2024 Summary of Benefits

PREMERA BLUE CROSS MEDICARE ADVANTAGE (HMO)

PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HMO)

PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HMO)

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037040 (10-01-2023)

PREMERA BLUE CROSS

2024 Summary of Benefits

PREMERA BLUE CROSS MEDICARE ADVANTAGE (HMO) H7245-001

PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HMO) H7245-002

PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HMO) H7245-005

Counties covered:

Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Cowlitz	Cowlitz	Spokane
Island	Island	Stevens
King	King	Walla Walla
Kitsap	Kitsap	
Lewis	Lewis	
Pierce	Pierce	
San Juan	San Juan	
Skagit	Skagit	
Snohomish	Snohomish	
Spokane	Thurston	
Thurston	Walla Walla	
Walla Walla	Whatcom	
Whatcom		

This is a summary of drug and health services covered by Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO) and Premera Blue Cross Medicare Advantage Total Health (HMO) from January 1, 2024 to December 31, 2024.

Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO) and **Premera Blue Cross Medicare Advantage Total Health (HMO)** are plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

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

To join **Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO)** or **Premera Blue Cross Medicare Advantage Total Health (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 **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., (Pacific Time), 7 days a week
April 1 – September 30, 8 a.m. to 8 p.m., (Pacific Time), Monday through Friday

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Monthly Plan Premium You must continue to pay your Medicare Part B premium	$0	$54	$23
Part C Deductible This plan does not have a deductible	$0	$0	$0
Part D Deductible	$0 for Tier 1, Tier 2 and Tier 6 $160 for Tier 3, Tier 4 and Tier 5	$0	$0
Maximum Out-of-Pocket Responsibility Includes copays and other costs for medical services for the year. Does not include prescription drugs.	$6,500	$5,000	$5,000
Inpatient Hospital Coverage* A benefit period begins the day you go into the hospital and ends when you have not received any inpatient hospital care for 60 days in a row. You pay nothing if readmitted within 60 days of receiving inpatient hospital care.	$450 copay per day: days 1-4 $0 copay per day: days 5 and beyond	$350 copay per day: days 1-4 $0 copay per day: days 5 and beyond	$350 copay per day: days 1-4 $0 copay per day: days 5 and beyond
Outpatient Hospital Coverage*	$350 copay	$300 copay	$275 copay
Outpatient Hospital Observation Coverage*	$90 copay	$90 copay	$90 copay
Ambulatory Surgery Center*	$150 per visit	$150 per visit	$150 per visit

^ PCP referral may be required.

* Prior authorization is required.

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Doctor Visits			
Primary care providers	$5 copay $0 copay per telehealth visit	$0 copay $0 copay per telehealth visit	$0 copay $0 copay per telehealth visit
Specialists PCP Referral may be required for out-of-network specialist services.	$40 copay $35 copay per telehealth visit	$30 copay $25 copay per telehealth visit	$30 copay $25 copay per telehealth visit
Preventive Care Such as flu vaccine and diabetic screening. For a full list of covered preventive services, see your plan's Evidence of Coverage.	$0 copay	$0 copay	$0 copay
Emergency Care Includes worldwide coverage. If you are admitted to the hospital within 24 hours, the Emergency Care copay is waived.	$90 copay	$90 copay	$90 copay
Urgently Needed Services If you are admitted to the hospital within 24 hours, the Urgently Needed Services copay is waived.	$35 copay $50 copay for worldwide coverage	$35 copay $50 copay for worldwide coverage	$35 copay $50 copay for worldwide coverage

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* Prior authorization is required.

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Diagnostic Services/Labs/Imaging			
Diagnostic tests and procedures* (per service location, per day)	$60 copay	$30 copay	$30 copay
Lab services*	$10 copay	$0 copay	$0 copay
Outpatient X-rays	$15 copay	$10 copay	$10 copay
Therapeutic radiology services (such as radiation treatment for cancer)* If your doctor provides additional services, a separate cost-sharing amount may apply.	20% coinsurance	20% coinsurance	20% coinsurance
Diagnostic radiology services* (such as MRI, CT scan)	$180 copay	$160 copay	$160 copay
Hearing Services			
Medicare-covered hearing exam	$35 copay	$30 copay	$30 copay
Routine hearing exam (1 per calendar year)	$35 copay	$30 copay	$30 copay
Hearing Care Solutions provider; higher copay applies to exams by all other providers.	$0 copay	$0 copay	$0 copay
Hearing aids when purchased through Hearing Care Solutions	$0 copay $1,000 annual allowance per ear	$0 copay $1,000 annual allowance per ear	$0 copay $1,000 annual allowance per ear

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* Prior authorization is required.

