

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)

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](https://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., (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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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			
<p>Inpatient mental health care*</p> <p>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.</p> <p>You pay nothing if readmitted within 60 days of receiving inpatient mental health care.</p>	<p>\$390 copay per day: days 1-4</p> <p>\$0 copay per day: days 5-90</p>	<p>\$390 copay per day: days 1-4</p> <p>\$0 copay per day: days 5-90</p>	<p>\$390 copay per day: days 1-4</p> <p>\$0 copay per day: days 5-90</p>
Outpatient mental health care	<p>\$30 copay per visit</p> <p>\$20 copay per telehealth visit</p>	<p>\$30 copay per visit</p> <p>\$20 copay per telehealth visit</p>	<p>\$30 copay per visit</p> <p>\$20 copay per telehealth visit</p>
Skilled Nursing Facility*	<p>\$0 copay per day: days 1-20</p> <p>\$160 copay per day: days 21-60</p> <p>\$0 copay per day: days 61-100</p>	<p>\$0 copay per day: days 1-20</p> <p>\$160 copay per day: days 21-60</p> <p>\$0 copay per day: days 61-100</p>	<p>\$0 copay per day: days 1-20</p> <p>\$160 copay per day: days 21-60</p> <p>\$0 copay per day: days 61-100</p>
Physical Therapy	\$20 copay	\$10 copay	\$10 copay
<p>Ambulance*</p> <p>Prior authorization required only for non-emergencies.</p> <p>(per one-way trip)</p>	<p>\$300 copay for ground</p> <p>\$300 copay for air</p>	<p>\$275 copay for ground</p> <p>\$275 copay for air</p>	<p>\$275 copay for ground</p> <p>\$275 copay for air</p>

^ 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 Nondiscrimination

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, sex, gender identity, or sexual orientation. 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
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - 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, sex, gender identity, or sexual orientation, 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, 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>.

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

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-850-8526 (TTY/TDD: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-850-8526 (TTY/TDD: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-850-8526 (TTY/TDD: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-888-850-8526 (TTY/TDD: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-850-8526 (TTY/TDD: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-850-8526 (TTY/TDD: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-888-850-8526 (TTY/TDD: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-850-8526 (TTY/TDD: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-850-8526 (TTY/TDD: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-850-8526 (TTY/TDD: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (1-888-850-8526 (TTY/TDD: 711)). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-850-8526 (TTY/TDD: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-850-8526 (TTY/TDD: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-850-8526 (TTY/TDD: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-850-8526 (TTY/TDD: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-850-8526 (TTY/TDD: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-888-850-8526 (TTY/TDD: 711) にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。