BlueCross BlueShield of Illinois

2024 Summary of Benefits

Blue Cross Medicare Advantage Choice Premier (PPO)[SM]

January 1, 2024 – December 31, 2024

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 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

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit getblueil.com/mapd or 1-877-774-8592 (TTY 711) to request 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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ 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, 2025.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not 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." You can also see the Evidence of Coverage on our website, getblueil.com/mapd.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Cross Medicare Advantage Choice Premier (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Blue Cross Medicare Advantage Choice Premier (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.
- 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 https://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.

Sections in this booklet

- Things to Know About **Blue Cross Medicare Advantage Choice Premier (PPO).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

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 1-877-774-8592 (TTY: 711).

Things to Know About Blue Cross Medicare Advantage Choice Premier (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. Local Time, 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 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.
- If you are a member of this plan, call us at 1-877-774-8592, TTY: 711.
- If you are not a member of this plan, call us at 1-877-213-1817, TTY: 711.
- Our website: getblueil.com/mapd.

Who can join?

To join **Blue Cross Medicare Advantage Choice Premier (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Illinois: Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry and Will.

Which doctors, hospitals, and pharmacies can I use?

Blue Cross Medicare Advantage Choice Premier (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's *Provider Finder* and *Pharmacy Directory* at our website (getblueil.com/mapd).

Or, call us at 1-877-774-8592 and we will send you a copy of the *Provider Directory* and *Pharmacy Directory*.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan *Formulary* (list of Part D prescription drugs) and any restrictions on our website, getblueil.com/mapd.
- Or, call us at 1-877-774-8592 and we will send you a copy of the *Formulary*.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Blue Cross and Blue Shield of Illinois

2 SECTION II - SUMMARY OF BENEFITS

Blue Cross Medicare Advantage Choice Premier (PPO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	You pay $135 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.
Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility	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: • $3,855 for services you receive from in-network providers. • $8,950 for services you receive from out-of-network providers. • $8,950 for services you receive from in and out-of-network providers combined.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	**In-Network:** Days 1-7: $250 copay per day. Days 8-90: $0 copay per day. $0 copay per day for days 91 and beyond **Out-of-Network:** $500 copay per day.
Outpatient Hospital	**In-Network:** $275 copay. **Out-of-Network:** $400 copay.

Ambulatory Surgical Center	**In-Network:** $175 copay. **Out-of-Network:** $350 copay.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 copay. Specialist visit: $40 copay. **Out-of-Network:** Primary care physician visit: $30 copay. Specialist visit: $75 copay.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. **Out-of-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Other preventive services are available. There are some covered services that have a cost. Please reference EOC for more detail. **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.
Emergency Care	$120 copay per visit. Worldwide Emergency Coverage: $120 copay. 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	$40 copay per visit. Worldwide Urgent Coverage: $120 copay.
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $0 - $100 copay. Lab services: $5 copay.

	Diagnostic Radiology Services (such as MRIs, CT scans): $0 - $200 copay. X-rays: $0 - $100 copay. Therapeutic radiology services (such as radiation treatment for cancer): $45 copay. **Out-of-Network:** Diagnostic tests and procedures: $0 - $200 copay. Lab services: $200 copay. Diagnostic Radiology Services (such as MRIs, CT scans): $0 - $400 copay. X-rays: $30 - $200 copay. Therapeutic radiology services (such as radiation treatment for cancer): 40% of the total cost.
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: $35 copay. Routine hearing exam (1 every year): $0 copay. Hearing aid fitting/evaluation: $0 copay Purchase includes unlimited provider visits for fitting and adjustments within 12 months of purchase of hearing aids. Hearing Aids: Benefit is limited to the TruHearing branded hearing aids. $699 copay per Advanced Aid or $999 copay per Premium Aid (1 per ear per year). **Out-of-Network:** Exam to diagnose and treat hearing and balance issues: $75 copay.
Dental Services	**In-Network:** Medicare-covered: $35 copay. **Out-of-Network:** Medicare-covered: $75 copay. **In-Network and Out-of-Network:** Preventive dental services: • Oral exam (2 every year): $0 copay. • Cleaning (2 every year): $0 copay. • Dental X-ray (1 every year): $0 copay. Comprehensive dental services:

