BlueCross BlueShield of Montana

Summary of Benefits

Blue Cross Medicare Advantage Basic (HMO)SM

January 1, 2017 – December 31, 2017

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."

Y0096_BEN_MT_HMOSB17a Accepted 351921.0617

INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2017 - December 31, 2017

	Blue Cross Medicare Advantage Basic (HMO)SM
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 Basic (HMO)**).
Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what **Blue Cross Medicare Advantage Basic (HMO)** 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 http://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 http://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 Basic (HMO)** • 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 and large print. This document may be available in a non-English language. For additional information, call us at 1-877-774-8592 (TTY/TDD users should call 711). Es posible que este documento esté disponible en un idioma distinto al inglés. Para obtener información adicional, llame a servicio al cliente al 1-877-774-8592 (los usuarios de TTY/TDD deben llamar al 711).
Hours of Operation	Things to Know About **Blue Cross Medicare Advantage Basic (HMO)** • From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Mountain time. • From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Mountain time.

	Blue Cross Medicare Advantage Basic (HMO)SM
Phone Numbers and Website	• If you are a member of this plan, call toll-free 1-877-774-8592 (TTY/TDD users should call 711). • If you are not a member of this plan, call toll-free 1-866-549-8043 (TTY/TDD users should call 711). • Our website: www.getbluemt.com/mapd
Who can join?	To join **Blue Cross Medicare Advantage Basic (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Montana: Missoula.
Which doctors, hospitals, and pharmacies can I use?	**Blue Cross Medicare Advantage Basic (HMO)** 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. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's provider and pharmacy directory at our website www.getbluemt.com/mapd. Or, call us and we will send you a copy of the provider and pharmacy directories.
What do we cover?	Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*. **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less. **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as 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, www.getbluemt.com/mapd. Or, call us 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.

SUMMARY OF BENEFITS

January 1, 2017 - December 31, 2017

	Blue Cross Medicare Advantage Basic (HMO)[SM]
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
How much is the monthly premium?	$24.60 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $6,700 for services you receive from in-network providers. 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.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

	Blue Cross Medicare Advantage Basic (HMO)[SM]
COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.	
INPATIENT CARE	
Inpatient Hospital Care[1,2]	Our plan covers an unlimited number of days for an inpatient hospital stay. $250 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 You pay nothing per day for days 91 and beyond
OUTPATIENT CARE AND SERVICES	
Doctor's Office Visits[1,2]	Primary care physician visit: You pay nothing Specialist visit: $50 copay

	Blue Cross Medicare Advantage Basic (HMO)[SM]
Preventive Care[1,2]	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$75 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services	$30 copay

	Blue Cross Medicare Advantage Basic (HMO)[SM]
Diagnostic Tests, Lab and Radiology Services, and X-Rays ***(Costs for these services may vary based on place of service)*** [1,2]	Diagnostic radiology services (such as MRIs, CT scans): $225 copay Diagnostic tests and procedures: $0-50 copay, depending on the service Lab services: $5 copay Outpatient X-rays: $5 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost
Hearing Services	Exam to diagnose and treat hearing and balance issues: $35 copay
Dental Services[2]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $35 copay Dental services: You pay nothing for a single office visit that includes: Cleaning (for up to 2 every year) Dental x-ray(s) (for up to 1 every year) Oral exam (for up to 2 every year)
Vision Services[1]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 copay Routine eye exam (for up to 1 every year): $10 copay Contact lenses: $0 copay Eyeglass frames: $0 copay Eyeglass lenses (for up to 1 every year): $25 copay Eyeglasses or contact lenses after cataract surgery: $0 copay Our plan pays up to $175 every two years for contact lenses, eyeglass lenses, and eyeglass frames.

	Blue Cross Medicare Advantage Basic (HMO)[SM]
Mental Health Care[1,2]	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. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. $225 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 Outpatient group therapy visit: $40 copay Outpatient individual therapy visit: $40 copay
Skilled Nursing Facility (SNF)[1,2]	Our plan covers up to 100 days in a SNF. You pay nothing per day for days 1 through 20 $164.50 copay per day for days 21 through 100
Outpatient Rehabilitation[1,2]	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: $35 copay Physical therapy and speech and language therapy visit: $35 copay
Ambulance[1]	$275 copay
Transportation	Not covered
Foot Care *(podiatry services)*[1,2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $45 copay

	Blue Cross Medicare Advantage Basic (HMO)[SM]
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	20% of t cost
Wellness Programs	**The Silver&Fit®† Exercise and Healthy Aging Program** Silver&Fit is offered to eligible Medicare Beneficiaries. Authorized Silver&Fit Program Affiliates only. Members have the following choices available at no or low cost to them: • A fitness facility membership: You can go to a Silver&Fit fitness club or exercise center near you, or • A Home Fitness program: You can choose from 17 home fitness kits if you can't get to a fitness facility or want to work out at home. You can get 2 kits each year. Silver&Fit members can also access low-impact Silver&Fit classes focusing on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination; Healthy Aging classes (online or DVD); a quarterly newsletter; and web tools. Included
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost
Acupuncture	Not covered
Chiropractic Care[1,2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay
Diabetes Supplies and Services[1,2]	Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing 0% of the cost for diabetic test strips from a preferred manufacturer; 0% for other diabetic supplies (testing monitors, lancets, diabetic therapeutic shoes); 20% of the cost for diabetic test strips from a non-preferred manufacturer.
Home Health Care[1,2]	You pay nothing

The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). All programs and services are not available in all areas.

