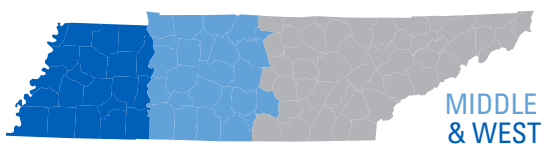


2025 Summary of Benefits

MEDICARE ADVANTAGE PLANS WITH
PART D PRESCRIPTION DRUG COVERAGE



Garnet

BlueAdvantage (PPO)SM

SUMMARY OF BENEFITS

Garnet Middle

Garnet West

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

<p>Monthly Plan Premium</p>	<p>\$0 per month.</p> <p>You must continue to pay your Medicare Part B premium.</p>	<p>\$0 per month.</p> <p>You must continue to pay your Medicare Part B premium.</p>
<p>Deductible</p>	<p>Medical Deductible: No deductible</p> <p>Prescription Drug Deductible: No deductible</p>	<p>Medical Deductible: No deductible</p> <p>Prescription Drug Deductible: No deductible</p>
<p>Maximum Out-of-Pocket Responsibility</p>	<p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$5,300 for services you receive from in-network providers. • \$9,550 for services you receive from in and out-of-network providers combined. <p>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 cost-sharing for your Part D prescription drugs.</p>	<p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$4,400 for services you receive from in-network providers. • \$9,550 for services you receive from in and out-of-network providers combined. <p>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 cost-sharing for your Part D prescription drugs.</p>

COVERED MEDICAL AND HOSPITAL BENEFITS

HEALTH BENEFITS

Garnet Middle

Garnet West

Inpatient Hospital and Inpatient Services in a Psychiatric Hospital

Prior authorization is required.

Our plan covers an unlimited number of days for an inpatient hospital stay.

Our plan covers a maximum of **190 days in a psychiatric hospital in a lifetime**. The **190-day** limit does not apply to mental health services provided in a psychiatric unit of a general hospital.

In-Network:

Days 1-5: **\$270** copay per day
Additional days: **\$0** copay per day

Out-of-Network:

Days 1-5: **\$320** copay per day
Additional days: **\$0** copay per day

In-Network:

Days 1-5: **\$295** copay per day
Additional days: **\$0** copay per day

Out-of-Network:

Days 1-5: **\$345** copay per day
Additional days: **\$0** copay per day

Outpatient Surgical Services

Prior authorization may be required.

In-Network:

Ambulatory Surgical Center: **\$275** copay
Outpatient hospital facility: **\$325** copay

Out-of-Network:

Ambulatory Surgical Center: **50%** of the Medicare-allowed amount
Outpatient hospital facility: **\$375** copay

In-Network:

Ambulatory Surgical Center: **\$275** copay
Outpatient hospital facility: **\$325** copay

Out-of-Network:

Ambulatory Surgical Center: **50%** of the Medicare-allowed amount
Outpatient hospital facility: **\$375** copay

HEALTH BENEFITS	Garnet Middle	Garnet West
<p>Doctor Visits</p>	<p><u>In-Network:</u> Primary care physician visit: \$0 copay</p> <p>Specialist visit: \$30 copay</p> <p><u>Out-of-Network:</u> Primary care physician visit: \$10 copay</p> <p>Specialist visit: \$40 copay</p>	<p><u>In-Network:</u> Primary care physician visit: \$0 copay</p> <p>Specialist visit: \$30 copay</p> <p><u>Out-of-Network:</u> Primary care physician visit: \$10 copay</p> <p>Specialist visit: \$40 copay</p>
<p>Preventive Care</p> <ul style="list-style-type: none"> • Bone mass measurements (bone density) • Cardiovascular disease screenings • Cervical & vaginal cancer screening • Colorectal cancer screenings • Diabetes screenings • Glaucoma tests • Mammograms (screening) • Prostate cancer screenings • Vaccines: <ul style="list-style-type: none"> ➢ COVID-19 ➢ Flu ➢ Hepatitis B ➢ Pneumococcal <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<p><u>In-Network:</u> \$0 copay for all preventive services covered under Original Medicare at zero cost sharing.</p> <p><u>Out-of-Network:</u> 50% of the total cost for all preventive services covered under Original Medicare at zero cost sharing.</p>	<p><u>In-Network:</u> \$0 copay for all preventive services covered under Original Medicare at zero cost sharing.</p> <p><u>Out-of-Network:</u> 50% of the total cost for all preventive services covered under Original Medicare at zero cost sharing.</p>