	• $1,000 annual maximum coverage. For more details on benefits and benefit limitations regarding your dental coverage, please see your Evidence of Coverage.
Vision Services	**<u>In-Network:</u>** **<u>Medicare-covered:</u>** • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 copay for an eye exam; $0 copay for one vision specialist exam. • Eyeglasses or contact lenses after cataract surgery: $35 copay **<u>Routine Vision:</u>** • Routine eye exam (1 every year): $0 copay • Contact lenses: $0 copay • Eyeglass lenses (1 pair every year): $0 copay (Standard lenses only. Progressive lenses excluded.) • Eyeglass frames (1 pair every year): $0 copay • $100 maximum plan coverage combined in-network and out-of-network for routine eye wear every year (including eyeglass frames, lenses, and contact lenses). **<u>Out-of-Network:</u>** **<u>Medicare-covered:</u>** • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $75 copay for an eye exam; $75 copay for one vision specialist exam. • Eyeglasses or contact lenses after cataract surgery: $75 copay **<u>Routine Vision:</u>** • $40 allowance every year for 1 routine eye exam. • Contact lenses: $0 copay • Eyeglass lenses (1 pair every year): $0 copay (Standard lenses only. Progressive lenses excluded.) • Eyeglass frames (1 pair every year): $0 copay

	• $100 maximum plan coverage combined in-network and out-of-network for routine eye wear every year (including eyeglass frames, lenses, and contact lenses).
Mental Health Services	**In-Network:** 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. Inpatient Mental Health Care: Days 1-7: $225 copay per day. Days 8-90: $0 copay per day. Outpatient group therapy visit: $30 copay. Outpatient Individual therapy visit: $30 copay. **Out-of-Network:** Inpatient Mental Health Care: $500 copay per day. Outpatient group therapy visit: $50 copay. Outpatient Individual therapy visit: $50 copay.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 copay per day. Days 21-39: $203 copay per day. Days 40-100: $0 copay per day. **Out-of-Network:** $250 copay per day.
Physical Therapy	**In-Network:** $40 copay. **Out-of-Network:** $75 copay.

Outpatient Rehabilitation	**In-Network:** Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $30 copay. Occupational therapy visit: $40 copay. **Out-of-Network:** Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $75 copay. Occupational therapy visit: $75 copay.
Ambulance	Ground Ambulance: $225 copay for each one-way trip. Air Ambulance: 20% of the total cost for each one-way trip.
Transportation	$0 copay. 12 one-way trips every year to plan-approved locations.
Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% of the total cost. Other Part B drugs: 0% - 20% of the total cost. For Part B Insulin Drugs: 0% - 20% of the total cost with a maximum copay amount per month of $35. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 40% of the total cost. Other Part B drugs: 40% of the total cost. For Part B Insulin Drugs: 40% of the total cost with a maximum copay amount per month of $35.

PRESCRIPTION DRUG BENEFITS	
Deductible	Prescription Drug Deductible: This plan does not have a deductible. **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.

Initial Coverage

You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing		
Tier	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$15 copay	$45 copay
Tier 2 (Generic)	$20 copay	$60 copay
Tier 3 (Preferred Brand)	$47 copay	$141 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$300 copay
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable
Preferred Retail Cost-Sharing		
Tier	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay
Tier 2 (Generic)	$8 copay	$24 copay
Tier 3 (Preferred Brand)	$47 copay	$141 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$300 copay
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable
Standard Mail Order		
Tier	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$15 copay	$30 copay
Tier 2 (Generic)	$20 copay	$40 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$300 copay
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable
Preferred Mail Order		
Tier	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay
Tier 2 (Generic)	$8 copay	$16 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$300 copay
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable

If you reside in a long-term facility, you pay the same as at a standard retail pharmacy. We cover prescriptions filled at out-of-network pharmacies in only limited situations.

