2023 SUMMARY OF BENEFITS

Blue Advantage Plus

January 1, 2023 - December 31, 2023

Patrius Health

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2023 Summary of Benefits Blue Advantage Plus (PPO)

This is a summary of drug and health services covered by **Blue Advantage Plus (PPO)**. This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. If you would like an Evidence of Coverage, you may call us at **1-888-950-0705 (TTY: 711)**, email **phmedicare@patriushealth.com** or view the information at **PatriusHealth.com/Documents**.

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

This document is available in other formats such as Braille, large print or audio. This document may be available in a non-English language. For additional information, call us at **1-888-950-0705 (TTY: 711).**

HOW TO CONTACT BLUE ADVANTAGE PLUS (PPO)

Hours of Operation

- 8 a.m. to 8 p.m. Central Time, seven (7) days a week. From April 1 to September 30, on weekends and holidays you may be required to leave a message. Calls will be returned the next business day.

Blue Advantage Plus (PPO) Phone Numbers and Website

- If you are a member of this plan, call toll-free **1-888-950-0705**. TTY users should call **711**.
- If you are not a member of this plan, call toll-free **1-855-457-5987**. TTY users should call **711**.
- Our website: **www.PatriusHealth.com**

Who can join?

To join **Blue Advantage Plus (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. The service area includes Hancock and Jackson counties in Mississippi.

Which doctors, hospitals, and pharmacies can I use?

You can see our plan's provider directory and pharmacy directory at our website **www.PatriusHealth.com/FindaDoctor**.

What drugs are covered?

You can see our plan's formulary (list of Part D prescription drugs) at our website **www.PatriusHealth.com/Documents**.

- This information is not a complete description of benefits. **Call 1-888-950-0705/TTY: 711** for more information.
- Out-of-network/non-contracted providers are under no obligation to treat **Blue Advantage Plus (PPO)** members, except in emergency situations. Please call our member services or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.
- Limitations, co-payments, and restrictions may apply.
- Benefits, premiums, deductibles, and co-payments/co-insurance may change on January 1 of each year.
- The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

PREMIUMS & BENEFITS	BLUE ADVANTAGE PLUS (PPO)
Monthly Plan Premium	$0 per month (Hancock and Jackson counties) In addition, you must keep paying your Medicare Part B premium.
Deductible	$0 for medical
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	• $5,100 for services you receive from in-network providers • $7,500 for services you receive from any provider
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-network:** • $265 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 90 • $0 copay for days 91 and after **Out-of-network:** 50% coinsurance
Outpatient Hospital	**In-network:** $0-$200 copay **Out-of-network:** 50% coinsurance
Doctor Visits *NOTE: No referrals required to see an in-network specialist*	**PRIMARY CARE PHYSICIAN VISIT/TELEHEALTH VISIT:** **In-network:** $0 copay **Out-of-network:** 50% coinsurance **SPECIALIST VISIT/TELEHEALTH VISIT:** **In-network:** $30 copay **Out-of-network:** 50% coinsurance
Preventive Care *Note: Preventive Care screenings are subject to limitations please consult with your doctor prior to scheduling any preventive care screening.*	**In-network:** You pay nothing **Out-of-network:** 50% coinsurance • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual Wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) NOTE: Coinsurance/copayments/deductibles may apply for Medicare-covered items or kits required to prepare for the colorectal cancer screening exam.

MEDICAL & HOSPITAL	BLUE ADVANTAGE PLUS (PPO)
Preventive Care *(Continued)* Note: Preventive Care screenings are subject to limitations please consult with your doctor prior to scheduling any preventive care screening.	• Depression screening • Diabetes screening • HIV screening • Lung cancer screening • Medical nutrition therapy • 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 and pneumonia shots • "Welcome to Medicare" preventive visit (one-time)
Annual Physical Exam	**In-network:** $0 copay **Out-of-network:** 50% coinsurance
Emergency Care	$110 copay *If you are admitted to the hospital within 24 hours, you pay nothing.*
Urgently Needed Services NOTE: Out-of-network providers may be covered at the same cost-sharing when In-network providers are temporarily unavailable.	$0 copay for Medicare-covered urgently needed Primary Care Physician visits $30 copay for Medicare-covered urgently needed Specialist visits
Diagnostic Services/ Labs/Imaging	*Diagnostic radiology services (such as MRIs, CT scans):* **In-network:** $90 copay **Out-of-network:** 50% coinsurance *Diagnostic tests and procedures:* **In-network:** You pay nothing **Out-of-network:** 50% coinsurance *Lab services:* **In-network:** You pay nothing **Out-of-network:** 50% coinsurance *Outpatient x-rays:* **In-network:** $10 copay **Out-of-network:** 50% coinsurance *Therapeutic radiology services (such as radiation treatment for cancer):* **In-network:** $55 copay **Out-of-network:** 50% coinsurance

