BlueCross BlueShield of Illinois

Summary of Benefits

Blue Cross Medicare Advantage Basic (HMO)SM

Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM

Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM

January 1, 2023 – December 31, 2023

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."

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-774-8592 (TTY/TDD: 711). We are open from 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit getblueil.com/mapd or call 1-877-774-8592 to view a copy of the EOC.
- ☐ Review the *Provider Finder* (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the *Pharmacy Directory* to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the *Provider Directory*).

2023 Summary of Benefits

Blue Cross Medicare Advantage Basic (HMO)

January 1, 2023 - December 31, 2023

Blue Cross Medicare Advantage Basic Plus (HMO-POS)

Blue Cross Medicare Advantage Premier Plus (HMO-POS)

HMO and HMO-POS plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HMO plan provided by Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC). HCSC and ILBCBSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and ILBCBSIC are Medicare Advantage organizations with a Medicare contract. Enrollment in HCSC's and ILBCBSIC's 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 call 1-877-774-8592 (TTY 711) and request the "Evidence of Coverage" or access it online at getblueil.com/mapd.

To join **Blue Cross Medicare Advantage Basic (HMO)**, **Blue Cross Medicare Advantage Basic Plus (HMO-POS)** or **Blue Cross Medicare Advantage Premier Plus (HMO-POS)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Illinois: Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, and Will.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services unless otherwise noted in your Evidence of Coverage (EOC).

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), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

For more information, please call us at 1-877-774-8592 (TTY users should call 711). Hours are 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays, or visit us at getblueil.com/mapd.

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Monthly Plan Premium *(includes both medical and drugs)*	You pay $0 per month. In addition, you must keep paying your Medicare Part B premium.	You pay $0 per month. In addition, you must keep paying your Medicare Part B premium.	You pay $81.00 per month. In addition, you must keep paying your Medicare Part B premium.
Part B Premium Buy-down (if applicable)	This plan does not have a Part B Premium Buy-down.	This plan does not have a Part B Premium Buy-down.	This plan does not have a Part B Premium Buy-down.
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility *(does not include Part D prescription drugs)*	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. **Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.**		
	Your yearly limit(s) in this plan: • $2,500 for services you receive from in-network providers.	Your yearly limit(s) in this plan: • $3,450 for services you receive from in-network providers.	Your yearly limit(s) in this plan: • $2,900 for services you receive from in-network providers.

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM
Inpatient Hospital	**In-Network:** • $195 copay per day for days 1-7 and $0 copay per day for days 8-90 • $0 copay per day for days 91 and beyond **Out-of-Network:** • Not Covered	**In-Network:** • $220 copay per day for days 1-7 and $0 copay per day for days 8-90 • $0 copay per day for days 91 and beyond **Out-of-Network:** • 40% of the total cost per stay	**In-Network:** • $190 copay per day for days 1-8 and $0 copay per day for days 9-90 • $0 copay per day for days 91 and beyond **Out-of-Network:** • 40% of the total cost per stay
Outpatient Hospital	**In-Network:**$250 copay **Out-of-Network:** Not Covered	**In-Network:**$250 copay **Out-of-Network:** 40% of the total cost	**In-Network:**$225 copay **Out-of-Network:** 40% of the total cost
Ambulatory Surgical Center (ASC)	**In-Network:** $100 copay **Out-of-Network:** Not Covered	**In-Network:** $200 copay **Out-of-Network:** 40% of the total cost	**In-Network:** $175 copay **Out-of-Network:** 40% of the total cost

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Doctor Visits ◦ Primary care provider ◦ Specialists	**Primary care provider visit** ◦ **In-Network:**$0 copay ◦ **Out-of-Network:** Not Covered **Specialists** ◦ **In-Network:**$25 copay ◦ **Out-of-Network:** Not Covered	**Primary care provider visit** ◦ **In-Network:**$0 copay ◦ **Out-of-Network:** $60 copay **Specialists** ◦ **In-Network:**$35 copay ◦ **Out-of-Network:** $75 copay	**Primary care provider visit** ◦ **In-Network:**$0 copay ◦ **Out-of-Network:** $60 copay **Specialists** ◦ **In-Network:**$30 copay ◦ **Out-of-Network:** $75 copay
Preventive Care (e.g., flu vaccine, diabetic screenings)	**In-Network:** $0 copay **Out-of-Network:** Not Covered **Important Message About What You Pay for Vaccines** Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.	**In-Network:** $0 copay **Out-of-Network:**$60 copay **Important Message About What You Pay for Vaccines** Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.	**In-Network:** $0 copay **Out-of-Network:**$60 copay **Important Message About What You Pay for Vaccines** Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.
	*Other preventive services are available. There are some covered services that have a cost. Please reference EOC for more detail.		