†Silver&Fit and the Silver&Fit logo are federally registered trademarks of ASH and used with permission herein.

	Blue Cross Medicare Advantage Basic (HMO)[SM]
Outpatient Substance Abuse[1,2]	Group therapy visit: $100 copay Individual therapy visit: $100 copay
Outpatient Surgery[1,2]	Ambulatory surgical center: $300 copay Outpatient hospital: $0-300 copay
Over-the-Counter Items	Please visit our website to see our list of covered over-the-counter items. $25 per month over-the-counter (OTC) purchase allowance: You will receive a card with a pre-funded monthly benefit allowance. With this allowance, you may purchase eligible OTC and health-related items (i.e. aspirin, cold & flu relief medications, and adhesive bandages) at any participating pharmacy.
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost
Renal Dialysis[1,2]	20% of the cost
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
PRESCRIPTION DRUG BENEFITS	
Initial Coverage	You pay the following until your total yearly drug costs reach $3,700. 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.

Standard Retail Cost-Sharing		
Tier	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$9 copay	$27 copay
Tier 2 (Generic)	$15 copay	$45 copay
Tier 3 (Preferred Brand)	$47 copay	$141 copay
Tier 4 (Non-Preferred Brand)	$99 copay	$297 copay
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost

	Blue Cross Medicare Advantage Basic (HMO)SM		
Initial Coverage (continued)	**Preferred Retail Cost-Sharing**		
	Tier	**One-month supply**	**Three-month supply**
	Tier 1 (Preferred Generic)	$0 copay	$0 copay
	Tier 2 (Generic)	$6 copay	$18 copay
	Tier 3 (Preferred Brand)	$39 copay	$117 copay
	Tier 4 (Non-Preferred Brand)	$85 copay	$255 copay
	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost
	Standard Mail Order Cost-Sharing		
	Tier	**Three-month supply**	
	Tier 1 (Preferred Generic)	$27 copay	
	Tier 2 (Generic)	$45 copay	
	Tier 3 (Preferred Brand)	$141 copay	
	Tier 4 (Non-Preferred Brand)	$297 copay	
	Tier 5 (Specialty Tier)	33% of the cost	
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.		

<table>
<tr><th></th><th colspan="4">Blue Cross Medicare Advantage Basic (HMO)SM</th></tr>
<tr><td>Coverage Gap</td><td colspan="4">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 $3,700.
After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Under this 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. See the chart that follows to find out how much it will cost you.</td></tr>
<tr><td></td><td colspan="4">Standard Retail Cost-Sharing</td></tr>
<tr><td></td><td>Tier</td><td>Drugs Covered</td><td>One-month supply</td><td>Three-month supply</td></tr>
<tr><td></td><td>Tier 1 (Preferred Generic)</td><td>All</td><td>$9 copay</td><td>$27 copay</td></tr>
<tr><td></td><td>Tier 2 (Generic)</td><td>All</td><td>$15 copay</td><td>$45 copay</td></tr>
<tr><td></td><td colspan="4">Preferred Retail Cost-Sharing</td></tr>
<tr><td></td><td>Tier</td><td>Drugs Covered</td><td>One-month supply</td><td>Three-month supply</td></tr>
<tr><td></td><td>Tier 1 (Preferred Generic)</td><td>All</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td></td><td>Tier 2 (Generic)</td><td>All</td><td>$6 copay</td><td>$18 copay</td></tr>
<tr><td></td><td colspan="4">Standard Mail Order Cost-Sharing</td></tr>
<tr><td></td><td>Tier</td><td>Drugs Covered</td><td colspan="2">Three-month supply</td></tr>
<tr><td></td><td>Tier 1 (Preferred Generic)</td><td>All</td><td colspan="2">$27 copay</td></tr>
<tr><td></td><td>Tier 2 (Generic)</td><td>All</td><td colspan="2">$45 copay</td></tr>
<tr><td>Catastrophic Coverage</td><td colspan="4">After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of:
• 5% of the cost, or
• $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.</td></tr>
</table>

BlueCross BlueShield of Montana

Blue Cross and Blue Shield of Montana 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 Montana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Montana:

- 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 Civil Rights Coordinator

If you believe that Blue Cross and Blue Shield of Montana 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, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, 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.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-774-8592 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-774-8592 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-774-8592 (TTY: 711) 。

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。 1-877-774-8592 (TTY: 711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-774-8592 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-774-8592 (ATS: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-774-8592 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. <1-877-774-8592> (TTY: 711) 번으로 전화해 주십시오.

لحوظ: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل رقم 1-877-774-8592 (رقم هاتف الصم والبكم: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-774-8592 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg.
Ring 1-877-774-8592 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-877-774-8592 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-774-8592 (телетайп: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-774-8592 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero 1-877-774-8592 (TTY: 711).

BlueCross BlueShield of Montana

This information is available for free in other languages. Please call our Customer Service number at 1-877-774-8592 (TTY/TDD users should call 711). We are open between 8:00 a.m. and 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Esta información está disponible en otros idiomas de forma gratuita. Comuníquese a nuestro número de Servicio al cliente al 1-877-774-8592 (los usuarios de TTY/TDD deben llamar al 711). Nuestro horario es de 8:00 a.m. a 8:00 p.m., hora local, los 7 días de la semana. Si usted llama del 15 de febrero al 30 de septiembre, durante los fines de semana y feriados, se usarán tecnologías alternas (por ejemplo, correo de voz).

You must continue to pay your Medicare Part B premium.

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 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.

Plan available in Missoula county.

HMO plans are provided by Blue Cross and Blue Shield of Montana, 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.