HEARING, DENTAL & VISION BENEFITS	BLUE ADVANTAGE PLUS (PPO)
Hearing Services • Routine hearing exam • Hearing aid	*Medicare-covered diagnostic hearing exam:* **In-network:** $10 copay **Out-of-network:** 50% coinsurance *Annual routine hearing exam:* **In-network:** You pay nothing **Out-of-network:** You pay nothing *Hearing Aids (one per ear, per year):* **$699** copay per aid for TruHearing Advanced **$999** copay per aid for TruHearing Premium NOTE: TruHearing Provider must be used for in-network and out-of-network hearing aid benefit and the annual Routine Hearing Exam. Please call **1-888-990-5525 (TTY:711)** to locate a TruHearing provider and to schedule an appointment.
Dental Services • Oral exams • Prophylaxis (cleaning) • Fluoride treatment • Dental x-rays • Extractions • Fillings	*Medicare-covered dental benefits:* **In-network:** $30 copay **Out-of-network:** 50% coinsurance **Dental Allowance:** **$750** allowance toward Preventive and Comprehensive dental benefits annually. The majority of Comprehensive Services are covered. Please call Member Services at **1-888-950-0705/TTY: 711** for any questions relating to your dental coverage.
Vision Services • One routine eye exam is covered once per year. A refraction is included in the routine eye exam, but not the diabetic retinopathy screening.	*Annual routine eye exam:* **In-network:** You pay nothing **Out-of-network:** 50% coinsurance **$100** allowance toward non-Medicare-covered prescription eyewear (glasses, lenses, frames, or contact lenses) per calendar year *Medicare-covered eye exam:* **In-network:** $30 copay **Out-of-network:** 50% coinsurance *Eyeglasses or contact lenses after cataract surgery:* **In-network:** You pay nothing **Out-of-network:** 50% coinsurance

OTHER BENEFITS	BLUE ADVANTAGE PLUS (PPO)
Mental Health Services/Telehealth Visits • Outpatient group therapy/ individual therapy visit	**In-network:** $30 copay **Out-of-network:** 50% coinsurance
Skilled Nursing Facility (SNF)	**In-network:** • You pay nothing per day for days 1 through 20 • $180 copay per day for days 21 through 100 **Out-of-network:** 50% coinsurance Our plan covers up to 100 days in a SNF.
Physical, Occupational, Speech Therapy	**In-network:** $30 copay **Out-of-network:** 50% coinsurance NOTE: A pre-certification by the Physician is required after the **20th** combined therapy visit.
Ambulance	$250 copay NOTE: Per one way trip
Transportation	Not covered
Medicare Part B Drugs	*Part B drugs (including chemotherapy and other Part B drugs):* **In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance

PRESCRIPTION DRUG BENEFITS	
Senior Savings Model—Insulin Savings Program	Your out-of-pocket costs for select insulins will be $28 for preferred cost-sharing (at preferred pharmacies and our mail-order preferred pharmacies) and $35 for standard cost-sharing (at standard pharmacies and our mail-order standard pharmacies) in Stage 1 Deductible, Stage 2 Initial Coverage and Stage 3 Coverage Gap.
Medicare Part D Deductible	Your yearly deductible for Part D prescription drugs is $150 except for drugs listed on Tier 1, Tier 2, and Tier 6 which are excluded from the deductible. For a complete listing of drugs and drug tiers, please visit **www.PatriusHealth.com/Documents.** NOTE: Save money on prescriptions with a 90-day supply from any Preferred Pharmacy and our Home Delivery Pharmacy Service. For more information, please visit **www.PatriusHealth.com/FindaDoctor** and select Looking for a Pharmacy.

Initial Coverage

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **$4,660**. 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 our home delivery pharmacy service.

Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. However, your costs may be less for your covered drugs if you use a pharmacy in our preferred network. Our Preferred Pharmacies for Blue Advantage Plus include: Walmart, Walgreens, Publix, Kroger, Winn Dixie, Costco and many local independent pharmacies. The network pharmacies listed may change at any time. Blue Advantage Plus members will receive notice when necessary.
For additional information about other pharmacies, physicians and providers in our network please contact member services at **1-888-950-0705 (TTY: 711)**. For more information about our Home Delivery Pharmacy Services please call AllianceRx Walgreens Pharmacy at **1-800-731-3588**, Amazon Pharmacy at **1-855-793-5326**, Costco Pharmacy at **1-800-607-6861**, Accredo/ESI at **1-833-715-0967** or Kroger PPS at **1-800-522-6694**.