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Dental Services			
Medicare-covered comprehensive dental services	$45 copay	$30 copay	$30 copay
Annual maximum allowance for non-Medicare covered preventive and comprehensive dental services	$1,000	$1,500	$1,500
Annual Comprehensive Dental Deductible (in-network and out-of-network)	$25 deductible. No deductible for preventive and Medicare-covered dental services.		
Preventive dental services	$0 copay for exams, fluoride, cleanings, and X-rays. Refer to your Evidence of Coverage (EOC) for limitations.		
Comprehensive dental services	$0 copay for covered comprehensive dental services, like fillings, extractions, crowns, and dentures. Refer to your Evidence of Coverage (EOC) for limitations.		

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* Prior authorization is required.

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Vision Services			
Medicare-covered vision exam Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year**	$0 copay	$0 copay	$0 copay
Medicare-covered exam to diagnose and treat diseases and conditions of the eye	$20 copay	$30 copay	$30 copay
Medicare-covered vision hardware	$0 copay	$0 copay	$0 copay
Routine vision exam (1 per calendar year)	$20 copay	$0 copay	$0 copay
Routine vision hardware for lenses and frames or contacts per calendar year	$150 allowance	$250 allowance	$200 allowance

^ PCP referral may be required.

* Prior authorization is required.

** Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Mental Health Services			
Inpatient mental health care* A benefit period begins the day you go into the hospital and ends when you have not received any inpatient hospital care for 60 days in a row. You pay nothing if readmitted within 60 days of receiving inpatient mental health care.	$390 copay per day: days 1-4 $0 copay per day: days 5-90	$390 copay per day: days 1-4 $0 copay per day: days 5-90	$390 copay per day: days 1-4 $0 copay per day: days 5-90
Outpatient mental health care	$30 copay per visit $20 copay per telehealth visit	$30 copay per visit $20 copay per telehealth visit	$30 copay per visit $20 copay per telehealth visit
Skilled Nursing Facility*	$0 copay per day: days 1-20 $160 copay per day: days 21-60 $0 copay per day: days 61-100	$0 copay per day: days 1-20 $160 copay per day: days 21-60 $0 copay per day: days 61-100	$0 copay per day: days 1-20 $160 copay per day: days 21-60 $0 copay per day: days 61-100
Physical Therapy	$20 copay	$10 copay	$10 copay
Ambulance* Prior authorization required only for non-emergencies. (per one-way trip)	$300 copay for ground $300 copay for air	$275 copay for ground $275 copay for air	$275 copay for ground $275 copay for air

^ PCP referral may be required.

* Prior authorization is required.

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Transportation	Not covered	Not covered	Not covered
Medicare Part B Drugs*	0%—20% coinsurance	0%—20% coinsurance	0%—20% coinsurance
Medicare Part B Insulin Drugs*	$35 copay	$35 copay	$35 copay
Over-the-Counter (OTC) Credit per quarter. Purchase products including At-Home COVID-19 tests available through OTC Health Solutions.	$50	$65	$65
Chiropractic Services (Medicare-covered)	$15 copay	$20 copay	$20 copay
Routine Chiropractic Services	$20 copay, 6 visits per year	$20 copay, 10 visits per year	$20 copay, 10 visits per year
Acupuncture* (Medicare-covered)	$40 copay	$30 copay	$30 copay
Routine Acupuncture	$20 copay, 6 visits per year	$20 copay, 10 visits per year	$20 copay, 10 visits per year
Routine Naturopathic Services	Not covered	$30 copay, 6 visits per year	$30 copay, 6 visits per year
Fitness Program Monthly credits available for use on gym memberships, fitness studio classes, at-home fitness accessories and equipment and unlimited access to premium digital wellness content.	$0 copay	$0 copay	$0 copay

^ PCP referral may be required.

* Prior authorization is required.

