2021 Summary of Benefits

Y0134_PBC2651_M
037040 (10-05-2020)

PREMERA BLUE CROSS

2021 Summary of Benefits

PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HMO) H7245-006
PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HMO) H7245-008
PREMERA BLUE CROSS MEDICARE ADVANTAGE (HMO) H7245-001
PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HMO) H7245-002
PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HMO) H7245-005
PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HMO) H9302-011
PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HMO) H9302-007
PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HMO) H9302-004
PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HMO) H9302-003
PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HMO) H7245-003

This is a summary of drug and health services covered by Premera Blue Cross Medicare Advantage Core (HMO), Premera Blue Cross Medicare Advantage Core Plus (HMO), Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO), Premera Blue Cross Medicare Advantage Total Health (HMO), Premera Blue Cross Medicare Advantage Peak + Rx (HMO), Premera Blue Cross Medicare Advantage Sound + Rx (HMO), Premera Blue Cross Medicare Advantage Alpine (HMO), Premera Blue Cross Medicare Advantage Charter + Rx (HMO), and Premera Blue Cross Medicare Advantage Classic Plus (HMO) January 1, 2021 to December 31, 2021.

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

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

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

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

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

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

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

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

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

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

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

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

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

Counties: Island, San Juan, Skagit, Walla Walla, Whatcom				
PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HM0)				
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 $180 for your Tier 3, 4, and 5 drugs.			
Initial Coverage Phase - You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,130.				
	Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost Sharing (in network) (up to 30-day supply)	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)
Tier 1: Preferred Generic	You pay a $4 copay.	You pay a $15 copay.	You pay a $0 copay.	You pay a $15 copay.
Tier 2: Generic	You pay a $12 copay.	You pay a $20 copay.	You pay a $36 copay.	You pay a $20 copay.
Tier 3: Preferred Brand	You pay a $42 copay.	You pay a $47 copay.	You pay a $126 copay.	You pay a $47 copay.
Tier 4: Non-Preferred Drugs	You pay 33% of the cost.	You pay 33% of the cost.	You pay 33% of the cost.	You pay 33% of the cost.
Tier 5: Specialty	You pay 29% of the cost.	You pay 29% of the cost.	Not offered.	You pay 29% of the cost.

Counties: Island, San Juan, Skagit, Walla Walla				
PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HM0)				
PRESCRIPTION DRUG BENEFITS FOR (PART D)				
Deductible Phase	During this stage, you pay the full cost of your Tier 4 and 5 drugs. You stay in this stage until you have paid $180 for your Tier 4 and 5 drugs.			
Initial Coverage Phase - You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,130.				
	Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost Sharing (in network) (up to 30-day supply)	Mail Order Cost Sharing (90-day supply)	Long-Term Cost Sharing (up to a 31-day supply)
Tier 1: Preferred Generic	You pay a $2 copay.	You pay a $12 copay.	You pay a $0 copay.	You pay a $12 copay.
Tier 2: Generic	You pay a $10 copay.	You pay a $20 copay.	You pay a $30 copay.	You pay a $20 copay.
Tier 3: Preferred Brand	You pay a $40 copay.	You pay a $47 copay.	You pay a $120 copay.	You pay a $47 copay.
Tier 4: Non-Preferred Drugs	You pay 33% of the cost.	You pay 33% of the cost.	You pay 33% of the cost.	You pay 33% of the cost.
Tier 5: Specialty	You pay 29% of the cost.	You pay 29% of the cost.	Not offered.	You pay 29% of the cost.

