Premera Blue Cross Medicare Advantage Plans

- Premera Blue Cross Medicare Advantage (HMO)
- Premera Blue Cross Medicare Advantage Plus (HMO)
- Premera Blue Cross Medicare Advantage (HMO-POS)
- Premera Blue Cross Medicare Advantage Plus (HMO-POS)
INTRODUCTION

This document provides you with an overview of information regarding your Premera Blue Cross Medicare Advantage Plan. It is NOT a replacement to your Summary of Benefits or Evidence of Coverage (EOC); however some of the information included in this document is not found in your other plan materials. This document is designed to be used as a reference guide for your convenience. For additional information regarding your benefits and plan rules, please see your EOC or Summary of Benefits. Thank you for being a member of Premera Blue Cross Medicare Advantage Plans.

The first section of this document is designed to give you more information about benefits and services that are available to all Premera Blue Cross Medicare Advantage Plan members. The second section of this document gives you additional information about your prescription drug benefits. This means that the information in Section 1 and Section 2 is applicable to you regardless of which Premera Blue Cross Medicare Advantage Plan you have.

Sections 3 and 4 of this document are plan specific. This means that you need to make sure you are referring to the section that corresponds to your Premera Blue Cross Medicare Advantage Plan. If you are a member of Premera Blue Cross Medicare Advantage (HMO) or Premera Blue Cross Medicare Advantage Plus (HMO), please refer to Section 3. If you are a member of Premera Blue Cross Medicare Advantage (HMO-POS) or Premera Blue Cross Medicare Advantage Plus (HMO-POS), please refer to Section 4. Copays and coinsurance may vary depending on which Premera Blue Cross Medicare Advantage Plan you have.

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

You must continue to pay your Medicare Part B premium.

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Benefits, formulary, pharmacy network, provider network, premium, and/or co-payments/co-insurance may change on January 1 of each year. Limitations, copayments and restrictions may apply.

Premera Blue Cross Medicare Advantage Customer Service is available at 1-888-850-8526. If you are hearing impaired and use a Teletype (TTY) Device, please call 711. Customer Service assistance is available to answer questions, seven days a week, between 8 a.m. and 8 p.m. (Pacific time).
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Section 1: Premera Blue Cross Medicare Advantage Plans

PLAN SERVICE AREA

The maps below indicate the counties where Premera Blue Cross Medicare Advantage Plans are offered.

Service Area:
- Premera Blue Cross Medicare Advantage (HMO)
- Premera Blue Cross Medicare Advantage Plus (HMO)
- Premera Blue Cross Medicare Advantage (HMO-POS)
- Premera Blue Cross Medicare Advantage Plus (HMO-POS)
ELIGIBILITY REQUIREMENTS

You can join a Premera Blue Cross Medicare Advantage Plan if you are entitled to Medicare Part A, are enrolled in Medicare Part B, and live in our service area and do not have End Stage Renal Disease (ESRD). Individuals with ESRD are generally not eligible to enroll in Premera Blue Cross Medicare Advantage Plans. If you have ESRD, you may qualify for an exception if you developed ESRD while you were a member of another plan we offer and have maintained continuous enrollment with our organization.

HOSPICE

If you elect hospice, you will still be a member of Premera Blue Cross Medicare Advantage Plans. Your hospice provider will bill Original Medicare (using your red, white, and blue card) for all hospice related services.

For non-hospice related services you receive while on hospice, you have two choices in how you get care.

1. You can follow your Premera Blue Cross Medicare Advantage Plan rules for needed services and pay only your member cost-sharing amount for those services. This means if your plan requires a referral or prior authorization for the non-hospice related service you need, your provider must get a referral or authorization for this option. In-network providers would still bill Original Medicare for these services first then bill us. We would pay the provider the difference between the amount Original Medicare paid and your plan cost sharing.

   OR:

2. You can follow Original Medicare rules and pay the Original Medicare cost sharing amount. If you select this option, the provider would bill Original Medicare (your red, white, and blue card) only. Premera Blue Cross Medicare Advantage Plans is not billed for these services and plan rules do not apply.

If you decide to revoke your hospice election, the above arrangement will end the first of the month following the month in which hospice was revoked. For example if hospice is revoked on June 6, you would need to resume following Premera Blue Cross Medicare Advantage Plan rules for all services beginning July 1.

Please call Customer Service if you have additional questions or see your Evidence of Coverage for more information (phone numbers are printed on the back cover of this booklet).
AMBULANCE SERVICES
For Premera Blue Cross Medicare Advantage Plan members, a copay applies each way for Medicare-covered Ambulance services. This includes ambulance transport between different facilities.

URGENTLY NEEDED CARE
As a member of Premera Blue Cross Medicare Advantage Plans, urgent care visits are covered worldwide. Your plan cost sharing would apply. If you receive urgent care services outside of the U.S., you will need to pay for these services up front and submit proof of payment to us for reimbursement. Please see the Frequently Asked Questions section or your Evidence of Coverage for additional information.

END-STAGE RENAL DISEASE
Out-of-area renal dialysis services do not require prior authorization for any member of Premera Blue Cross Medicare Advantage Plans. Your plan cost sharing would apply.