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM
Emergency Care	$120 copay per visit Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital" section of this booklet for other costs.	$120 copay per visit Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital" section of this booklet for other costs.	$90 copay per visit Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital" section of this booklet for other costs.
Urgently Needed Services	$25 copay per visit	$30 copay per visit	$30 copay per visit

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Diagnostic Services/ Labs/Imaging ◦ MRI, CAT Scan X-Rays ◦ Diagnostic tests and procedures ◦ Lab services	**Diagnostic radiology services (such as MRIs, CT scans)** **In-Network:** • $125 copay at a free-standing clinic, $175 copay for services in an outpatient hospital setting **Out-of-Network:** • Not Covered **Diagnostic tests and procedures** **In-Network:** • $0 - $50 copay **Out-of-Network:** • Not Covered **Lab services** **In-Network:** • $0 copay **Out-of-Network:** • Not Covered **Outpatient X-rays** **In-Network:**	**Diagnostic radiology services (such as MRIs, CT scans)** **In-Network:** • $175 copay at a free-standing clinic, $225 copay for services in an outpatient hospital setting **Out-of-Network:** • 40% of the total cost **Diagnostic tests and procedures** **In-Network:** • $0 - $50 copay **Out-of-Network:** • 40% of the total cost **Lab services** **In-Network:** • $0 copay **Out-of-Network:** • 40% of the total cost **Outpatient X-rays** **In-Network:**	**Diagnostic radiology services (such as MRIs, CT scans)** **In-Network:** • $150 copay at a free-standing clinic, $200 copay for services in an outpatient hospital setting **Out-of-Network:** • 40% of the total cost **Diagnostic tests and procedures** **In-Network:** • $0 - $50 copay **Out-of-Network:** • 40% of the total cost **Lab services** **In-Network:** • $0 copay **Out-of-Network:** • 40% of the total cost **Outpatient X-rays** **In-Network:**

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
	• $0 copay **Out-of-Network:** • Not Covered **Therapeutic radiology services (such as radiation treatment for cancer)** **In-Network:** • 20% of the total cost **Out-of-Network:** • Not Covered	• $0 copay **Out-of-Network:** • 40% of the total cost **Therapeutic radiology services (such as radiation treatment for cancer)** **In-Network:** • 20% of the total cost **Out-of-Network:** • 40% of the total cost	• $0 copay **Out-of-Network:** • 40% of the total cost **Therapeutic radiology services (such as radiation treatment for cancer)** **In-Network:** • 20% of the total cost **Out-of-Network:** • 40% of the total cost

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Hearing Services ◦ Medicare-covered hearing exam ◦ Routine hearing exam ◦ Hearing aid	**Exam to diagnose and treat hearing and balance issues** **In-Network:** • $35 copay **Out-of-Network:** • Not Covered **Routine hearing exam** **In-Network** • $0 copay for 1 routine hearing exam each year **Out-of-Network:** • Not Covered **Hearing aid fitting/evaluation** **In-Network:** • $0 copay • Purchase includes unlimited provider visits for fitting and adjustments within 12 months of purchase of hearing aids. **Out-of-Network:** • Not Covered	**Exam to diagnose and treat hearing and balance issues** **In-Network:** • $5 copay **Out-of-Network:** • 40% of the total cost **Routine hearing exam** • Not Covered **Hearing aid fitting/evaluation** • Not Covered	**Exam to diagnose and treat hearing and balance issues** **In-Network:** • $5 copay **Out-of-Network:** • 40% of the total cost **Routine hearing exam** **In-Network** • $0 copay for 1 routine hearing exam each year **Out-of-Network:** • Not Covered **Hearing aid fitting/evaluation** **In-Network:** • $0 copay • Purchase includes unlimited provider visits for fitting and adjustments within 12 months of purchase of hearing aids. **Out-of-Network:** • Not Covered

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
	Hearing aids **In-Network:** • $699 to $999 copay for up to 1 per ear per year **Out-of-Network** • Not Covered	**Hearing Aids** • Not Covered	**Hearing aids** **In-Network:** • $699 to $999 copay for up to 1 per ear per year **Out-of-Network** • Not Covered

