2019

Summary of Benefits

Blue Advantage®
A Medicare Approved PPO

COMPLETE AND PREMIER

January 1, 2019 - December 31, 2019

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Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- 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)
- 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 our 1557 Compliance Coordinator. If you believe that we have 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 in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance 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 Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-630-6823 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-630-6823 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果┌使用繁體中文，┌可以免費獲得語言援助服務。請致電1-855-630-6823（TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-630-6823 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-630-6823 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-630-6823 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-630-6823 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-630-6823 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-630-6823 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-630-6823 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-630-6823 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-630-6823 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-630-6823 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-630-6823 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-630-6823 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-630-6823 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-630-6823 (TTY: 711).

Japanese: 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。1-855-630-6823（TTY: 711）まで、お電話にてご連絡ください。

2019 Summary of Benefits

Blue Advantage
A Medicare Approved PPO

Blue Advantage (PPO)

This is a summary of drug and health services covered by **Blue Advantage (PPO)**.

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

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio. This document may be available in a non-English language. For additional information, call us at **1-888-234-8266**.

How to Contact Blue Advantage (PPO)

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Central Time.
- From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. Central Time. From April 1 to September 30, on weekends and holidays you may be required to leave a message. Calls will be returned the next business day.

Blue Advantage (PPO) Phone Numbers and Website

- If you are a member of this plan, call toll-free **1-888-234-8266.** TTY users should call **711.**
- If you are not a member of this plan, call toll-free **1-888-873-4707.** TTY users should call **711.**
- Our website: **www.bcbsalmedicare.com**

Who can join?

To join **Blue Advantage (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes Alabama.

Which doctors, hospitals, and pharmacies can I use?

You can see our plan's provider directory and pharmacy directory at our website **https://bcbsalmedicare.com/sales/web/medicare/plans/blueadvantage/tools.html.**

What drugs do we cover?

You can see our plan's formulary (list of Part D prescription drugs) at our website **https://bcbsalmedicare.com/sales/web/medicare/plans/blueadvantage/benefits.**

- **Blue Advantage (PPO)** is a Medicare-approved PPO plan. Enrollment in **Blue Advantage (PPO)** depends on CMS contract renewal.
- This information is not a complete description of benefits. Call **1-888-234-8266 / TTY: 711** for more information.
- Out-of-network/non-contracted providers are under no obligation to treat **Blue Advantage (PPO)** members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.
- Limitations, co-payments, and restrictions may apply.
- Benefits, premiums, deductibles and co-payments/co-insurance may change on January 1 of each year.
- The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

TruHearing is an independent company offering exclusive hearing aid savings for Blue Cross and Blue Shield of Alabama members.

Premiums and Benefits	Blue Advantage Complete (PPO)	Blue Advantage Premier (PPO)
Monthly Plan Premium	$0 per month *(All Alabama counties)*	$159 per month *(All Alabama counties)*
	In addition, you must keep paying your Medicare Part B premium.	
Deductible	$0 for medical	$0 for medical
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	• $4,900 for services you receive from in-network providers. • $7,500 for services you receive from any provider.	• $3,400 for services you receive from in-network providers. • $5,100 for services you receive from any provider.
Inpatient Hospital	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-network:** • $215 copay per day for days 1 through 7 • You pay nothing per day for days 8 and beyond **Out-of-network:** 50% of the cost per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-network:** • $175 copay per day for days 1 through 5 • You pay nothing per day for days 6 and beyond **Out-of-network:** 50% of the cost per stay
Outpatient Hospital	**In-network:** $250 copay **Out-of-network:** 50% of the cost	**In-network:** $150 copay **Out-of-network:** 50% of the cost
Doctor Visits	*Primary care physician visit:* **In-network:** $10 copay **Out-of-network:** 50% of the cost *Specialist visit:* **In-network:** $40 copay **Out-of-network:** 50% of the cost	*Primary care physician visit:* **In-network:** $5 copay **Out-of-network:** 50% of the cost *Specialist visit:* **In-network:** $30 copay **Out-of-network:** 50% of the cost
Preventive Care	**In-network:** You pay nothing **Out-of-network:** 50% of the cost	**In-network:** You pay nothing **Out-of-network:** 50% of the cost
Emergency Care	$90 copay *If you are admitted to the hospital within 24 hours, you pay nothing.*	$120 copay *If you are admitted to the hospital within 24 hours, you pay nothing.*
Urgently Needed Services	$10 copay for Medicare-covered urgently needed Primary Care Physician visits $40 copay for Medicare-covered urgently needed Specialist visits	$5 copay for Medicare-covered urgently needed Primary Care Physician visits $30 copay for Medicare-covered urgently needed Specialist visits