PREVENTIVE SERVICES
Premera Blue Cross Medicare Advantage Plans offer Medicare covered preventive services at no cost to you. These services include:

- Abdominal Aortic Aneurysm screening
- Bone Mass Measurement
- Cardiovascular Screening
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)
- Colorectal Cancer Screening
- Diabetes Screening
- Influenza Vaccine
- Hepatitis B Vaccine
- HIV Screening
- Breast Cancer Screening (Mammogram)
- Medical Nutrition Therapy Services
- Personalized Prevention Plan Services (Annual Wellness Visits)
- Pneumococcal Vaccine
- Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only)
- Smoking and Tobacco Use Cessation (Counseling to stop smoking and tobacco use)
- Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)
- Obesity Screening and Counseling
- Depression Screening
- Cardiovascular Disease Behavioral Counseling
- Alcohol Misuse Screening and Counseling
- Sexually Transmitted Infections Screening and Counseling
Medicare covered preventive services do not require a prior authorization. However, additional services received at the same time may require a referral. **Preventive services are covered at no cost to you only if obtained using an in-network provider.** A separate office visit cost share may apply. Please contact Customer Service for more information regarding limitations to preventive services (phone numbers are printed on the back of this booklet).

**FITNESS CENTER MEMBERSHIP**

All members are eligible for a free, basic membership at participating fitness centers. If you live more than 15 miles from a participating fitness center, you are eligible for an at home fitness kit at no charge. Please call Customer Service or see your Evidence of Coverage for more information (phone numbers are printed on the back of this booklet).

**DRUGS COVERED UNDER MEDICARE PART B**

When you have a Premera Blue Cross Medicare Advantage Plan, some outpatient drugs may be covered under your medical benefits (Part B), while most outpatient drugs will be covered by your Part D prescription drug benefit. Depending on your plan, your cost sharing may vary. Additionally, some Part B drugs may require prior authorization. Please contact Customer Service or see your Evidence of Coverage for more information (phone numbers are printed on the back of this booklet). The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs:

- **Injectable Drugs:** Most injectable drugs administered incident to a physician’s service, (medications administered in your provider’s office) for example, chemotherapy regimens.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Erythropoietin (Epogen®️, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa):**
  By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Inhalation and Infusion Drugs:** Provided through durable medical equipment (DME).
- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.

**APPEALS AND GRIEVANCES PROCESS**

Additional details about the Premera Blue Cross Medicare Advantage Plans’ Appeals and Grievances process is outlined in your Evidence of Coverage (EOC).
Appeals
If we make a coverage decision and you are not satisfied with our decision, you or your representative can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. We must receive your appeal request within 60 calendar days from the date on the written notice and/or Explanation of Benefits. This is known as a Level One Appeal.

When you make a Level One Appeal, we review the coverage decision that was made to check if the benefits were applied appropriately. When we have completed the review we give you our decision in writing.

If we say “no” to all or part of your Level One Appeal, you can go on to a Level Two Appeal. The Level Two Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level Two Appeal, you may be able to continue through several more levels of appeal. These additional levels are explained in your Evidence of Coverage.

You or your representative may file an appeal by faxing your written appeal request to 1-800-396-4778 or you may send it to the following address:

Premera Blue Cross Medicare Advantage Plans
Attn: Appeals and Grievances Department
PO Box 4158
Portland OR 97208-4158

Grievances
If you have a complaint about quality of care, waiting times, or the Customer Service you receive, you or your representative may call 1-888-850-8526 (TTY line at 711). We will try to resolve your complaint over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints.

To file a formal grievance, you may call or submit your grievance in writing. If you file a written grievance, request a written response, and/or your complaint is related to quality of care and you have given us consent to investigate, we will respond to you in writing.

We must receive your complaint within 60 calendar days from the date in which the issue occurred.

You or your representative may file a grievance by calling 1-888-850-8526 (TTY line at 711). You may fax your grievance request to 1-800-396-4778 or you may send it in writing to the following address:

Premera Blue Cross Medicare Advantage Plans
Attn: Appeals and Grievances Department
PO Box 4158
Portland OR 97208-4158
VALUE ADDED SERVICES

Premera Blue Cross Medicare Advantage Plans offer access to extra values and discounts through our value added programs. Please see below for a list of options available to you as a member of Premera Blue Cross Medicare Advantage Plans.

Premera 24/7 Nurse Line
Premera’s 24/7 Nurse Line is a free advice line for Premera Blue Cross Medicare Advantage Plans’ members only. As a member, you can call with your health-related questions and speak to a registered nurse, day or night, seven days a week. Premera’s 24/7 Nurse Line can be reached at 1-855-339-8123.

Online Health Resources
Premera Blue Cross Medicare Advantage Plans provide health information and tools to help you stay healthy. Visit www.premera.com to find out more.

Member Discounts
Premera Medicare Advantage Extras! program allows members to save money with special discounts with no extra fees. Members can make purchases in person, over the phone, or online with your health plan ID card. Visit www.premera.com to find out more information on a variety of discounts for services including but not limited to:

- Fitness and Weight Management
- Eye Care Services and Hardware
- Alternative Care Services
- Hearing Aids and Screenings

Contact Customer Service for more information (phone numbers are printed on the back of this booklet).

HOW TO READ YOUR EXPLANATION OF BENEFITS (EOB)

Each month, Premera Blue Cross Medicare Advantage Plans will send you a statement in the mail called an Explanation of Benefits (EOB). It is not a bill. Your EOB is informational only.

It has information we hope you will find useful. The EOB includes the name of the provider, detailed information on the services that were billed, what we paid, your cost-sharing amount, as well as a tally of your out-of-pocket costs. It also includes your appeal rights should you disagree with how your claim was processed.

You can use your EOBs to keep track of your medical expenses as well as match them with any provider bills you might receive.

You will receive a separate EOB for any Part D medications you received the previous month.