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

Counties: Island, San Juan, Skagit, Walla Walla, Whatcom		Counties: Island, San Juan, Skagit, Walla Walla
PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE (HM0)		**PREMERA BLUE CROSS MEDICARE ADVANTAGE CORE PLUS (HM0)**
OPTIONAL SUPPLEMENTAL BENEFITS		**OPTIONAL SUPPLEMENTAL BENEFITS**
Optional Supplemental Dental Benefit		**Not applicable**
Monthly Premium	You pay additional $22.50 per month.	
Deductible	There is no deductible.	
Annual Benefit Maximum	There is no annual maximum limit.	
You pay a $0 copay for routine dental services. • Routine oral exams – two per calendar year. • Comprehensive periodontal exam – one per calendar year. • Routine cleaning – limited up to two routine cleaning (prophylaxis) per calendar year OR • Periodontal maintenance – limited up to three periodontal maintenance per calendar year. • Fluoride treatment – twice per calendar year. • Bitewing x-ray – up to one set of four bitewing x-rays every year. • Panoramic or complete series x-ray – once every 60 months. • Limited emergency exam – limited to once per calendar year. • Emergency palliative treatment of dental pain. • Periapical x-rays.		

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

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

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

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

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

PREMIUM AND BENEFITS	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)	Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)	Counties: Spokane and Stevens PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)
Mental Health Services			
Inpatient mental health care	You pay a $390 copay per day for days 1–4. You pay a $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 $40 copay for each Medicare-covered individual or group therapy visit. You pay a $35 copay for each telemental health visit. **Prior Authorization rules may apply.**	You pay a $40 copay for each Medicare-covered individual or group therapy visit. You pay a $35 copay for each telemental health visit. **Prior Authorization rules may apply.**	You pay a $40 copay for each Medicare-covered individual or group therapy visit. You pay a $35 copay for each telemental health visit. **Prior Authorization rules may apply.**
Skilled Nursing Facility	You pay a $0 copay per day for days 1–20. You pay a $160 copay per day for days 21–60. You pay a $0 copay per day for days 61–100. **Prior Authorization rules may apply.**	You pay a $0 copay per day for days 1–20. You pay a $160 copay per day for days 21–60. You pay a $0 copay per day for days 61–100. **Prior Authorization rules may apply.**	You pay a $0 copay per day for days 1–20. You pay a $160 copay per day for days 21–60. You pay a $0 copay per day for days 61–100. **Prior Authorization rules may apply.**
Physical Therapy	You pay a $40 copay per visit.	You pay a $20 copay per visit.	You pay a $20 copay per visit.
Ambulance	You pay a $300 copay each way for Medicare-covered ambulance transport. **Prior Authorization rules may apply.**	You pay a $330 copay each way for Medicare-covered ambulance transport. **Prior Authorization rules may apply.**	You pay a $370 copay each way for Medicare-covered ambulance transport. **Prior Authorization rules may apply.**

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

Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Spokane, and Thurston			Counties: Cowlitz, King, Kitsap, Lewis, Pierce, Snohomish, Thurston, and Whatcom			Counties: Spokane and Stevens		
PREMERA BLUE CROSS MEDICARE ADVANTAGE (HM0)			PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HM0)			PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)		
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 $180 for your Tier 3, 4, and 5 drugs.		**Deductible Phase**	During this stage, you pay the full cost of your Tier 4 and 5 drugs. You stay in this stage until you have paid $180 for your Tier 4 and 5 drugs.		**Deductible Phase**	During this stage, you pay the full cost of your Tier 4 and 5 drugs. You stay in this stage until you have paid $180 for your Tier 4 and 5 drugs.	
Initial Coverage Phase - You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,130.			**Initial Coverage Phase** - You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,130.			**Initial Coverage Phase** - You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,130.		
	Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost sharing (in network) (up to 30-day supply)		Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost sharing (in network) (up to 30-day supply)		Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost Sharing (in network) (up to 30-day supply)
Tier 1: Preferred Generic	You pay a $4 copay.	You pay a $15 copay.	**Tier 1: Preferred Generic**	You pay a $2 copay.	You pay a $12 copay.	**Tier 1: Preferred Generic**	You pay a $2 copay.	You pay a $12 copay.
Tier 2: Generic	You pay a $12 copay.	You pay a $20 copay.	**Tier 2: Generic**	You pay a $10 copay.	You pay a $20 copay.	**Tier 2: Generic**	You pay a $10 copay.	You pay a $20 copay.
Tier 3: Preferred Brand	You pay a $42 copay.	You pay a $47 copay.	**Tier 3: Preferred Brand**	You pay a $40 copay.	You pay a $47 copay.	**Tier 3: Preferred Brand**	You pay a $40 copay.	You pay a $47 copay.
Tier 4: Non-Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.	**Tier 4: Non-Preferred Drugs**	You pay 33% of the total cost.	You pay 33% of the total cost.	**Tier 4: Non-Preferred Drugs**	You pay 33% of the total cost.	You pay 33% of the total cost.
Tier 5: Specialty	You pay 29% of the total cost.	You pay 29% of the total cost.	**Tier 5: Specialty**	You pay 29% of the total cost.	You pay 29% of the total cost.	**Tier 5: Specialty**	You pay 29% of the total cost.	You pay 29% of the total cost.