Premiums and Benefits	Blue Advantage Complete (PPO)	Blue Advantage Premier (PPO)
Diagnostic Services/ Labs/Imaging	*Diagnostic radiology services (such as MRIs, CT scans):* **In-network:** $50 copay **Out-of-network:** 50% of the cost *Diagnostic tests and procedures:* **In-network:** You pay nothing **Out-of-network:** 50% of the cost *Lab services:* **In-network:** You pay nothing **Out-of-network:** 50% of the cost *Outpatient x-rays:* **In-network:** $15 copay **Out-of-network:** 50% of the cost *Therapeutic radiology services (such as radiation treatment for cancer):* **In-network:** $50 copay **Out-of-network:** 50% of the cost	*Diagnostic radiology services (such as MRIs, CT scans):* **In-network:** $25 copay **Out-of-network:** 50% of the cost *Diagnostic tests and procedures:* **In-network:** You pay nothing **Out-of-network:** 50% of the cost *Lab services:* **In-network:** You pay nothing **Out-of-network:** 50% of the cost *Outpatient x-rays:* **In-network:** $5 copay **Out-of-network:** 50% of the cost *Therapeutic radiology services (such as radiation treatment for cancer):* **In-network:** $50 copay **Out-of-network:** 50% of the cost
Hearing Services • Routine hearing exam • Hearing aid	*Medicare-covered hearing exam:* **In-network:** $10 copay **Out-of-network:** 50% of the cost *Routine hearing exam (for up to 1 every year):* **In-network:** You pay nothing **Out-of-network:** You pay nothing *Hearing Aids* $699 copay per aid for TruHearing Advanced $999 copay per aid for TruHearing Premium **Note:** TruHearing Provider must be used for in-network and out-of-network hearing aid benefit.	*Medicare-covered hearing exam:* **In-network:** $10 copay **Out-of-network:** 50% of the cost *Routine hearing exam (for up to 1 every year):* **In-network:** You pay nothing **Out-of-network:** You pay nothing *Hearing Aids* $699 copay per aid for TruHearing Advanced $999 copay per aid for TruHearing Premium **Note:** TruHearing Provider must be used for in-network and out-of-network hearing aid benefit.
Dental Services	*Medicare-covered dental exams:* **In-network:** $40 copay **Out-of-network:** 50% of the cost $250 allowance toward in-network and out-of-network preventive dental benefits annually.	*Medicare-covered dental exams:* **In-network:** $30 copay **Out-of-network:** 50% of the cost $250 allowance toward in-network and out-of-network preventive dental benefits annually.