If you have any questions about your Explanation of Benefits, please call Customer Service (phone numbers are printed on the back of this booklet).
OTHER IMPORTANT INFORMATION

Flu Shot
Please note that you may receive a flu shot each year at no cost. You may go to any provider for a flu shot. It is important to know that if you see a provider, such as your Primary Care Provider (PCP), you may have a separate cost share for any additional services you might receive with the flu vaccine.

Non-covered Items/Services
If you receive plan excluded or non-covered items or services, you will be financially responsible for these items and services.

FREQUENTLY ASKED QUESTIONS

Q. Will I have coverage when I leave the country?
A. Yes. The coverage provided through your Premera Blue Cross Medicare Advantage Plan is limited to emergency and urgent care services outside of the U.S. and its territories. The term “outside the U.S.” means anywhere other than the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Cruise ships are considered outside of the U.S.

If you receive emergency or urgent care service outside of the U.S., you should expect to pay for these services up front. Please make sure you receive and keep proof of your payment and an itemized statement of the services. You may also be asked to provide us copies of medical records. Submit copies of these items to us. We will reimburse you for the services less any applicable cost-sharing. Please note we will not reimburse conversion fees.

In most other situations, Premera Blue Cross Medicare Advantage Plans will not pay for health care or supplies you receive outside of the U.S. This would include, but is not limited to, evacuation services, routine care, or follow up services. You can choose to buy a travel insurance policy to get additional coverage. An insurance agent or travel agent can give you more information about buying travel insurance. Travel insurance doesn’t necessarily include health insurance, so it’s important to read the conditions or restrictions carefully.

Q. Can I fill my prescriptions out of the country?
A. No, prescription drugs purchased outside of the U.S. are not covered under your Medicare Part D Benefit, even when supplied after an emergency or urgent care visit. If you travel outside of the country, please make sure you have an adequate supply that will last through the duration of your trip. Premera Blue Cross Medicare Advantage Plans will not reimburse you for prescriptions filled outside of the United States or its territories.
Q. What happens if I move or my address changes?
A. Please notify us of any change in address whether temporary or permanent. When we are notified of your permanent move outside of our service area, you will be disenrolled the 1st of the following month. For example, if you notify us on March 22, your coverage will end April 1. For permanent address changes, please notify the Social Security Administration as well.

To remain an eligible member, you must reside in our service area for at least 6 months out of the year. You can have an out-of-area mailing address; however your permanent residential address must be in our service area.

If you travel, your permanent address must be in our service area and you cannot be away for longer than 6 months out of the year. To help us keep our records current, please respond to any address verification requests you might receive.

Please see your Evidence of Coverage for more information.

Q. Can my spouse/family member/friend call on my behalf if I am unable to?
A. Yes, however we would need your permission to give specific information to any individual other than yourself. The best way to ensure they can act on your behalf is to fill out a consent form or provide us a copy of an existing Power of Attorney or other legal guardianship documentation. Customer Service can mail out a consent form to you at any time. Our consent form is valid for 24 months unless you choose an earlier date.

Q. How do I pay my premium and when is it due?
A. There are 3 ways you can make your monthly premium payment:

- Receive a monthly invoice and return the payment coupon with a check or money order.
  - If you select this option, you will get a statement around the 15th of each month for the next month’s premium. Payments are due the first of each month. Payments received after the 15th of each month are considered late. If your payment is late you might receive a notice letting you know your account needs to be current by the end of our 90 day grace period to keep your coverage.

- Electronic Funds Transfer (EFT)–Your premium is automatically withdrawn from your checking account between the 15th and 20th of each month.
  - To select this option, please call Customer Service and request an EFT form.
  - Please be aware it may take 2-3 months for EFT to begin. This gives us time to verify we entered the information correctly before we pull any premium payments.
Social Security (SSA) / Railroad Retirement Board (RRB) – You can elect to have your premium automatically withheld from your Social Security or Railroad Retirement benefit check each month.

- Please note this option can take up to 3 months to set up. This delay allows the Centers for Medicare and Medicaid Services (CMS) time to communicate with the SSA of RRB and set up this method of payment.
- You are responsible for premiums that come due before the withhold request is accepted. You will receive monthly premium invoices until the premium withhold is effective. Once the premium withhold is effective, you will stop receiving invoices. Please be sure to keep your account current until the premium withhold begins. Premium payments are due on the first of the month however they are not considered late until the 15th. Failure to pay plan premiums may cause you to be disenrolled from the plan.

Q. Is there anything else I should know if I choose to have my premium deducted from my Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check?

A. If you elect to have your monthly premium withheld from your SSA or RRB benefit check, please be aware that there may be a delay in the start date. To help make sure that the request is successful, the effective date will be 2-3 months after you make the request. This gives the Centers for Medicare and Medicaid Services (CMS) time to communicate with the SSA or RRB and set up this method of payment.

Please be aware that SSA or RRB withholds the current month’s premium from the previous month’s benefit check. For example, if SSA premium withhold is set to begin June 1, you will see June’s premium payment withheld from your May Social Security check. You would still need to pay us directly for May’s premium. You will continue to receive monthly premium invoices until the premium withhold is effective. Please be sure to keep your account current until the premium withhold begins.

Q: What if I am late making a premium payment?

A: Premium payments are due the 1st of the month however they are not considered late until the 15th. If your payment is late you will receive a notice letting you know your account needs to be current by the end of our 90 day grace period to keep your coverage. This means your account must be paid in full by the end of grace period in order to keep your coverage with us. For example, if a member’s February premium is late, the letter would be sent in February letting him/her know the payment was late and grace period ends April 30. The member would need to make sure the February, March, and April premiums are all paid in full by April 30 to keep his/her coverage. Please see your Evidence of Coverage for more information.

