2016

HMO-POS

Summary of Benefits

King, Pierce, Snohomish, Spokane and Thurston Counties

premera.com/ma

PREMERA BLUE CROSS

Premera Blue Cross Medicare Advantage (HMO-POS)

Section 1

Introduction to the Summary of Benefits for
Premera Blue Cross Medicare Advantage (HMO-POS)
January 1, 2016 - December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Premera Blue Cross Medicare Advantage (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Premera Blue Cross Medicare Advantage (HMO-POS)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Premera Blue Cross Medicare Advantage (HMO-POS)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This information is available in different formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at 888-850-8526.

Section 1

Introduction to the Summary of Benefits for
Premera Blue Cross Medicare Advantage (HMO-POS)
January 1, 2016 - December 31, 2016

Things to Know About Premera Blue Cross Medicare Advantage (HMO-POS)

Hours of Operation

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time.

Premera Blue Cross Medicare Advantage (HMO-POS) Phone Numbers and Website

- If you are a member of this plan, call toll-free 888-850-8526.
- If you are not a member of this plan, call toll-free 888-868-7767.
- Our website: http://www.premera.com

Who can join?

To join **Premera Blue Cross Medicare Advantage (HMO-POS)**, 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: King, Pierce, Snohomish, Spokane, and Thurston.

Which doctors, hospitals, and pharmacies can I use?

Premera Blue Cross Medicare Advantage (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's *Provider and Pharmacy Directory* at our website (www.premera.com).
Or, call us and we will send you a copy of the *Provider and Pharmacy Directory*.

Section 1

Introduction to the Summary of Benefits for
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What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers — and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.premera.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible (if applicable): Initial Coverage, Coverage Gap, and Catastrophic Coverage.

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MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
	Premera Blue Cross Medicare Advantage (HMO-POS)
How much is the monthly premium?	$69 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	$200 per year for Part D prescription drugs except for drugs listed on Tier 1, which are excluded from the deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. • $6,700 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

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COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	
	Premera Blue Cross Medicare Advantage (HMO-POS)
OUTPATIENT CARE AND SERVICES	
Acupuncture	Not covered
Ambulance	• In-network: $300 copay • Out-of-network: $300 copay This copay applies to each way of a Medicare-covered or medically approved ambulance transport.
Chiropractic Care[2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 40% of the cost Benefit is limited to Medicare-covered chiropractic services.
Dental Services[1,2]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $50 copay • Out-of-network: 40% of the cost Medicare-covered dental includes surgery of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or service that would be covered if provided by a medical provider.

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	Preventive dental services: Cleaning: • In-network: You pay nothing. You are covered for up to 2 every year. • Out-of-network: You pay nothing. There may be a limit to how often these services are covered. Dental x-ray(s): • In-network: You pay nothing. You are covered for up to 1 every year. • Out-of-network: You pay nothing. There may be a limit to how often these services are covered. Fluoride treatment: • In-network: You pay nothing. You are covered for up to 1 every year. • Out-of-network: You pay nothing. There may be a limit to how often these services are covered. Oral Exam: • In-network: You pay nothing. You are covered for up to 2 every year. • Out-of-network: You pay nothing. There may be a limit to how often these services are covered. Bitewing X-rays: Limited to one set of four every calendar year. Panoramic or Complete Series X-rays (not both): Once every 60 months. Out-of-network: You are responsible for any amount above the Premera plan-allowed amount for a covered service.

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Diabetes Supplies and Services	Diabetes monitoring supplies: • In-network: 20% of the cost • Out-of-network: 40% of the cost Diabetes self-management training: • In-network: You pay nothing • Out-of-network: 40% of the cost Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 40% of the cost If your doctor provides any additional services, a separate cost-sharing amount may apply.

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Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may be different if received in an outpatient surgery setting)*[1,2]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: 20% of the cost • Out-of-network: 40% of the cost Diagnostic tests and procedures: • In-network: 20% of the cost • Out-of-network: 40% of the cost Lab services: • In-network: $20 copay • Out-of-network: 40% of the cost Outpatient X-rays: • In-network: $20 copay • Out-of-network: 40% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 20% of the cost • Out-of-network: 40% of the cost Diagnostic radiology services include ultrasounds. If your doctor provides additional services, a separate cost-sharing amount may apply.