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Dental Services ◦ Medicare-covered dental ◦ Preventive Dental ◦ Supplemental Dental Services	**Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)** **In-Network:** • $35 copay **Out-of-Network:** • Not Covered **Preventive dental services** **Cleanings** **In-Network and Out-of-Network:** • $0 copay for up to 2 cleaning(s) per year **Dental X-rays** **In-Network and Out-of-Network:** • $0 copay for up to 1 bitewing X-ray per year	**Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)** **In-Network:** • $35 copay **Out-of-Network:** • 40% of the total cost **Preventive dental services** **Cleanings** **In-Network and Out-of-Network:** • $0 copay for up to 2 cleaning(s) per year **Dental X-rays** **In-Network and Out-of-Network:** • $0 copay for up to 1 bitewing X-ray per year	**Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)** **In-Network:** • $45 copay **Out-of-Network:** • 40% of the total cost **Preventive dental services** **Cleanings** **In-Network and Out-of-Network:** • $0 copay for up to 2 cleaning(s) per year **Dental X-rays** **In-Network and Out-of-Network:** • $0 copay for up to 1 bitewing X-ray per year

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
	Oral exams **In-Network and Out-of-Network:** • $0 copay for up to 2 oral exam(s) per year **Comprehensive dental services** **In-Network and Out-of-Network:** • $2,000 annual maximum coverage. For more details on benefits and benefit limitations regarding your dental coverage, please see your Evidence of Coverage.	**Oral exams** **In-Network and Out-of-Network:** • $0 copay for up to 2 oral exam(s) per year **Comprehensive dental services** • Not Covered	**Oral exams** **In-Network and Out-of-Network:** • $0 copay for up to 2 oral exam(s) per year **Comprehensive dental services** **In-Network and Out-of-Network:** • $1,000 annual maximum coverage. For more details on benefits and benefit limitations regarding your dental coverage, please see your Evidence of Coverage.

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Vision Services ◦ Medicare-covered eye exam ◦ Medicare-covered eyewear ◦ Routine eye exam ◦ Routine eyewear	**Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)** **In-Network:** • $0 copay for Medicare-covered eye exam; $0 copay for one vision specialist exam **Out-of-Network:** • Not Covered **Routine eye exam** **In-Network:** • $0 copay for 1 routine eye exam every year **Out-of-Network:** • Not Covered	**Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)** **In-Network:** • $0 copay for Medicare-covered eye exam; $0 copay for one vision specialist exam **Out-of-Network:** • 40% of the total cost **Routine eye exam** **In-Network:** • $0 copay for 1 routine eye exam every year **Out-of-Network:** • Not Covered	**Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)** **In-Network:** • $0 copay for Medicare-covered eye exam; $0 copay for one vision specialist exam **Out-of-Network:** • 40% of the total cost **Routine eye exam** **In-Network:** • $0 copay for 1 routine eye exam every year **Out-of-Network:** • Not Covered

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
	Eyeglasses or contact lenses after cataract surgery **In-Network:** • $35 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **Out-of-Network:** • Not Covered **Routine eye wear** **Contact lenses** **In-Network** • $0 copay **Eyeglass frames** **In-Network** • $0 copay for 1 pair of eyeglass frames every year	**Eyeglasses or contact lenses after cataract surgery** **In-Network:** • $35 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **Out-of-Network:** • 40% of the total cost for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **Routine eye wear** • Not covered	**Eyeglasses or contact lenses after cataract surgery** **In-Network:** • $0 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **Out-of-Network:** • 40% of the total cost for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery **Routine eye wear** **Contact lenses** **In-Network** • $0 copay **Eyeglass frames** **In-Network** • $0 copay for 1 pair of eyeglass frames every year

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
	Eyeglass lenses **In-Network** • $0 copay for 1 pair of eyeglass lenses every year (Standard lenses only. Progressive lenses excluded) $200 maximum plan coverage limited in-network for routine eye wear every year (including eyeglass frames, lenses, and contact lenses)		**Eyeglass lenses** **In-Network** • $0 copay for 1 pair of eyeglass lenses every year (Standard lenses only. Progressive lenses excluded) $200 maximum plan coverage limited in-network for routine eye wear every year (including eyeglass frames, lenses, and contact lenses)