Q. How do I get a new ID card?

A. Please call Customer Service to request a new ID card (phone numbers are listed on the back of this booklet). You will receive the card in 7-10 business days. To protect your privacy, please be aware that the ID card is sent in a plain white envelope with no distinguishing marking.
Q. Do I still have to pay my Part B Premium while I am enrolled in my Premera Blue Cross Medicare Advantage Plan?
A. Yes. You must continue paying your Medicare Part B premium in order to remain a member of the plan.

Q. What is the difference between a referral and prior authorization?
A. A referral is a request from your Primary Care Provider (PCP) to go to another type of provider. A prior authorization is a request for coverage of specific services from your Premera Blue Cross Medicare Advantage Plan.

Q. How can I find out what I will pay for specific services?
A. You may refer to your Evidence of Coverage (EOC) for more detailed information about coinsurance, copays, and out of pocket costs. If you do not find the information you need in your EOC you may call Customer Service for more information (phone numbers are printed on the back of this booklet). Please be aware that we are unable to provide specific cost-sharing as we are unable to know the exact services your provider will perform.

Q. Does my plan cover glasses and if so how much do they cost?
A. Your plan covers one pair of eyeglasses or contact lenses after cataract surgery that includes insertion of an intraocular lens and corrective lenses/frames, as well as replacement lenses needed after a cataract removal without a lens implant.

Q. Where can I go to get my post cataract glasses?
A. If you are a member of a Premera Blue Cross Medicare Advantage (HMO) or Premera Blue Cross Medicare Advantage Plus (HMO) you will need to go to an in-network provider to get your post cataract eyewear. If you are a member of a Premera Blue Cross Medicare Advantage (HMO-POS) or Premera Blue Cross Medicare Advantage Plus (HMO-POS) Plan you have the option to go to an out-of-network provider to get your post cataract eyewear, but you may pay more for out-of-network services. For a list of in-network providers in your area, please refer to your Provider and Pharmacy Directory or call Customer Service (phone numbers are printed on the back of this booklet).

Q. Do I have to get my lens and frames from the same post-cataract eyewear provider?
A. No, as long as you follow the Provider network requirements based on Premera Blue Cross Medicare Advantage Plans, you can get your lens and eyewear at separate locations.

Q. Can I buy my Durable Medical Equipment (DME) and Supplies?
A. We look at several factors in deciding whether a durable medical equipment (DME) item must be rented or whether it can be purchased or converted to purchase. These factors include medical criteria, type of equipment, duration of use, and other factors. Please contact Customer Service for more details (phone numbers are printed on the back of this booklet).
Q. What happens if I lose or break my medical equipment?
A. Premera Blue Cross Medicare Advantage Plans will not pay for lost, stolen, or broken medical equipment. If your equipment malfunctions or is defective, we will cover repair and/or replacement as necessary. Please contact Customer Service or your medical equipment supplier for specific details (phone numbers are printed on the back of this booklet).

Q. How long do I have to pay for my Durable Medical Equipment (DME) and Supplies?
A. There are several factors that affect how long you will pay for your durable medical equipment (DME) and supplies. Please contact Customer Service for more details (phone numbers are listed on the back of this booklet).

Q. What is D-IRMAA?
A. D-IRMAA, (Part D Income Related Monthly Adjustment Amount) is an additional Part D monthly premium amount assessed and collected by CMS based on your taxable income. It is only applicable if you are enrolled in a plan that includes Part D, (also known as prescription drug) coverage. We at the plan do not bill for D-IRMAA. CMS does not tell us which members have to pay D-IRMAA. This means we are unable to tell if an overpayment made to us is for D-IRMAA or a premium prepayment. If you have made an overpayment to us, we can send you a refund for that amount. If you have questions regarding D-IRMAA, please contact 1-800-MEDICARE.

Q. What is an observation stay?
A. You might go into the emergency room and end up spending a few days at the hospital without actually being admitted. This is considered ‘observation’. Observation usually happens when you aren’t ready to be discharged, but your condition isn’t serious enough to be ‘admitted’ into the hospital. Observation is a PART B service. Some plans require coinsurance for this.

Q. What are Preventive Labs?
A. Preventive Labs are labs that are ordered by a provider, usually during a routine visit or wellness visit to screen for a condition. Preventive Labs do not check the progression of an existing condition. Please note that if you receive additional services other than just the preventive labs, a copay may apply.

Q. What is Mental Health Partial Hospitalization?
A. Mental Health Partial Hospitalization is intensive outpatient treatment, however the member does not reside or stay overnight at the facility. Our plans do not cover overnight residential facility treatment. Partial Hospitalization services are coordinated through Optum (UBH), our mental health and chemical dependency care partner. For further information please refer to your Evidence of Coverage or call Customer Service (phone numbers are printed on the back of this booklet).

Q. What is the difference between an Annual Wellness Visit and a Routine Preventive Visit?
A. An Annual Wellness Visit is an exam designed to provide a thorough screening for Medicare members. Your doctor will have a list of questions. Some clinics send this list
out to the patient prior to the visit. Your doctor will review the completed form with you during the visit and can order any lab tests he or she feels are appropriate.

A Routine Preventive Visit is a more traditional visit with your primary doctor where he or she would check up on known conditions, and address your concerns but without the form used in the wellness visit. In this exam your doctor can also order any tests he or she feels are appropriate.

Premera Blue Cross Medicare Advantage Plans will cover an Annual Wellness Visit or a Routine Preventive Visit once per year. We will not cover both exams received within the same calendar year.