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

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

Counties: Spokane and Stevens		
PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HM0)		
	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)
Tier 1: Preferred Generic	You pay a $0 copay.	You pay a $12 copay.
Tier 2: Generic	You pay a $30 copay.	You pay a $20 copay.
Tier 3: Preferred Brand	You pay a $120 copay.	You pay a $47 copay.
Tier 4: Non-Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.
Tier 5: Specialty	Not offered.	You pay 29% of the total cost.
Cost sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.		
Coverage Gap		
After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach $6,550, which is the end of the Coverage Gap. Not everyone will reach the Coverage Gap.		

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

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

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

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

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

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

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

Available to residents of these counties: King, Pierce, Snohomish, Thurston, and Whatcom									
PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HM0)					**PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HM0)**				
PRESCRIPTION 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.				**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.			
Initial Coverage Phase - You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,130.					**Initial Coverage Phase -** You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,130.				
	Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost Sharing (in network) (up to 30-day supply)	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)		Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost Sharing (in network) (up to 30-day supply)	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)
Tier 1: Preferred Generic	You pay a $3 copay.	You pay a $12 copay.	You pay a $0 copay.	You pay a $12 copay.	**Tier 1: Preferred Generic**	You pay a $2 copay.	You pay a $12 copay.	You pay a $0 copay.	You pay a $12 copay.
Tier 2: Generic	You pay a $12 copay.	You pay a $20 copay.	You pay a $36 copay.	You pay a $20 copay.	**Tier 2: Generic**	You pay a $12 copay.	You pay a $20 copay.	You pay a $36 copay.	You pay a $20 copay.
Tier 3: Preferred Brand	You pay a $42 copay.	You pay a $47 copay.	You pay a $126 copay.	You pay a $47 copay.	**Tier 3: Preferred Brand**	You pay a $42 copay.	You pay a $47 copay.	You pay a $126 copay.	You pay a $47 copay.
Tier 4: Non-Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.	You pay 33% of the total cost.	You pay 33% of the total cost.	**Tier 4: Non-Preferred Drugs**	You pay 33% of the total cost.	You pay 33% of the total cost.	You pay 33% of the total cost.	You pay 33% of the total cost.
Tier 5: Specialty	You pay 30% of the total cost.	You pay 30% of the total cost.	Not offered.	You pay 30% of the total cost.	**Tier 5: Specialty**	You pay 30% of the total cost.	You pay 30% of the total cost.	Not offered.	You pay 30% of the total cost.
Cost sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.					Cost sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.				