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Mental Health Services ◦ Inpatient mental health ◦ Outpatient group therapy/ individual therapy visit	**Inpatient visit** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.		
	In-Network: • $260 copay per day for days 1-7 and a $0 copay per day for days 8-90 **Out-of-Network:** • Not Covered **Outpatient group therapy visit** **In-Network:** • $30 copay **Out-of-Network:** • Not Covered	**In-Network:** • $215 copay per day for days 1-7 and a $0 copay per day for days 8-90 **Out-of-Network:** • 40% of the total cost per stay **Outpatient group therapy visit** **In-Network:** • $30 copay **Out-of-Network:** • 40% of the total cost	**In-Network:** • $225 copay per day for days 1-7 and a $0 copay per day for days 8-90 **Out-of-Network:** • 40% of the total cost per stay **Outpatient group therapy visit** **In-Network:** • $30 copay **Out-of-Network:** • 40% of the total cost

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
	Outpatient individual therapy visit **In-Network:** • $30 copay **Out-of-Network:** • Not Covered	**Outpatient individual therapy visit** **In-Network:** • $30 copay **Out-of-Network:** • 40% of the total cost	**Outpatient individual therapy visit** **In-Network:** • $30 copay **Out-of-Network:** • 40% of the total cost
Skilled Nursing Facility (SNF)	**Our plan covers up to 100 days in a SNF.** Inpatient hospital stay is not required prior to admission. **In-Network:** $0 copay per day for days 1-20. $196 copay per day for days 21-39. $0 copay per day for days 40-100. **Out-of-Network:** Not Covered	**Our plan covers up to 100 days in a SNF.** Inpatient hospital stay is not required prior to admission. **In-Network:** $0 copay per day for days 1-20. $196 copay per day for days 21-39. $0 copay per day for days 40-100. **Out-of-Network:** 40% of the total cost per stay	**Our plan covers up to 100 days in a SNF.** Inpatient hospital stay is not required prior to admission. **In-Network:** $0 copay per day for days 1-20. $196 copay per day for days 21-39. $0 copay per day for days 40-100. **Out-of-Network:** 40% of the total cost per stay
Physical Therapy	**In-Network:** $35 copay **Out-of-Network:** Not Covered	**In-Network:** $40 copay **Out-of-Network:** 40% of the total cost	**In-Network:** $40 copay **Out-of-Network:** 40% of the total cost

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Outpatient Rehabilitation	**Cardiac (heart) rehab services** (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks) **In-Network:** • $30 copay **Out-of-Network:** • Not Covered **Occupational therapy visit** **In-Network:** • $35 copay **Out-of-Network:** • Not Covered	**Cardiac (heart) rehab services** (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks) **In-Network:** • $30 copay **Out-of-Network:** • 40% of the total cost **Occupational therapy visit** **In-Network:** • $35 copay **Out-of-Network:** • 40% of the total cost	**Cardiac (heart) rehab services** (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks) **In-Network:** • $30 copay **Out-of-Network:** • 40% of the total cost **Occupational therapy visit** **In-Network:** • $35 copay **Out-of-Network:** • 40% of the total cost
Ambulance	**In-Network:** $250 copay for each one-way ground transportation trip,20% of the total cost for each one-way air transportation trip. **Out-of-Network:** Not Covered	**In-Network:** $250 copay for each one-way ground transportation trip,20% of the total cost for each one-way air transportation trip. **Out-of-Network:**$250 copay for each one-way ground transportation trip, 20% of the total cost for each one-way air transportation trip.	**In-Network:** $225 copay for each one-way ground transportation trip,20% of the total cost for each one-way air transportation trip. **Out-of-Network:**$225 copay for each one-way ground transportation trip, 20% of the total cost for each one-way air transportation trip.

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Transportation	$0 copay for up to 12 one-way trips every year to plan-approved locations.	$0 copay for up to 24 one-way trips every year to plan-approved locations.	$0 copay for up to 12 one-way trips every year to plan-approved locations.
Medicare Part B Drugs	**In-Network:** 20% of the total cost for chemotherapy drugs. 20% of the total cost for other Part B drugs **Out-of-Network:** Not Covered	**In-Network:** 20% of the total cost for chemotherapy drugs. 20% of the total cost for other Part B drugs **Out-of-Network:** 40% of the total cost for chemotherapy drugs. 40% of the total cost for other Part B drugs	**In-Network:** 20% of the total cost for chemotherapy drugs. 20% of the total cost for other Part B drugs **Out-of-Network:** 40% of the total cost for chemotherapy drugs. 40% of the total cost for other Part B drugs