Q. What happens if my provider does not accept Medicare Assignment?
A. If a provider does not accept Medicare, you may pay more for services you receive. All providers in the Premera Blue Cross Medicare Advantage Plans’ network accept the Medicare allowable or contracted rates with us. Please be aware some services require prior authorization to be covered out of network.

If you see an out-of-network provider that accepts Original Medicare, that provider is required to accept the Medicare allowable amount for services as payment in full and should not balance bill you. This means you are only responsible for paying your plan cost-sharing amount for services. The provider cannot bill you for any difference in the amount they charged and the amount Medicare sets as the allowable.

If you see an out-of-network provider that does not accept Original Medicare, the provider is not required to accept the Medicare allowable amount as payment in full and may balance bill you up to the limiting charge amount set by Original Medicare. This means you may pay more out of pocket.

Services received from a provider that has elected to opt out of Original Medicare are excluded under all Premera Blue Cross Medicare Advantage Plans and will not be reimbursed.

**PRIVACY STATEMENT**

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don’t see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn’t providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. The plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.
The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service (phone numbers are printed on the back of this booklet).

**THIRD PARTY LIABILITY**

This section describes your duties if you receive services for which any third party may be responsible. A “third party” is any person other than you or Premera Blue Cross Medicare Advantage Plans (the “first” and “second” parties), and includes any insurer providing any coverage available to you.

1. Once any third party is found responsible and able to pay for services you have received, Premera Blue Cross Medicare Advantage Plans will not cover those services.

2. Premera Blue Cross Medicare Advantage Plans will need detailed information from you. A questionnaire will be sent to you, which must be completed and returned as soon as possible. If you have any questions, please contact us. A Premera Blue Cross Medicare Advantage Plans employee who specializes in this area can help you.

3. If you make a claim against a third party, you must notify that party of Premera Blue Cross Medicare Advantage Plans’ interest.

4. To the fullest extent permitted by Medicare, Premera Blue Cross Medicare Advantage Plans is entitled to repayment from any money recovered from a third party, whether or not the recovery is described as for something other than medical expenses and whether or not you are “made whole” for your losses. Premera Blue Cross Medicare Advantage Plans is entitled to be repaid from any workers’ compensation recovery whether or not a loss is found compensable under those laws.

5. Premera Blue Cross Medicare Advantage Plans is entitled to be repaid the full value of benefits, calculated using Premera Blue Cross Medicare Advantage Plans’ usual and customary charges, less a pro rata share of the expenses and attorney fees incurred to make the recovery.

6. Before accepting settlement of a third party claim, you must notify Premera Blue Cross Medicare Advantage Plan in writing of the terms offered.

7. If Premera Blue Cross Medicare Advantage Plans is not repaid by the third party, you must repay Premera Blue Cross Medicare Advantage Plans. Premera Blue Cross Medicare Advantage Plans may request refunds from your medical providers, who will then bill you.
8. You must cooperate with Premera Blue Cross Medicare Advantage Plans in obtaining repayment. If you hire an attorney, you must require the attorney to reimburse Premera Blue Cross Medicare Advantage Plans. You must complete a trust agreement, by which you and your attorney confirm your duty to repay. Premera Blue Cross Medicare Advantage Plans may withhold benefits until you deliver the signed agreement, or if you revoke that confirmation. This document is not necessary for Premera Blue Cross Medicare Advantage Plans to have rights, but it reminds you and obligates your attorney to respect these rights.

9. After you receive a third party recovery, you must pay all medical expenses for treatment of the illness or injury that Premera Blue Cross Medicare Advantage Plans would otherwise pay.

10. Only when you prove to Premera Blue Cross Medicare Advantage Plans’ satisfaction that the recovery has been exhausted will Premera Blue Cross Medicare Advantage Plans again begin paying. Premera Blue Cross Medicare Advantage Plans will then pay the amount the cost of services exceeds the net recovery.

11. If you fail to repay Premera Blue Cross Medicare Advantage Plans, Premera Blue Cross Medicare Advantage Plans may recover the repayment out of future benefits owed under this plan.

12. If you do not make a claim against a responsible third party, or fail to cooperate with Premera Blue Cross Medicare Advantage Plans in any claim you do make, Premera Blue Cross Medicare Advantage Plans may collect directly from the third party. To the fullest extent permitted by Medicare, Premera Blue Cross Medicare Advantage Plans may assume your rights against a third party, may sue the third party in your name, may intervene in any suit you bring, and has a lien on any recovery to the extent Premera Blue Cross Medicare Advantage Plans has paid benefits, or has incurred expenses to obtain a recovery.

Your failure to comply with your duties permits Premera Blue Cross Medicare Advantage Plans to deny claims arising from the condition and to terminate your coverage.

PRIOR AUTHORIZATION REQUIREMENTS
Listed below are services that require Prior Authorization in order to receive services.