Premiums and Benefits	Blue Advantage Complete (PPO)	Blue Advantage Premier (PPO)
Vision Services	*Medicare-covered eye exam:* **In-network:** $30 copay **Out-of-network:** 50% of the cost *Routine eye exam (for up to 1 every year):* **In-network:** You pay nothing **Out-of-network:** 50% of the cost *Eyeglasses or contact lenses after cataract surgery:* **In-network:** You pay nothing **Out-of-network:** 50% of the cost $100 allowance toward non-Medicare-covered prescription eyewear (glasses, lenses, frames, or contact lenses) per calendar year.	*Medicare-covered eye exam:* **In-network:** $30 copay **Out-of-network:** 50% of the cost *Routine eye exam (for up to 1 every year):* **In-network:** You pay nothing **Out-of-network:** 50% of the cost *Eyeglasses or contact lenses after cataract surgery:* **In-network:** You pay nothing **Out-of-network:** 50% of the cost $100 allowance toward non-Medicare-covered prescription eyewear (glasses, lenses, frames, or contact lenses) per calendar year.
Mental Health Services • Outpatient group therapy/individual therapy visit	**In-network:** $35 copay **Out-of-network:** 50% of the cost	**In-network:** $30 copay **Out-of-network:** 50% of the cost
Skilled Nursing Facility (SNF)	**In-network:** • You pay nothing per day for days 1 through 20 • $150 copay per day for days 21 through 54 • You pay nothing per day for days 55 through 100 **Out-of-network:** 50% of the cost per stay Our plan covers up to 100 days in a SNF.	**In-network:** • You pay nothing per day for days 1 through 20 • $100 copay per day for days 21 through 55 • You pay nothing per day for days 56 through 100 **Out-of-network:** 50% of the cost per stay Our plan covers up to 100 days in a SNF.
Physical Therapy	**In-network:** $40 copay **Out-of-network:** 50% of the cost **Note:** These services may require prior authorization.	**In-network:** $30 copay **Out-of-network:** 50% of the cost **Note:** These services may require prior authorization.
Ambulance	$200 copay	$150 copay
Transportation	Not Covered	Not Covered
Medicare Part B Drugs	*For Part B drugs such as chemotherapy drugs:* **In-network:** 20% of the cost **Out-of-network:** 50% of the cost *Other Part B drugs:* **In-network:** 20% of the cost **Out-of-network:** 50% of the cost	*For Part B drugs such as chemotherapy drugs:* **In-network:** 20% of the cost **Out-of-network:** 50% of the cost *Other Part B drugs:* **In-network:** 20% of the cost **Out-of-network:** 50% of the cost

Premiums and Benefits	Blue Advantage Complete (PPO)	Blue Advantage Premier (PPO)
Prescription Drug Benefits		
Medicare Part D Deductible	Your yearly deductible for Part D prescription drugs is $100 except for drugs listed on Tier 1, Tier 2, and Tier 6 which are excluded from the deductible.	Your yearly deductible for Part D prescription drugs is $0.

Initial Coverage

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

		Blue Advantage Complete (PPO)		Blue Advantage Premier (PPO)	
Standard Retail Cost-Sharing	**Tier**	**One-month supply**	**Three-month supply**	**One-month supply**	**Three-month supply**
	Tier 1 (Preferred Generic)	$10 copay	$30 copay	$10 copay	$30 copay
	Tier 2 (Generic)	$20 copay	$60 copay	$15 copay	$45 copay
	Tier 3 (Preferred Brand)	$47 copay	$141 copay	$47 copay	$141 copay
	Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	50% of the cost	50% of the cost
	Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	33% of the cost	33% of the cost
	Tier 6 (Select Care Drugs)	$2 copay	$6 copay	$2 copay	$6 copay

Prescription Drug Benefits (continued)

		Blue Advantage Complete (PPO)		Blue Advantage Premier (PPO)	
Mail Order and Preferred Retail Cost-Sharing	**Tier**	**One-month supply**	**Three-month supply**	**One-month supply**	**Three-month supply**
	Tier 1 (Preferred Generic)	$3 copay	$6 copay	$3 copay	$6 copay
	Tier 2 (Generic)	$13 copay	$26 copay	$8 copay	$16 copay
	Tier 3 (Preferred Brand)	$40 copay	$80 copay	$40 copay	$80 copay
	Tier 4 (Non-Preferred Drug)	45% of the cost	45% of the cost	45% of the cost	45% of the cost
	Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	33% of the cost	33% of the cost
	Tier 6 (Select Care Drugs)	$2 copay	$4 copay	$2 copay	$4 copay

If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. Cost-sharing may differ relative to the pharmacy's status as preferred or non-preferred, mail-order, Long Term Care (LTC) or home infusion, and 30-day or 90-day supply.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. You also pay a $2 copay for Tier 6 (Select Care Drugs) during this coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of:

- 5% of the cost, or
- $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs.

Notes

Blue Advantage (PPO) is a Medicare-approved PPO plan.
Enrollment in Blue Advantage (PPO) depends on CMS contract renewal.

BlueCross BlueShield of Alabama