehensive services	• 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 • 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.		

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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)**	**Premera Blue Cross Medicare Advantage Alpine (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.	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.
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.	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 $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 $20 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 $300 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.

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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)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
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.	You pay a $595 copay per day for days 1–2. You pay a $0 copay per day for days 3–90.
Outpatient mental health care	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 $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.	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.	You pay a $35 copay per visit.
Ambulance* No prior authorization required for emergencies	You pay a $280 copay each way for Medicare-covered ambulance transport.	You pay a $285 copay each way for Medicare-covered ambulance transport.	You pay a $255 copay each way for Medicare-covered ambulance transport.
Transportation	Not covered.	Not covered.	Not covered.
Medicare Part B Drugs*	You pay 20% of the cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.

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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)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
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: 6 visits/ $20 copay.	Medicare-covered copay: $20. Routine Chiropractic Services: 12 visits/ $20 copay.
Acupuncture*	Medicare-covered copay: $40. Routine Acupuncture: 6 visits/ $20 copay.	Medicare-covered copay: $45. Routine Acupuncture: 6 visits/ $20 copay.	Medicare-covered copay: $45. Routine Acupuncture: 12 visits/ $20 copay.
Routine Naturopathic Services	Not covered.	Not covered.	25 visits/ $30 copay.

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Counties: King, Pierce, Snohomish, Thurston, and Whatcom				
Premera Blue Cross Medicare Advantage Peak + Rx (HMO)		**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**		**Premera Blue Cross Medicare Advantage Alpine (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, if eligible.	**Deductible Phase**	Because there is no deductible for the plan, this payment stage does not apply to you.	**Not applicable.**
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 $4,660. During this stage, your out-of-pocket costs for Select Insulins will be $35, if eligible.				
	Standard Retail Cost Sharing (in-network)(up to 30-day supply)		Standard Retail Cost Sharing (in-network)(up to 30-day supply)	
Tier 1: Preferred Generic	You pay a $3 copay.	**Tier 1: Preferred Generic**	You pay a $2 copay.	
Tier 2: Generic	You pay a $12 copay.	**Tier 2: Generic**	You pay a $12 copay.	
Tier 3: Preferred Brand	You pay a $42 copay. $35 copay for Select Insulins, if eligible.	**Tier 3: Preferred Brand**	You pay a $42 copay. $35 copay for Select Insulins, if eligible.	
Tier 4: Non-Preferred Drugs	You pay $100.	**Tier 4: Non-Preferred Drugs**	You pay $100.	
Tier 5: Specialty	You pay 30% of the cost.	**Tier 5: Specialty**	You pay 33% of the cost.	

Counties: King, Pierce, Snohomish, Thurston, and Whatcom						
Premera Blue Cross Medicare Advantage Peak + Rx (HMO)			**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**			**Premera Blue Cross Medicare Advantage Alpine (HMO)**
	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)	**Not applicable.**
Tier 1: Preferred Generic	You pay a $0 copay.	You pay a $3 copay.	**Tier 1: Preferred Generic**	You pay a $0 copay.	You pay a $2 copay.	
Tier 2: Generic	You pay a $36 copay.	You pay a $12 copay.	**Tier 2: Generic**	You pay a $36 copay.	You pay a $12 copay.	
Tier 3: Preferred Brand	You pay a $126 copay. $105 copay for Select Insulins, if eligible.	You pay a $42 copay. $35 copay for Select Insulins, if eligible.	**Tier 3: Preferred Brand**	You pay a $126 copay. $105 copay for Select Insulins, if eligible.	You pay a $42 copay. $35 copay for Select Insulins, if eligible.	
Tier 4: Non-Preferred Drugs	You pay $300.	You pay $100.	**Tier 4: Non-Preferred Drugs**	You pay $300.	You pay $100.	
Tier 5: Specialty	Not offered.	You pay 30% of the cost.	**Tier 5: Specialty**	Not offered.	You pay 33% of the cost.	
Cost sharing may change when you enter another of the four phases of the Part D benefit.			Cost sharing may change 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)**	**Premera Blue Cross Medicare Advantage Alpine (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 $7,400, which is the end of the Coverage Gap. During this stage, your out-of-pocket costs for Select Insulins will be $35, if eligible. Not everyone will reach the Coverage Gap.		**Not applicable.**
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay whichever of these is larger: • 5% of the cost of the drug, or • $4.15 copay for a generic drug, or a drug that is treated like a generic and $10.35 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 $7,400, you pay whichever of these is larger: • 5% of the cost of the drug, or • $4.15 copay for a generic drug, or a drug that is treated like a generic and $10.35 copay for all other drugs.	**Not applicable.**

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Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.