1. All
   • Inpatient hospital (including maternity) admissions
   • Skilled Nursing Facility (SNF) admissions
   • Inpatient Rehabilitation Facility admissions
   • Mental Health and/or Chemical Dependency services.
     Authorizing agent: Optum (UBH) Phone: 1-800-711-4577

2. Non-emergency procedures, including, but not limited to, the following categories:
   • Miscellaneous cosmetic, reconstructive, nasal and oral / dental / orthognathic procedures
   • Cervical, thoracic and lumbar spinal surgeries
   • Bariatric surgery
• Organ / tissue and bone marrow transplants (including pre-transplant evaluations and HLA typing)
• Uvulectomy, uvulopalatopharyngoplasty (UPPP) and laser-assisted uvulopalatoplasty (LAUP)

3. Premera Blue Cross Medicare Advantage (HMO) and Premera Blue Cross Medicare Advantage Plus (HMO) members only: All services provided by out-of-network providers

4. Services and procedures without specific CPT codes (unlisted services and procedures)

5. Procedures / surgeries/treatment that may be considered experimental or investigational

6. Genetic testing / cytogenetic studies / counseling

7. Pulmonary rehabilitation

8. Cardiac rehabilitation

9. High Tech Diagnostic Imaging: MRI, MRA, SPECT, CT, CTA, PET and Nuclear cardiology

10. General anesthesia for dental services

11. Neuropsychological testing

12. Certain Durable Medical Equipment items including but not limited to:
   • Power-wheel chairs and supplies
   • Seat lift mechanisms
   • Select nerve stimulators
   • Skin substitutes
   • Oral appliances
   • Flexion / extension devices
   • Wound therapy pumps
   • Speech generating devices
   • Purchase of CPAP post trial/rental period

Authorization does not guarantee benefits or payment. Benefits are based on eligibility at the time the service is rendered and are subject to any applicable contract terms.

PLAN EXCLUSIONS

In addition to the list in your Evidence of Coverage (EOC), the following are items and services that are not covered by Premera Blue Cross Medicare Advantage Plans:

1. Services that are not covered under Original Medicare, unless such services are specifically listed as covered.

2. Services that you get from out-of-network providers (unless you are enrolled on a Premera Blue Cross Medicare Advantage (HMO-POS) or Premera Blue Cross Medicare Advantage Plus (HMO-POS) and use your Point of Service (POS) benefit), except for care for a medical emergency and urgently needed care, renal (kidney)
dialysis services that you get when you are temporarily outside the plan’s service area, and care from out-of-network providers that is arranged or approved by an in-network provider. Services that you get without a referral from your Primary Care Provider (PCP), when a referral from your PCP is required for getting that service (are using your Point of Service (POS) benefit).

3. Services that you get without prior authorization, when prior authorization is required for getting that service.

4. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.

5. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered. Dental is generally not covered under the plan or is limited according to Original Medicare guidelines except surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a medical doctor or doctor of dentistry. Covered dental services are limited to surgery related to the facial area below the eyes including the reduction of any fractures of the jaw or facial bones. Items and services in connection with the care, treatment, filling, removal or replacement of teeth such as routine exams, cleanings, X-rays, tooth extractions, crowns and bridgework and their supporting structures are not covered. The supporting structures of the teeth include gingivae, dentogingival junction, periodontal membrane, and cementum of the teeth and alveolar process.

6. Lens extras for cataract hardware are not covered unless medically necessary. Examples of lens extras include tints, anti-reflective coating, U-V lenses, or oversize lenses.

7. If a cataract extraction is performed on one eye and then is performed on the other eye and no eyeglasses or contact lenses are purchased between the two surgical procedures, Premera Blue Cross Medicare Advantage Plans will cover only one pair of eyeglasses or contact lenses after the second surgery.

8. Subnormal vision aids, aniseikonic lenses or plain (non-prescription lenses) glasses, replacement for lost or broken lenses, sunglasses, or two pair of glasses and other low vision aids and services.

9. Procedures, services, supplies and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by Premera Blue Cross Medicare Advantage Plans or Original Medicare.

10. Charges for missed appointments or completion of claim forms.

11. Reports, evaluations, or routine physical exams primarily for insurance, licensing, employment or other third party and non-preventive purposes.

12. Treatment or counseling in the absence of illness, including marriage counseling.

13. Treatment prior to coverage—services or supplies received by a member before the member was covered under this agreement are not covered.

14. Autopsies and services related to autopsies are not covered.

15. Additional days in the hospital for pure convenience or desire of the patient are not covered.

16. Appliances, equipment, or supplies primarily for comfort or a convenience—These non-covered items include equipment used for environmental control, such as air conditioners, humidifiers, air filters, whirlpools, heat lamps, or tanning lights.

17. Injections, which can be self-administered, under your medical (Part B) benefits.
Some self-administered injections, such as insulin, may be covered under your drug (Part D) benefits.

18. Long-term rehabilitation, including physical, occupational and speech therapy.
19. Massage therapy services.
20. Orthognathic surgery—services and supplies to shorten or lengthen the upper or lower jaw are not covered, except when medically necessary as determined by Premera Blue Cross Medicare Advantage Plans.

21. Outpatient drugs and medicines you buy and administer yourself with or without a doctor's prescription.*
22. Out-of-area services if the need could have reasonably been foreseen prior to leaving the service area except for renal dialysis services.
23. Psychological enrichment or self-help programs for mentally healthy individuals.
24. Guest meals in a hospital or skilled nursing facility.
25. Surrogate parenting—All costs associated with surrogate parenting.
26. Care for conditions that state or local law requires to be treated in a public facility.
27. Services or supplies that are not medically necessary for the treatment of an illness or injury as determined by Premera Blue Cross Medicare Advantage Plans in accordance with generally accepted medical standards are not covered. The only exceptions to this provision are the preventive care benefits described in the benefits section, and medically necessary infertility benefits.