HEALTH BENEFITS	Garnet Middle	Garnet West
<p>Emergency Care</p> <p>Copay is waived if you are admitted to the hospital within 24 hours for the same condition. All emergency care is considered in network.</p>	<p><u>Domestic:</u> \$125 copay per visit</p> <p><u>Worldwide:</u> \$90 copay per visit</p>	<p><u>Domestic:</u> \$125 copay per visit</p> <p><u>Worldwide:</u> \$90 copay per visit</p>
<p>Urgently Needed Services</p> <p>Copay is waived if you are admitted to the hospital within 24 hours for the same condition.</p>	<p><u>Domestic:</u> \$25 copay per visit</p> <p><u>Worldwide:</u> \$90 copay per visit</p>	<p><u>Domestic:</u> \$25 copay per visit</p> <p><u>Worldwide:</u> \$90 copay per visit</p>

HEALTH BENEFITS	Garnet Middle	Garnet West
<p>Diagnostic Services / Labs/ Imaging</p> <p>Prior authorization may be required</p>	<p><u>In-Network:</u></p> <p>Diagnostic tests and procedures:</p> <p>\$0 copay at a Primary Care Provider's office</p> <p>\$30 copay at a Specialist's office</p> <p>\$40 copay at a Free-Standing Facility</p> <p>\$100 copay at an Outpatient Hospital</p> <p><u>Out-of-Network:</u></p> <p>Diagnostic tests and procedures:</p> <p>\$10 copay at a Primary Care Provider's office</p> <p>\$40 copay at a Specialist's office</p> <p>50% of the Medicare-allowed amount at a Free-Standing Facility</p> <p>50% of the Medicare-allowed amount at an Outpatient Hospital</p> <p><u>In-Network:</u></p> <p>Lab services:</p> <p>\$0 copay at a Primary Care Provider's office</p> <p>\$0 copay at a Specialist's office</p> <p>\$0 copay at a Free-Standing Facility</p> <p>\$40 copay at an Outpatient Hospital</p> <p><u>Out-of-Network:</u></p> <p>Lab services:</p> <p>\$10 copay at a Primary Care Provider's office</p> <p>\$40 copay at a Specialist's office</p> <p>50% of the Medicare-allowed amount at a Free-Standing Facility</p> <p>50% of the Medicare-allowed amount at an Outpatient Hospital</p>	<p><u>In-Network:</u></p> <p>Diagnostic tests and procedures:</p> <p>\$0 copay at a Primary Care Provider's office</p> <p>\$30 copay at a Specialist's office</p> <p>\$40 copay at a Free-Standing Facility</p> <p>\$100 copay at an Outpatient Hospital</p> <p><u>Out-of-Network:</u></p> <p>Diagnostic tests and procedures:</p> <p>\$10 copay at a Primary Care Provider's office</p> <p>\$40 copay at a Specialist's office</p> <p>50% of the Medicare-allowed amount at a Free-Standing Facility</p> <p>50% of the Medicare-allowed amount at an Outpatient Hospital</p> <p><u>In-Network:</u></p> <p>Lab services:</p> <p>\$0 copay at a Primary Care Provider's office</p> <p>\$0 copay at a Specialist's office</p> <p>\$0 copay at a Free-Standing Facility</p> <p>\$40 copay at an Outpatient Hospital</p> <p><u>Out-of-Network:</u></p> <p>Lab services:</p> <p>\$10 copay at a Primary Care Provider's office</p> <p>\$40 copay at a Specialist's office</p> <p>50% of the Medicare-allowed amount at a Free-Standing Facility</p> <p>50% of the Medicare-allowed amount at an Outpatient Hospital</p>