PREFERRED RETAIL COST-SHARING & HOME DELIVERY PHARMACY SERVICE

	BLUE ADVANTAGE PLUS (PPO)	
	1-month supply	3-month supply
Tier 1 (Preferred Generic)	$3 copay	$6 copay
Tier 2 (Generic)	$13 copay	$26 copay
Tier 3 (Preferred Brand)	$40 copay	$80 copay
Tier 4 (Non-Preferred Drug)	$93 copay	$186 copay
Tier 5 (Specialty Tier)	30% coinsurance	30% coinsurance
Tier 6 (Select Care Drugs)	$0 copay	$0 copay
Select Insulins (Tiers 3 & 4)	$28 copay	$56 copay

STANDARD RETAIL COST-SHARING

	BLUE ADVANTAGE PLUS (PPO)	
	1-month supply	3-month supply
Tier 1 (Preferred Generic)	$10 copay	$30 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)	30% coinsurance	30% coinsurance
Tier 6 (Select Care Drugs)	$0 copay	$0 copay
Select Insulins (Tiers 3 & 4)	$35 copay	$105 copay

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

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$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. You also continue to pay a **$0** copay for Tier 6 (Select Care Drugs) and **$28/$35** for Select Insulins during this coverage gap. Not everyone will enter the pay coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through our home delivery pharmacy service) reach **$7,400**, you pay the greater of:

- **5%** coinsurance, **or**
- **$4.15** copay for generic (including brand drugs treated as generic) and a **$10.35** copayment for all other drugs.

ADDITIONAL BENEFITS	Blue Advantage Plus (PPO)
Medicare-Covered Foot Care (Podiatry)	**In-network:** $20 copay **Out-of-network:** 50% coinsurance
Inpatient Mental Health Services	**In-network:** • $265 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 90 • $0 copay for each additional hospital day up to the 190 day lifetime limit for an Inpatient Psychiatric Hospital. The limit does not apply to Psychiatric services in a General Hospital. **Out-of-network:** 50% coinsurance
Outpatient Hospital and Observation Services	**In-network:** $200 copay **Out-of-network:** 50% coinsurance
Ambulatory Surgical Center	**In-network:** $200 copay **Out-of-network:** 50% coinsurance
Home Health	**In-network:** You pay nothing **Out-of-network:** 50% coinsurance
Hospice	**In-network:** You pay nothing **Out-of-network:** 50% coinsurance
Durable Medical Equipment	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance

OUTPATIENT REHABILITATION	Blue Advantage Plus (PPO)
Cardiac Rehabilitation	**In-network:** $20 copay **Out-of-network:** 50% coinsurance
Pulmonary Rehabilitation	**In-network:** $20 copay **Out-of-network:** 50% coinsurance
Supervised Exercise Therapy (SET)	**In-network:** $10 copay **Out-of-network:** 50% coinsurance
DIABETES MANAGEMENT	
Diabetes Monitoring Supplies	**In-network:** You pay nothing **Out-of-network:** 50% coinsurance NOTE: Ascensia (Contour) and LifeScan (OneTouch) products must be used for diabetic test strips and blood glucose meters to obtain the $0 cost-sharing at our in-network pharmacy or through our mail-order pharmacies. All other brands are non-covered. Diabetic test strips are limited to 204 strips every 30 days.
Diabetes Self-Management Training	**In-network:** You pay nothing **Out-of-network:** 50% coinsurance
Diabetic Therapeutic Shoes or Inserts	**In-network:** You pay nothing **Out-of-network:** 50% coinsurance

MORE BENEFITS WITH YOUR PLAN

Blue Advantage Plus offer the supplemental benefits below, in addition to Part C benefits and Part D benefits.

Post Discharge Meals

14 home delivered meals provided by the approved vendor upon each in-patient hospital discharge with two of the following diagnoses:

- COPD
- Vascular Disease
- Congestive Heart Failure
- Diabetes
- Rheumatoid Arthritis

AirMed International

If you're hospitalized more than 150 miles from your home, AirMed International will provide an air ambulance to bring you to your local hospital. There is no cost to you for this service.

Worldwide Emergency/Urgent Coverage

$50,000 annual coverage for Medical services provided outside the United States that would be classified as emergency or urgently needed services had they been covered in the United States. The coverage includes ambulance services. In-network copays will apply. Please call Member Services at **1-888-950-0705** Monday through Friday from 8 a.m. to 8 p.m. for more information.

Ambulatory Surgical Center
An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Brand Name Drug
A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredients as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage
The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent **$7,400** in covered drugs during the covered year.

Coinsurance
An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 25%).

Combined Maximum Out-of-Pocket Amount
This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers.

Copayment (or “copay”)
An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $30 for a Specialist Physician visit.

Cost-Sharing
Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received.

A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier
Every drug on the list of covered drugs is in one of 6 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Covered Drugs
The term we use to mean all of the prescription drugs covered by our plan.