28. Elective sterilizations.
29. Services relating to intrauterine devices.
30. Religious non-medical health care institutions/practitioner's services.
31. Conception by artificial means, such as in vitro fertilization, zygote intra-fallopian transfers and gamete intra-fallopian transfers (GIFT).
32. Ambulance claims where transport is refused.
33. For Premera Blue Cross Medicare Advantage (HMO) only: routine vision examinations.
34. For Premera Blue Cross Medicare Advantage (HMO) only: routine hearing examinations.
35. Premera Blue Cross Medicare Advantage Plans and Original Medicare do not cover the following list of Medical supplies. This list is not all-inclusive and is subject to change. There may be other medical supplies or Durable Medical Equipment (DME) items not included in this listing that are not covered:

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Air cleaners
Air conditioners
Bathtub lifts
Bathtub seats
Bed baths (home type)
Bed lifters (bed elevator)
Bedboards
Beds-lounge (power or manual)
Beds-oscillating
Blood glucose analyzer reflectance colorimeter
Braille teaching texts

Incontinent pads
Injectors (hypodermic jet pressure powered devices for injection of insulin
Irrigating kits
Leotards
Massage devices
Oscillating Beds
Overbed tables
Paraffin bath units (standard)
Parallel bars
Portable room heaters
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* These drugs may be covered under your Part D benefit.
Carafes
Dehumidifiers (room or central heating system type)
Diathermy machines (standard or pulsed wave types)
Disposable sheets and bags
Elastic stockings
Electric air cleaners
Electrical stimulation for wounds
Electrostatic machines
Elevators
Emesis basins
Esophageal dilators
Exercise equipment
Fabric supports
Face masks (surgical)
Grab bars
Heat and massage foam cushion pad
Heating and cooling plants
Humidifiers (room or central heating system types)

Portable whirlpool pumps
Preset portable oxygen systems
Pressure leotards
Pulse tachometer
Raised toilet seats
Sauna baths
Spare tanks of oxygen
Speech teaching machines
Stairway elevators
Standing tables
Support hose
Surgical leggings
Syringes*
Telephone alert system
Telephone arms
Toilet seats
Treadmill exercisers
Whirlpool pumps
White canes

* These items may be covered under your Part D benefit.
Section 2: Prescription Drugs

FILLING A PRESCRIPTION

When filling prescriptions at your pharmacy make sure that you use your Premera Blue Cross Medicare Advantage Plan Identification Card. Ask the pharmacy to process the prescription claim using your Premera Blue Cross Medicare Advantage Plan identification number. This is the best way to make sure that your prescription out-of-pocket expenses are tracked. Please remember that you will never pay more than what the drug costs.

PREFERRED NETWORK PHARMACIES (NETWORK DIFFERENTIAL)

Preferred network pharmacies and network pharmacies are pharmacies in the Premera Blue Cross Medicare Advantage Plans’ network where Premera Blue Cross Medicare Advantage Plans has negotiated a lower price for covered prescription drugs. However, you may pay more for a 90-day supply at a network pharmacy than you would pay at a preferred network pharmacy.

- If you purchase a 90-day supply at a network pharmacy a charge in addition to your copayment or coinsurance will be assessed. This charge is the negotiated price difference between preferred network and network reimbursement rates.
- If you purchase a 90-day supply at a preferred network pharmacy no additional charge will be applied. You will always be charged the lowest copayment or coinsurance amount by using a preferred network pharmacy.

You may go to either of these types of pharmacies to receive your covered prescription drugs. You have nationwide access to network pharmacies. You may refer to your Provider and Pharmacy Directory, visit our website www.premera.com, or call Customer Service, whichever is easiest for you (phone numbers are printed on the back of this booklet).

PART D VACCINATIONS

What you pay at the time you get the vaccination can vary depending on the circumstances. What you pay depends on three things:

1. **The type of vaccine (what you are being vaccinated for):** Vaccines may be considered a medical benefit or Part D benefit.

2. **Where you get the vaccine medication:** You can get vaccinated at your participating pharmacy or your doctor’s office.

3. **Who gives you the vaccine shot:** You get the medication at your preferred network or network pharmacy and take it to your doctor’s office where they give you the vaccination shot.
The rules for coverage of vaccinations can be complicated. For example:

- Zostavax (used to prevent shingles) is a Part D benefit. It should be obtained at a preferred network or network pharmacy to minimize your out-of-pocket cost. If you obtain it at your doctor’s office, you may pay more.
- Tetanus vaccine is a Part D benefit and should be obtained at a preferred network or network pharmacy unless it is related to an injury. If you obtain it at your doctor’s office, you may pay more.

We can tell you about how your vaccination is covered and explain your share of the cost. Please call Customer Service for assistance (phone numbers are printed on the back of this booklet). It may be to your benefit to get your Part D vaccinations from your preferred network or network immunizing pharmacy. If you get your vaccinations at your doctor’s office you may pay more than you would if you use a preferred network or network pharmacy. Contact plan for details. If you are in the coverage gap you are responsible for the entire cost of the vaccination and administration.

**EXTRA HELP**

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office.

Drugs received outside the United States cannot be provided under Medicare Part D coverage.
Section 3: Premera Blue Cross Medicare Advantage (HMO) and Premera Blue Cross Medicare Advantage Plus (HMO)

OUT-OF-POCKET MAXIMUM

With our Premera Blue Cross Medicare Advantage (HMO) and Premera Blue Cross Medicare Advantage Plus (HMO) Plans there is an out-of-pocket maximum. This is the maximum cost-share amount you will pay for medical services. This applies to in-network services that are Medicare covered. This out-of-pocket maximum applies to your authorized medical Medicare covered services only.

REFERRALS

While a member of either Premera Blue Cross Medicare Advantage (HMO) or Premera Blue Cross Medicare Advantage Plus (HMO), you are required to get a referral from your Primary Care Provider (PCP) in order to receive specialty care. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for patients with cancer.
- Cardiologists, who care for patients with heart conditions.
- Orthopedists, who care for patients with certain bone, joint, or muscle conditions.