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]			
Outpatient Prescription Drugs				
Deductible	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you. You begin in the Initial Coverage Stage when you fill your first prescription of the year. **Important Message About What You Pay for Insulin** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.			
	Preferred Retail Rx 30-day supply	Standard Retail Rx 30-day supply	Preferred Mail Order 90-day supply	Standard Mail Order 90-day supply
Initial Coverage				
Tier 1: Preferred Generic	$0 copay	$10 copay	$0 copay	$20 copay
Tier 2: Generic	$10 copay	$20 copay	$20 copay	$40 copay
Tier 3: Preferred Brand	$47 copay	$47 copay	$94 copay	$94 copay
Tier 4: Non-Preferred Drug	$100 copay	$100 copay	$300 copay	$300 copay
Tier 5: Specialty Tier *If you reside in a long-term facility, you pay the same as at a standard retail pharmacy.	33% of the total cost	33% of the total cost	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)SM
Outpatient Prescription Drugs	
Coverage Gap	Your plan provides additional coverage through the gap. For Tier 1, you continue to pay the same amounts as you did in the Initial Coverage Stage. Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under your plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.

Premiums and Benefits	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM			
Outpatient Prescription Drugs				
Deductible	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you. You begin in the Initial Coverage Stage when you fill your first prescription of the year. **Important Message About What You Pay for Insulin** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.			
	Preferred Retail Rx 30-day supply	Standard Retail Rx 30-day supply	Preferred Mail Order 90-day supply	Standard Mail Order 90-day supply
Initial Coverage				

Premiums and Benefits	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]			
Outpatient Prescription Drugs				
Tier 1: Preferred Generic	$0 copay	$10 copay	$0 copay	$20 copay
Tier 2: Generic	$10 copay	$20 copay	$20 copay	$40 copay
Tier 3: Preferred Brand	$47 copay	$47 copay	$94 copay	$94 copay
Tier 4: Non-Preferred Drug	$100 copay	$100 copay	$300 copay	$300 copay
Tier 5: Specialty Tier *If you reside in a long-term facility, you pay the same as at a standard retail pharmacy.	33% of the total cost	33% of the total cost	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Coverage Gap	Your plan provides additional coverage through the gap. For Tier 1, you continue to pay the same amounts as you did in the Initial Coverage Stage. Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under your plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.			

Premiums and Benefits	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]			
Outpatient Prescription Drugs				
Deductible	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you. You begin in the Initial Coverage Stage when you fill your first prescription of the year. **Important Message About What You Pay for Insulin** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.			
	Preferred Retail Rx 30-day supply	Standard Retail Rx 30-day supply	Preferred Mail Order 90-day supply	Standard Mail Order 90-day supply
Initial Coverage				
Tier 1: Preferred Generic	$0 copay	$10 copay	$0 copay	$20 copay
Tier 2: Generic	$10 copay	$20 copay	$20 copay	$40 copay
Tier 3: Preferred Brand	$47 copay	$47 copay	$94 copay	$94 copay
Tier 4: Non-Preferred Drug	$100 copay	$100 copay	$300 copay	$300 copay
Tier 5: Specialty Tier *If you reside in a long-term facility, you pay the same as at a standard retail pharmacy.	33% of the total cost	33% of the total cost	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

Premiums and Benefits	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Outpatient Prescription Drugs	
Coverage Gap	Your plan provides additional coverage through the gap. For Tier 1, you continue to pay the same amounts as you did in the Initial Coverage Stage. Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under your plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.

Premiums and Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Outpatient Prescription Drugs			
Catastrophic Coverage *(after you or others on your behalf pay $7,400)* ◦ Generic Drugs ◦ Brand-Name Drugs	**Generic Drugs:** • You pay $4.15 or 5% (whichever costs more) **Brand-Name Drugs:** • You pay $10.35 or 5% (whichever costs more)	**Generic Drugs:** • You pay $4.15 or 5% (whichever costs more) **Brand-Name Drugs:** • You pay $10.35 or 5% (whichever costs more)	**Generic Drugs:** • You pay $4.15 or 5% (whichever costs more) **Brand-Name Drugs:** • You pay $10.35 or 5% (whichever costs more)
Cost-Sharing may change depending on the pharmacy you choose.			