Deductible
The amount you must spend on drugs or services before your plan pays insurance benefits. (This may vary based upon the type of plan.)

Durable Medical Equipment (DME)
Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency
A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care
Covered services that are: (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Generic Drug
A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Hospice
A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay
A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Initial Coverage Limit
The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage
This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached **$4,660**.

In-Network Maximum Out-of-Pocket Amount (MOOP)
The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

List of Covered Drugs (Formulary or "Drug List")
A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Network Pharmacy
A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider
"Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "network providers" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan.

Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare)
Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress.

You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share.

Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy
A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility
A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you.

Precertification
A required review used to determine the medical necessity of the treatment prior to the service.

Preferred Cost-Sharing
Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs when filled at a preferred network pharmacy.

Preferred Provider Organization (PPO) Plan
A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount.

A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers.

PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium
The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive Care
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Rehabilitation Services
These services include physical therapy, speech and language therapy, and occupational therapy.

Skilled Nursing Facility (SNF) Care
Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Standard Cost-Sharing
Standard cost-sharing is offered for certain covered Part D drugs when filled at a standard network pharmacy. A member's copay or coinsurance may be higher at a standard pharmacy compared to purchasing the same drug from a preferred pharmacy.

Urgently Needed Services
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Is a CPAP machine considered Durable Medical Equipment (DME)?

Answer: Yes, along with the necessary supplies such as hoses, masks, tubing and filters.

Is a prescription required for certain DME supplies?

Answer: Yes

When do you own rented DME equipment?

Answer: Usually, members will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. However, it depends on the type of DME equipment. For example, CPAP machines are rented whereas prosthetics are owned by the member. Please call Member Services at **1-888-950-0705 (TTY: 711)** Monday through Friday from 8 a.m. to 8 p.m. for more information.

Is a diabetic eye exam covered?

Answer: Yes, one per calendar year from an in-network provider.

Do contacts qualify for the eyewear allowance?

Answer: Yes

Do I need a precertification for physical therapy?

Answer: Yes, after the 20th combined physical/occupational/speech therapy visit.

Do I have to pay a copay every time I go for physical therapy?

Answer: Yes, each visit is subject to a copay.

What is the difference in the Preferred vs. Standard drug network?

Answer: A preferred pharmacy is a pharmacy that is contracted with Patrius Health to offer lower cost-sharing to our members. Preferred pharmacies also offer a discount on a 90-day drug supply. Whereas a standard pharmacy is an in-network pharmacy that does not offer the same low cost-sharing as a preferred pharmacy.

What is the difference between Part B vs Part D drugs?

Answer: Part B drugs are drugs administered under medical supervision and a 20% coinsurance would apply. Whereas, Part D drugs are purchased from the pharmacy or through our home delivery pharmacy service and the cost-sharing amount of the drug would vary.

Do I have to pay a copay every time I get a colonoscopy?

Answer: Only if the colonoscopy is being done to address a specific medical condition or illness. A routine preventive colonoscopy does not require a copay. (Please note: Cost-sharing may apply for Medicare-covered items or kits required to prepare for the colorectal cancer screening exam.)

Am I covered when I go out of state?

Answer: With the Blue Advantage Visitor and Travel Program, it's easy to find providers wherever you go. In most states, you'll enjoy the same low in-network cost-sharing from participating providers that you do in Mississippi. Please call Member Services at **1-888-950-0705 (TTY: 711)** Monday through Friday from 8 a.m. to 8 p.m. for participating states.

Does an inpatient hospital copay cover just the stay or the services associated with it?

Answer: Both, for more details of the services included please reference the Inpatient hospital section of your Evidence of Coverage (EOC) or call Member Services at **1-888-950-0705 (TTY: 711)** Monday through Friday from 8 a.m. to 8 p.m. for more information.

During a Skilled Nursing Facility (SNF) stay, who pays the first 20 days?

Answer: There is no member cost-sharing for the first 20 days. However, copays may apply for Primary Care Physician and Specialist visits.

Notes

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Notes

Patrius Notice of Nondiscrimination

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

Patrius Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Patrius Health, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-888-950-2260, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@patriushealth.com (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-950-2260. Someone who speaks English can help you. This is a free service

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-950-2260. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-950-2260。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-950-2260。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-950-2260. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au

service d'interprétation, il vous suffit de nous appeler au 1-888-950-2260. 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 1-888-950-2260 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-950-2260. 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 1-888-950-2260. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-950-2260. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أيأ سئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-950-2260 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-950-2260 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-950-2260. 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 1-888-950-2260. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-950-2260. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-950-2260. 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、1-888-950-2260 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。

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

Patrius Health is an independent licensee of the Blue Cross and Blue Shield Association.