IN-NETWORK VERSUS OUT-OF-NETWORK PROVIDERS

As a member of either Premera Blue Cross Medicare Advantage (HMO) or Premera Blue Cross Medicare Advantage Plus (HMO), there is a network (group of providers) that Premera Blue Cross has contracted with to provide your care. These are called in-network providers.

You must use in-network providers except in emergency or urgent care situations, or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers neither Original Medicare nor Premera Blue Cross Medicare Advantage Plans will be responsible for the costs.

VISION SERVICES

Eye exams to diagnose and treat diseases and conditions of the eye, such as Glaucoma screenings are covered at no cost to you. For Premera Blue Cross Medicare Advantage Plus (HMO) members, you will have a copay for routine eye exams. A routine eye exam is covered once every year. For Premera Blue Cross Medicare Advantage (HMO) members, a routine eye exam is not covered.

OTHER PART B SERVICES

Other physician services include Part B services such as: Allergy Serum Administration, Chemotherapy Administration, Injection Administration and Infusion Therapy. These services are usually provided at a physician’s office, infusion clinic, or hospital outpatient infusion suite. Coinsurance may apply for certain services. This list is just an example, contact plan for details.

- In-Network you pay 20% of the cost for some Part B services.
OUTPATIENT HOSPITAL OBSERVATION
You pay 20% of the cost for outpatient hospital observation. If you are provided drugs to take home and/or self-administer, they may be covered under your Part D benefits. Your Part D cost-share will apply to these drugs.

OUTPATIENT PHYSICIAN FACILITY-BASED VISITS
You pay 20% of the cost of outpatient physician facility-based visits.
Section 4: Premera Blue Cross Medicare Advantage (HMO-POS) and Premera Blue Cross Medicare Advantage Plus (HMO-POS)

OUT-OF-POCKET MAXIMUM

With Premera Blue Cross Medicare Advantage (HMO-POS) and Premera Blue Cross Medicare Advantage Plus (HMO-POS), there is an out-of-pocket maximum. This is the maximum cost-share amount you will pay for medical services. This applies to a combination of both in-network and out-of-network services that are Medicare-covered. This out-of-pocket maximum applies to your authorized medical Medicare-covered services only.

REFERRALS

While a member of either Premera Blue Cross Medicare Advantage (HMO-POS) or Premera Blue Cross Medicare Advantage Plus (HMO-POS), unless you choose to use your point of service (POS) benefit, you are required to get a referral from your Primary Care Provider (PCP) in order to receive specialty care. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for patients with cancer.
- Cardiologists, who care for patients with heart conditions.
- Orthopedists, who care for patients with certain bone, joint, or muscle conditions.

If you choose to use your POS benefit you will pay more for medical services.

IN-NETWORK VERSUS OUT-OF-NETWORK PROVIDERS

In-Network

As a member of either Premera Blue Cross Medicare Advantage (HMO-POS) or Premera Blue Cross Medicare Advantage Plus (HMO-POS), there is a network (group of providers) that Premera Blue Cross has contracted with to provide your care. These are called in-network providers. Please note, if you see an in-network specialist without a referral from your PCP, the out-of-network point of service (POS) cost-sharing will apply.

Out-of-Network

As a member of either Premera Blue Cross Medicare Advantage (HMO-POS) or Premera Blue Cross Medicare Advantage Plus (HMO-POS), you have the option of going out of the Premera Blue Cross Medicare Advantage network. If you go to a provider outside of the Premera Blue Cross Medicare Advantage network, your cost share (copay or coinsurance) will be higher. In addition, if a doctor or supplier chooses not to accept Medicare assignment, you may pay more. If a doctor or supplier has elected to opt out of Original Medicare, your services are excluded under all Premera Blue Cross Medicare Advantage Plans and will not be reimbursed.

Premera Blue Cross Medicare Advantage (HMO-POS) and Premera Blue Cross Medicare Advantage Plus (HMO-POS) will only cover services obtained using your out-of-network benefit when the services provided are Medicare covered and follow plan rules.
The following are excluded as point-of-service (opt-out) benefits and must be provided by an in-network provider and prior authorized by Premera Blue Cross Medicare Advantage Plans:

- Organ and bone marrow transplants (including pre-transplant evaluations and HLA typing).

VISION SERVICES
Eye exams to diagnose and treat diseases and conditions of the eye, such as Glaucoma screenings are covered at no cost to you. You will have a copay for routine eye exams. Premera Blue Cross Medicare Advantage (HMO-POS) and Premera Blue Cross Medicare Advantage Plus (HMO-POS) cover one routine eye exam every year.

OTHER PART B SERVICES
Other physician services include Part B services such as: Allergy Serum Administration, Chemotherapy Administration, Injection Administration and Infusion Therapy. These services are usually provided at a physician’s office, infusion clinic, or hospital outpatient infusion suite. Coinsurance may apply for certain services. This list is just an example, contact plan for details.

- In-Network you pay 20% of the cost for some Part B services.
- Out-of-Network you pay 20% of the cost for some Part B services.

OUTPATIENT HOSPITAL OBSERVATION
You pay 20% of the cost for outpatient hospital observation. If you are provided drugs to take home and/or self-administer, they may be covered under your Part D benefits. Your Part D cost-share will apply to these drugs.

OUTPATIENT PHYSICIAN FACILITY-BASED VISITS
You pay 20% of the cost of outpatient physician facility-based visits.
www.premera.com

Premera Blue Cross
P.O. Box 4196
Portland, OR 97208-4196
888-850-8526; TTY 711

Customer Service is available between 8 a.m. and 8 p.m., seven days a week (Pacific Time).

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

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