	Please call us or see the plan's **"Evidence of Coverage"** on our website (getblueil.com/mapd) for complete information about your costs for covered drugs.
Coverage Gap	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. 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 $8,000, which is the end of the coverage gap. Our plan covers Tier 1 Preferred Generics in the coverage gap. For Tier 1, you continue to pay the same amounts as you did in the Initial Coverage Stage.
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $8,000, you pay nothing for covered Part D drugs.

Additional Member Benefits	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
Acupuncture for Chronic Low Back Pain	**In-Network:** • $40 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:** • $75 copay
Diabetes Supplies and Services - Diabetes Monitoring Supplies - Diabetes self-management training - Therapeutic shoes or inserts	**In-Network:** **Diabetes monitoring supplies** • 0% or 20% of the total cost. **Diabetes self-management training** • $0 copay **Therapeutic shoes or inserts** • 20% of the total cost **Out-of-Network:** **Diabetes monitoring supplies** • 20% of the total cost **Diabetes self-management training** • $0 copay **Therapeutic shoes or inserts** • 20% of the total cost
Durable Medical Equipment	**In-Network:**

Additional Member Benefits	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
(wheelchairs, oxygen, etc.)	• 20% of the total cost **<u>Out-of-Network:</u>** • 20% of the total cost
Wellness Programs	$0 copay for SilverSneakers®† Fitness Program SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers online and at participating locations[1]. You have access to a nationwide network of participating locations where you can take classes[2] and use exercise equipment and other amenities. Enroll in as many locations as you like, at any time. You also have access to instructors who lead specially designed group exercise classes in-person and online, seven days a week. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers LIVE classes, SilverSneakers On-Demand videos and the SilverSneakers GO mobile app. Activate your free online account at SilverSneakers.com to view your SilverSneakers Member ID number, and all program features available to you at no additional cost. For additional questions, go to SilverSneakers.com 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. 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 is a registered trademark of Tivity Health, Inc. © 2023 Tivity Health, Inc. All rights reserved.
Foot Care ***(podiatry services)***	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions** **<u>In-Network:</u>** • $45 copay

Additional Member Benefits	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
	Out-of-Network: • $75 copay
Home Health Care	**In-Network:** • $0 copay **Out-of-Network:** • 40% of the total cost
Opioid Treatment Program Services	**In-Network:** • $40 copay **Out-of-Network:** • $75 copay
Outpatient Substance Abuse Services	**In-Network:** **Group therapy visit** • $75 copay **Individual therapy visit** • $75 copay **Out-of-Network:** **Group therapy visit** • $100 copay **Individual therapy visit** • $100 copay
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*	**In-Network:** **Prosthetic devices** • 20% of the total cost

Additional Member Benefits	Blue Cross Medicare Advantage Choice Premier (PPO)[SM]
	Related medical supplies • 20% of the total cost **Out-of-Network:** **Prosthetic devices** • 20% of the total cost **Related medical supplies** • 20% of the total cost
Meals	Not Covered
Renal Dialysis	**In-Network:** • 20% of the total cost **Out-of-Network:** • 40% of the total cost
Telehealth Services	• $0 copay for urgent care visits through MDLive
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.

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-877-774-8592 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-877-774-8592 (TTY: 711).

Blue Cross Medicare Advantage Choice Premier is a Local PPO plan with a Medicare contract. Enrollment in **Blue Cross Medicare Advantage Choice Premier** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Illinois members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

Health coverage is offered by Health Care Service Corporation.

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.

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

Hindi: हमारेस्वास्थ्य या दवा की योजना केबारेमेंआपकेकिसी भी प्रश्न केजवाब देनेकेलिए हमारेपास मुफ्त दुभाषिया सेवाएँउपलब्ध हैं. एक दुभाषिया प्राप्त करनेकेलिए, बस हमें 1-877-774-8592 (TTY/TDD: 711). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता हैआपकी 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。

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.

PPO plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC'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.

THANK YOU

Connect with us

Contact Information: 1-877-774-8592, TTY: 711

Organization Name: Blue Cross and Blue Shield of Illinois

Organization website: getblueil.com/mapd