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Doctor's Office Visits[2]	Primary care physician visit: • In-network: $18 copay • Out-of-network: 40% of the cost Specialist visit: • In-network: $50 copay • Out-of-network: 40% of the cost While you may see an out-of-network PCP at a higher cost-share, a network PCP must be selected as well. Out-of-network cost-sharing applies when seeing an in-network specialist without a referral. If your doctor provides any additional services, a separate cost-sharing amount may apply.
Durable Medical Equipment *(wheelchairs, oxygen, etc.)[1]*	• In-network: 20% of the cost • Out-of-network: 40% of the cost We cover all medically necessary durable medical equipment per Original Medicare guidelines. Certain limitations may apply.
Emergency Care	$75 copay Worldwide coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.

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Foot Care *(podiatry services)[2]*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $50 copay per visit • Out-of-network: 40% of the cost If your doctor provides any additional services, a separate cost-sharing amount may apply.
Hearing Services[1,2]	Exam to diagnose and treat hearing and balance issues: • In-network: $50 copay • Out-of-network: 40% of the cost Routine hearing exam: • In-network: $50 copay You are covered for up to 1 every year. • Out-of-network: 40% of the cost There may be a limit to how often these services are covered. You are eligible for up to 1 routine hearing exam per calendar year whether the services are received in-network or out-of-network. If your doctor provides any additional services, a separate cost-sharing amount may apply.
Home Health Care	• In-network: You pay nothing • Out-of-network: 40% of the cost

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Mental Health Care[1,2]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In-network: • $390 copay per day for days 1 through 4 • You pay nothing per day for days 5 through 90 Out-of-network: 40% of the cost per stay Outpatient group therapy visit: • In-network: $40 copay • Out-of-network: 40% of the cost

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	Outpatient individual therapy visit: • In-network: $40 copay • Out-of-network: 40% of the cost This benefit is administered by Optum.
Outpatient Rehabilitation[1]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $40 copay • Out-of-network: 40% of the cost Occupational therapy visit: • In-network: $40 copay • Out-of-network: 40% of the cost Physical therapy and speech and language therapy visit: • In-network: $40 copay • Out-of-network: 40% of the cost Cost-sharing amount for occupational therapy, physical therapy, speech and language therapy are administered separately as a per provider, per day benefit.

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Outpatient Substance Abuse[1]	Group therapy visit: • In-network: $40 copay • Out-of-network: 40% of the cost Individual therapy visit: • In-network: $40 copay • Out-of-network: 40% of the cost This benefit is administered by Optum.
Outpatient Surgery[1]	Ambulatory surgical center: • In-network: 20% of the cost • Out-of-network: 40% of the cost Outpatient hospital: • In-network: 20% of the cost • Out-of-network: 40% of the cost
Over-the-Counter Items	Not Covered

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Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 40% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 40% of the cost Only Medicare-covered prosthetic devices and related medical supplies will be covered.
Renal Dialysis[1,2]	• In-network: 20% of the cost • Out-of-network: 40% of the cost Kidney disease education: • In-network: You pay nothing • Out-of-network: 40% of the cost
Transportation	Not covered
Urgently Needed Services	$50 copay Worldwide coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services. See the "Inpatient Hospital Care" section of this booklet for other costs.

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Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: You pay nothing • Out-of-network: You pay nothing Routine eye exam: • In-network: $50 copay. You are covered for up to 1 every year. • Out-of-network: 40% of the cost. There may be a limit to how often these services are covered. Contact lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses (frames and lenses): • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $150 every year for contact lenses and eyeglasses (frames and lenses) from an in-network provider. There is a limit to how much our plan will pay from an out-of-network provider.

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	Routine vision exam and hardware benefits are based on a calendar year. The routine hardware allowance includes frames, lenses, contacts, fittings, and extras. Any amount over $150 would be your responsibility.
Preventive Care	• In-network: You pay nothing • Out-of-network: 40% of the cost Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling

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	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. If your doctor provides additional services, a separate cost-sharing amount may apply. Some services have limits or must be provided by your PCP.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Original Medicare pays for your care once hospice begins. We may coordinate benefits with Original Medicare for any non-hospice related care provided plan rules are followed.