Additional Member Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Acupuncture for Chronic Low Back Pain	**In-Network:** • $25 copay **Out-of-Network:** • Not Covered	**In-Network:** • $35 copay **Out-of-Network:** • $75 copay	**In-Network:** • $30 copay **Out-of-Network:** • $75 copay
Chiropractic Care	**Medicare-covered manipulation of the spine to correct a subluxation** (when 1 or more of the bones of your spine move out of position) **In-Network:** • $20 copay **Out-of-Network:** • Not Covered	**Medicare-covered manipulation of the spine to correct a subluxation** (when 1 or more of the bones of your spine move out of position) **In-Network:** • $20 copay **Out-of-Network:** • 40% of the total cost	**Medicare-covered manipulation of the spine to correct a subluxation** (when 1 or more of the bones of your spine move out of position) **In-Network:** • $20 copay **Out-of-Network:** • 40% of the total cost

Additional Member Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Diabetes Supplies and Services - Diabetes Monitoring Supplies - Diabetes self-management training - Therapeutic shoes or inserts	**Diabetes monitoring supplies** **In-Network:** 0% or 35% of the total cost **Out-of-Network:** Not Covered **Diabetes self-management training** **In-Network:** $0 copay **Out-of-Network:** Not Covered **Therapeutic shoes or inserts** **In-Network:** 35% of the total cost **Out-of-Network:** Not Covered	**Diabetes monitoring supplies** **In-Network:** 0% or 20% of the total cost **Out-of-Network:** 20% of the total cost **Diabetes self-management training** **In-Network:** $0 copay **Out-of-Network:**40% of the total cost **Therapeutic shoes or inserts** **In-Network:** 20% of the total cost **Out-of-Network:**20% of the total cost	**Diabetes monitoring supplies** **In-Network:** 0% or 20% of the total cost **Out-of-Network:** 20% of the total cost **Diabetes self-management training** **In-Network:** $0 copay **Out-of-Network:**40% of the total cost **Therapeutic shoes or inserts** **In-Network:** 20% of the total cost **Out-of-Network:**20% of the total cost
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	**In-Network:** • 20% of the total cost **Out-of-Network:** • Not Covered	**In-Network:** • 20% of the total cost **Out-of-Network:** • 20% of the total cost	**In-Network:** • 20% of the total cost **Out-of-Network:** • 20% of the total cost

Additional Member Benefits	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM
Wellness Programs	$0 copay for SilverSneakers® † Fitness Program This benefit includes SilverSneakers instructor-led group fitness classes. At participating locations, you can take classes plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms. SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and a mobile app, SilverSneakers GO™. Plus, you get access to GetSetUp3, with thousands of live online classes to ignite your interests in topics like cooking, technology and art. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. 1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. 3. GetSetUp is a third-party service provider and is not owned or operated by Tivity Health, Inc. ("Tivity") or its affiliates. Users must have internet service to access GetSetUp service. Internet service charges are responsibility of user. Charges may apply for access to certain GetSetUp classes or functionality. Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. †SilverSneakers, SilverSneakers FLEX, SilverSneakers On-Demand, and SilverSneakers GO are registered trademarks or trademarks of Tivity Health, Inc.		

Additional Member Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Foot Care *(podiatry services)*	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions** **In-Network:** • $35 copay **Out-of-Network:** • Not Covered	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions** **In-Network:** • $40 copay **Out-of-Network:** • 40% of the total cost	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions** **In-Network:** • $40 copay **Out-of-Network:** • 40% of the total cost
Home Health Care	**In-Network:** • $0 copay **Out-of-Network:** • Not Covered	**In-Network:** • $0 copay **Out-of-Network:** • 40% of the total cost	**In-Network:** • $0 copay **Out-of-Network:** • 40% of the total cost
Opioid Treatment Program Services	**In-Network:** • $25 copay **Out-of-Network:** • Not Covered	**In-Network:** • $35 copay **Out-of-Network:** • $75 copay	**In-Network:** • $30 copay **Out-of-Network:** • $75 copay

Additional Member Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Outpatient Substance Abuse Services	**Group therapy visit** **In-Network:** • $75 copay **Out-of-Network:** • Not Covered **Individual therapy visit** **In-Network:** • $75 copay **Out-of-Network:** • Not Covered	**Group therapy visit** **In-Network:** • $75 copay **Out-of-Network:** • 40% of the total cost **Individual therapy visit** **In-Network:** • $75 copay **Out-of-Network:** • 40% of the total cost	**Group therapy visit** **In-Network:** • $75 copay **Out-of-Network:** • 40% of the total cost **Individual therapy visit** **In-Network:** • $75 copay **Out-of-Network:** • 40% of the total cost
Over-the-Counter Items	• $70 allowance every three months for specific over-the-counter drugs and other health-related products. Unused OTC amounts do not roll over to the next calendar year.	• $105 allowance every three months for specific over-the-counter drugs and other health-related products. Unused OTC amounts do not roll over to the next calendar year.	• $75 allowance every three months for specific over-the-counter drugs and other health-related products. Unused OTC amounts do not roll over to the next calendar year.