Important Message About What You Pay for Vaccines

Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Refer to your plan's Drug List or contact Member Services for coverage and cost-sharing details about specific vaccines.

Important Message About What You Pay for Insulin

You won't pay more than $35 for a one-month (up to 30-day) supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

If you qualify for "Extra Help", you could benefit from reduced cost sharing for the insulins covered under Part D. Please refer to your plan's drug list to find a comprehensive list of Part D insulins covered by your plan.

Prescription Drug Benefits (Part D):

Deductible Phase

Medicare Advantage (HMO)

No deductible for Tier 1, Tier 2, and Tier 6. This plan has a **$160** deductible for Tier 3, Tier 4, and Tier 5 drugs. You pay the full cost of these drugs, except for Part D covered insulins as noted above, until you reach **$160**. Then, you only pay your cost-share.

Medicare Advantage Classic (HMO) and Medicare Advantage Total Health (HMO)

No deductible.

Initial Coverage Phase (after you pay your deductible, if applicable)

You begin in this stage when you fill your first prescription of the year. You stay in the Initial Coverage Stage until your total drug costs for the year reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and your plan. Once you reach this amount, you will enter the Coverage Gap.

Coverage Gap

After you enter the coverage gap, you pay **25%** coinsurance of the plan's cost for covered brand name drugs and **25%** of the plan's cost for covered generic drugs until your out-of-pocket costs total **$8,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$8,000**, your cost for covered drugs will be $0.

	Medicare Advantage (HMO)		Medicare Advantage Classic (HMO)		Medicare Advantage Total Health (HMO)	
	Retail Cost Sharing (up to 30-day supply)	Mail Order Cost Sharing (90-day supply)	Retail Cost Sharing (up to 30-day supply)	Mail Order Cost Sharing (90-day supply)	Retail Cost Sharing (up to 30-day supply)	Mail Order Cost Sharing (90-day supply)
Tier 1: Preferred Generic	$4 copay (30-day supply)	$0 copay (90-day supply)	$2 copay (30-day supply)	$0 copay (90-day supply)	$2 copay (30-day supply)	$0 copay (90-day supply)
Tier 2: Generic	$12 copay (30-day supply)	$36 copay (90-day supply)	$10 copay (30-day supply)	$30 copay (90-day supply)	$10 copay (30-day supply)	$30 copay (90-day supply)
Tier 3: Preferred Brand	$42 copay (30-day supply)	$126 copay (90-day supply)	$40 copay (30-day supply)	$120 copay (90-day supply)	$40 copay (30-day supply)	$120 copay (90-day supply)
Tier 4: Non-Preferred Drugs	$100 copay (30-day supply)	$300 copay	$100 copay (30-day supply)	$300 copay (90-day supply)	$100 copay (30-day supply)	$300 copay (90-day supply)
Tier 5: Specialty	30% coinsurance	Not offered	33% coinsurance	Not offered	33% coinsurance	Not offered
Tier 6: Select Care Drugs	$0 copay (100-day supply)	$0 copay (100-day supply)	$0 copay (100-day supply)	$0 copay (100-day supply)	$0 copay (100-day supply)	$0 copay (100-day supply)
	Cost sharing may change when you enter another of the four phases of the Part D benefit.		Cost sharing may change when you enter another of the four phases of the Part D benefit.		Cost sharing may change when you enter another of the four phases of the Part D benefit.	

You pay the copays and coinsurance in the chart shown above until your total yearly drug costs reach **$5,030**.

When you get a 31- to 90-day supply of drugs in Tiers 1-4, the copays listed above in the chart will be multiplied as follows:
- If you get a 31- to 60 day supply from one of our retail pharmacies, (retail or mail order), you pay twice the copay amount.
- If you get a 61- to 90-day supply from one of our retail pharmacies, you pay three times the copay amount.

Notice of availability and nondiscrimination 888-850-8526 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ຕ່ຣະ ການບໍລິການ ຕ່ຣະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມຕ່ຣະບບບໍ່ເສຍຄ່າ.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

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, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, Premera Blue Cross Medicare Advantage Plans, PO Box 21481, Eagan, MN 55121, Phone: 888-850-8526, TTY: 711, Fax: 800-889-1076, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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.

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

PREMERA | BLUE CROSS
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