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	Premera Blue Cross Medicare Advantage (HMO-POS)
INPATIENT CARE	
Inpatient Hospital Care[1]	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. In-network: • $440 copay per day for days 1 through 4 • You pay nothing per day for days 5 through 90 • You pay nothing per day for days 91 and beyond Out-of-network: • 40% of the cost per stay Benefit periods begin the day you go into a hospital or skilled nursing facility and end when you haven't received any inpatient hospital care or skilled nursing facility care for 60 days in a row.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet. This benefit is administered by Optum.

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Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. In-network: • You pay nothing per day for days 1 through 20 • $160 copay per day for days 21 through 60 • You pay nothing for days 61 through 100 Out-of-network: • 40% of the cost per stay Benefit periods begin the day you go into a hospital or skilled nursing facility. They end when you haven't received any inpatient hospital care or skilled nursing facility care for 60 days in a row. There is no limit to the number of benefit periods. No prior hospital stay is required.

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PRESCRIPTION DRUG BENEFITS					
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: • In-network: 20% of the cost • Out-of-network: 40% of the cost Other Part B drugs[1]: • In-network: 20% of the cost • Out-of-network: 40% of the cost A separate cost-sharing amount may apply for the cost of the administration.				
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.				
Preferred Retail Cost-Sharing					
Initial Coverage-continued	**Tier**	**1-month supply**	**2-month supply**	**3-month supply**	
	Tier 1 (Preferred Generic)	$4 copay	$8 copay	$12 copay	
	Tier 2 (Generic)	$12 copay	$24 copay	$36 copay	
	Tier 3 (Preferred Brand)	$45 copay	$90 copay	$135 copay	
	Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$300 copay	
	Tier 5 (Injectable Drugs)	25% of the cost	Not Offered	Not Offered	
	Tier 6 (Specialty Tier)	25% of the cost	Not Offered	Not Offered	

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PRESCRIPTION DRUG BENEFITS					
Standard Retail Cost-Sharing					
Initial Coverage-continued	**Tier**	**1-month supply**	**2-month supply**	**3-month supply**	
	Tier 1 (Preferred Generic)	$12 copay	$24 copay	$36 copay	
	Tier 2 (Generic)	$20 copay	$40 copay	$60 copay	
	Tier 3 (Preferred Brand)	$45 copay	$90 copay	$135 copay	
	Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$300 copay	
	Tier 5 (Injectable Drugs)	25% of the cost	Not Offered	Not Offered	
	Tier 6 (Specialty Tier)	25% of the cost	Not Offered	Not Offered	
Preferred Mail Order Cost-Sharing					
Initial Coverage-continued	**Tier**	**1-month supply**	**2-month supply**	**3-month supply**	
	Tier 1 (Preferred Generic)	$4 copay	$8 copay	$12 copay	
	Tier 2 (Generic)	$12 copay	$24 copay	$36 copay	
	Tier 3 (Preferred Brand)	$45 copay	$90 copay	$135 copay	
	Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$300 copay	
	Tier 5 (Injectable Drugs)	25% of the cost	Not Offered	Not Offered	
	Tier 6 (Specialty Tier)	25% of the cost	Not Offered	Not Offered	
Standard Mail Order Cost-Sharing					
Initial Coverage-continued	**Tier**	**1-month supply**	**2-month supply**	**3-month supply**	
	Tier 1 (Preferred Generic)	$12 copay	$24 copay	$36 copay	
	Tier 2 (Generic)	$20 copay	$40 copay	$60 copay	
	Tier 3 (Preferred Brand)	$45 copay	$90 copay	$135 copay	
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	Tier 5 (Injectable Drugs)	25% of the cost	Not Offered	Not Offered	
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PRESCRIPTION DRUG BENEFITS	
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter 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 $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copayment (copay) for generic (including brand drugs treated as generic) and a $7.40 copayment (copay) for all other drugs.

For more information

Premera Blue Cross Medicare Advantage
PO Box 4196
Portland, OR 97208-4196

Call toll free **888-868-7767 (TTY: 711)**
Representatives are available between
8 a.m. and 8 p.m., Monday through Friday
(7 days a week, 8 a.m. to 8 p.m., from
October 1 through February 14)

premera.com/ma

24/7 Nurse Line

Call **855-339-8123**. Free and confidential.

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. Benefits, premium, and/or copayments/coinsurance may change on January 1 of each year. The formulary, pharmacy network and provider network may change at any time. You will receive notice when necessary.

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PREMERA | BLUE CROSS

An Independent icensee of the Blue Cross Blue S ield Asso ia ion

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