Additional Member Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Prosthetic Devices *(braces, artificial limbs, etc.)*	**Prosthetic devices** **In-Network:** • 20% of the total cost **Out-of-Network:** • Not Covered **Related medical supplies** **In-Network:** • 20% of the total cost **Out-of-Network:** • Not Covered	**Prosthetic devices** **In-Network:** • 20% of the total cost **Out-of-Network:** • 20% of the total cost **Related medical supplies** **In-Network:** • 20% of the total cost **Out-of-Network:** • 20% of the total cost	**Prosthetic devices** **In-Network:** • 20% of the total cost **Out-of-Network:** • 20% of the total cost **Related medical supplies** **In-Network:** • 20% of the total cost **Out-of-Network:** • 20% of the total cost
Meals	• 2 meals per day for 7 days. Limited to one time per year.	• 2 meals per day for 7 days. Limited to one time per year.	• 2 meals per day for 7 days. Limited to one time per year.
Renal Dialysis	**In-Network:** • 20% of the total cost **Out-of-Network:** • Not Covered	**In-Network:** • 20% of the total cost **Out-of-Network:** • 40% of the total cost	**In-Network:** • 20% of the total cost **Out-of-Network:** • 40% of the total cost
Telehealth Services	**In-Network:** • $0 copay for urgent care visits through MDLive	**In-Network:** • $0 copay for urgent care visits through MDLive	**In-Network:** • $0 copay for urgent care visits through MDLive

Additional Member Benefits	Blue Cross Medicare Advantage Basic (HMO)[SM]	Blue Cross Medicare Advantage Basic Plus (HMO-POS)[SM]	Blue Cross Medicare Advantage Premier Plus (HMO-POS)[SM]
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

Optional Supplemental Benefits	Blue Cross Medicare Advantage Basic (HMO)SM	Blue Cross Medicare Advantage Basic Plus (HMO-POS)SM	Blue Cross Medicare Advantage Premier Plus (HMO-POS)SM
OSB Package ◦ Monthly Premium	• You pay additional $31.60 per month ◦ Dental	• You pay additional $32.80 per month ◦ Vision ◦ Dental ◦ Hearing	• You pay additional $36.60 per month ◦ Dental

BlueCross BlueShield of Illinois

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

Blue Cross and Blue Shield of Illinois:

- 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 a Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois 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, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960. You can file a grievance by phone, mail, or fax. If you need help filing a grievance, a 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 Avenue, 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.

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 1-877-774-8592 (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 1-877-774-8592 (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 1-877-774-8592 (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 1-877-774-8592 (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 1-877-774-8592 (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 1-877-774-8592 (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 quí vị cần thông dịch viên xin gọi 1-877-774-8592 (TTY/TDD: 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phi.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-774-8592 (TTY/TDD: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-774-8592 (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 1-877-774-8592 (TTY/TDD: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: سيقوم شخص ما يتحدث العربية إإننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول 1-877-774-8592 (TTY/TDD: 711). بمساعدتك. هذه خدمة مجانية على مترجم فوري، ليس عليك سوى الاتصال بنا على

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 1-877-774-8592 (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 1-877-774-8592 (TTY/TDD: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-877-774-8592 (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 1-877-774-8592 (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 1-877-774-8592 (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ございます。通訳をご用命になるには、1-877-774-8592 (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。

BlueCross BlueShield of Illinois

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Medicare 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.

This information is not a complete description of benefits. Call 1-877-774-8592 (TTY: 711) for more information.

HMO and HMO-POS plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HMO plan provided by Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC). HCSC and ILBCBSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and ILBCBSIC are Medicare Advantage organizations with a Medicare contract. Enrollment in HCSC's and ILBCBSIC's plans depends on contract renewal.

Premium, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.