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

Available to residents of these counties: King, Pierce, Snohomish, Thurston, and Whatcom		
PREMERA BLUE CROSS MEDICARE ADVANTAGE PEAK + Rx (HM0)		**PREMERA BLUE CROSS MEDICARE ADVANTAGE SOUND + Rx (HM0)**
OPTIONAL SUPPLEMENTAL BENEFITS		**OPTIONAL SUPPLEMENTAL BENEFITS**
Optional Supplemental Dental Benefit		**Not applicable**
Monthly Premium	You pay additional $22.50 per month.	
Deductible	There is no deductible.	
Annual Benefit Maximum	There is no annual maximum limit.	
You pay a $0 copay for routine dental services. • Routine oral exams - two per calendar year. • Comprehensive periodontal exam - one per calendar year. • Routine cleaning – limited up to two routine cleaning (prophylaxis) per calendar year OR Periodontal maintenance – limited up to three periodontal maintenance per calendar year. • Fluoride treatment–twice per calendar year. • Bitewing x-ray–up to one set of four bitewing x-rays every year. • Panoramic or complete series x-ray–once every 60 months. • Limited emergency exam–limited to once per calendar year. • Emergency palliative treatment of dental pain. • Periapical x-rays.		

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

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

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

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

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

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

Counties: King, Pierce, Snohomish, Thurston, and Whatcom				Counties: King, Pierce, Snohomish, and Thurston		
PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	**PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)**			**PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)**		
PRESCRIPTION DRUG BENEFITS (PART D)	**PRESCRIPTION DRUG BENEFITS (PART D)**			**PRESCRIPTION DRUG BENEFITS (PART D)**		
Not applicable.	**Deductible Phase**	During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $160 for your Tier 3, 4, and 5 drugs.		**Deductible Phase**	During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $180 for your Tier 3, 4, and 5 drugs.	
	Initial Coverage Phase - You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,130.			**Initial Coverage Phase -** You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,130.		
		Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost Sharing (in network) (up to 30-day supply)		Preferred Retail Cost Sharing (in network) (up to a 30-day supply)	Standard Retail Cost Sharing (in network) (up to 30-day supply)
	Tier 1: Preferred Generic	You pay a $2 copay.	You pay a $12 copay.	**Tier 1: Preferred Generic**	You pay a $4 copay.	You pay a $12 copay.
	Tier 2: Generic	You pay a $12 copay.	You pay a $20 copay.	**Tier 2: Generic**	You pay a $12 copay.	You pay a $20 copay.
	Tier 3: Preferred Brand	You pay a $42 copay.	You pay a $47 copay.	**Tier 3: Preferred Brand**	You pay a $42 copay.	You pay a $47 copay.
	Tier 4: Non-Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.	**Tier 4: Non-Preferred Drugs**	You pay 33% of the total cost.	You pay 33% of the total cost.
	Tier 5: Specialty	You pay 30% of the total cost.	You pay 30% of the total cost.	**Tier 5: Specialty**	You pay 29% of the total cost.	You pay 29% of the total cost.

Counties: King, Pierce, Snohomish, Thurston, and Whatcom				Counties: King, Pierce, Snohomish, and Thurston		
PREMERA BLUE CROSS MEDICARE ADVANTAGE ALPINE (HM0)	PREMERA BLUE CROSS MEDICARE ADVANTAGE CHARTER + Rx (HM0)			PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC PLUS (HM0)		
Not applicable.		Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)		Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)
	Tier 1: Preferred Generic	You pay a $0 copay.	You pay a $12 copay.	**Tier 1: Preferred Generic**	You pay a $0 copay.	You pay a $12 copay.
	Tier 2: Generic	You pay a $36 copay.	You pay a $20 copay.	**Tier 2: Generic**	You pay a $36 copay.	You pay a $20 copay.
	Tier 3: Preferred Brand	You pay a $126 copay.	You pay a $47 copay.	**Tier 3: Preferred Brand**	You pay a $126 copay.	You pay a $47 copay.
	Tier 4: Non-Preferred Drugs	You pay 33% of the total cost.	You pay 33% of the total cost.	**Tier 4: Non-Preferred Drugs**	You pay 33% of the total cost.	You pay 33% of the total cost.
	Tier 5: Specialty	Not offered.	You pay 30% of the total cost.	**Tier 5: Specialty**	Not offered.	You pay 29% of the total cost.
	Cost sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.			Cost sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.		

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

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

Discrimination is Against the Law

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

Language Assistance

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888-850-8526（TTY：711）。

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

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

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

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

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

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

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

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

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

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

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

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

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

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