	<p><u>In-Network:</u></p> <p>X-rays:</p> <p>\$0 copay at a Primary Care Provider's office</p> <p>\$30 copay at a Specialist's office</p> <p>\$40 copay at a Free-Standing Facility</p> <p>\$50 copay at an Outpatient Hospital</p> <p><u>Out-of-Network:</u></p> <p>X-rays:</p> <p>\$10 copay at a Primary Care Provider's office</p> <p>\$40 copay at a Specialist's office</p> <p>50% of the Medicare-allowed amount at a Free-Standing Facility</p> <p>50% of the Medicare-allowed amount at an Outpatient Hospital</p> <p><u>In-Network:</u></p> <p>Advanced Imaging (such as MRI, CT Scan):</p> <p>\$225 copay</p> <p><u>Out-of-Network:</u></p> <p>Advanced Imaging Services (such as MRI, CT Scan):</p> <p>50% of the Medicare-allowed amount</p> <p><u>In-Network:</u></p> <p>Therapeutic Radiology services :</p> <p>\$60 copay</p> <p><u>Out-of-Network:</u></p> <p>Therapeutic Radiology Services:</p> <p>50% of the Medicare-allowed amount</p>	<p><u>In-Network:</u></p> <p>X-rays:</p> <p>\$0 copay at a Primary Care Provider's office</p> <p>\$30 copay at a Specialist's office</p> <p>\$40 copay at a Free-Standing Facility</p> <p>\$50 copay at an Outpatient Hospital</p> <p><u>Out-of-Network:</u></p> <p>X-rays:</p> <p>\$10 copay at a Primary Care Provider's office</p> <p>\$40 copay at a Specialist's office</p> <p>50% of the Medicare-allowed amount at a Free-Standing Facility</p> <p>50% of the Medicare-allowed amount at an Outpatient Hospital</p> <p><u>In-Network:</u></p> <p>Advanced Imaging (such as MRI, CT Scan):</p> <p>\$225 copay</p> <p><u>Out-of-Network:</u></p> <p>Advanced Imaging Services (such as MRI, CT Scan):</p> <p>50% of the Medicare-allowed amount</p> <p><u>In-Network:</u></p> <p>Therapeutic Radiology services :</p> <p>\$60 copay</p> <p><u>Out-of-Network:</u></p> <p>Therapeutic Radiology Services:</p> <p>50% of the Medicare-allowed amount</p>
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HEALTH BENEFITS**Garnet Middle****Garnet West****In-Network:****Coumadin Services:****\$0** copay at a Primary Care Provider's office**\$0** copay at a Specialist's office**\$0** copay at a Free Standing Facility**\$10** copay at an Outpatient Hospital**Out-of-Network:****Coumadin Services:****\$10** copay at a Primary Care Provider's office**\$40** copay at a Specialist's office**50%** of the Medicare-allowed amount at a Free Standing Facility**50%** of the Medicare-allowed amount at an Outpatient Hospital**In-Network:****Sleep Studies:****\$10** copay for in-home**\$40** copay at an Outpatient Facility**Out-of-Network:****Sleep Studies:****50%** of the Medicare-allowed amount for in-home**50%** of the Medicare-allowed at an Outpatient Facility**In-Network:****Coumadin Services:****\$0** copay at a Primary Care Provider's office**\$0** copay at a Specialist's office**\$0** copay at a Free Standing Facility**\$10** copay at an Outpatient Hospital**Out-of-Network:****Coumadin Services:****\$10** copay at a Primary Care Provider's office**\$40** copay at a Specialist's office**50%** of the Medicare-allowed amount at a Free Standing Facility**50%** of the Medicare-allowed amount at an Outpatient Hospital**In-Network:****Sleep Studies:****\$10** copay for in-home**\$40** copay at an Outpatient Facility**Out-of-Network:****Sleep Studies:****50%** of the Medicare-allowed amount for in-home**50%** of the Medicare-allowed at an Outpatient Facility

HEALTH BENEFITS	Garnet Middle	Garnet West
<p>Hearing Services</p> <p>Cost-sharing for hearing aids does not count toward the maximum out-of-pocket amounts.</p>	<p><u>In-Network:</u></p> <p>Medicare-covered exam to diagnose and treat hearing and balance issues: \$10 copay</p> <p>Routine hearing exam (1 per year): \$0 copay at TruHearing® provider</p> <p>Hearing Aid: copay depending on model</p> <p>\$399 (Standard) \$599 (Advanced) \$899 (Premium)</p> <p>Limited to one per ear, per year. Benefit is limited to TruHearing Standard, Advanced and Premium hearing aids, which come in various styles and colors.</p> <p>You must see a TruHearing provider to use this benefit.</p> <p><u>Out-of-Network:</u></p> <p>Routine hearing exam and Hearing aids: Not covered – must use designated vendor</p>	<p><u>In-Network:</u></p> <p>Medicare-covered exam to diagnose and treat hearing and balance issues: \$10 copay</p> <p>Routine hearing exam (1 per year): \$0 copay at TruHearing® provider</p> <p>Hearing Aid: copay depending on model</p> <p>\$399 (Standard) \$599 (Advanced) \$899 (Premium)</p> <p>Limited to one per ear, per year. Benefit is limited to TruHearing Standard, Advanced and Premium hearing aids, which come in various styles and colors.</p> <p>You must see a TruHearing provider to use this benefit.</p> <p><u>Out-of-Network:</u></p> <p>Routine hearing exam and Hearing aids: Not covered – must use designated vendor</p>

HEALTH BENEFITS	Garnet Middle	Garnet West
<p>Dental Services</p> <p>Comprehensive and preventive dental benefits do not count toward the maximum out-of-pocket amount.</p> <p>(Service limits and other restrictions may apply to the comprehensive dental benefits.) Included as covered benefits with service limits in this plan, but not limited to: • Standard diagnostic exam (limited to 2 per year) • Problem-focused oral evaluations • Cleaning (limited to 2 per year) • Bitewing x-ray (limited to 1 per year) • Panoramic x-ray (limited to 1 per 36 months) • Fillings (limited to 1 per tooth surface per year) • Crowns (limited to 1 per tooth per 5 years) • Extractions • Bridges (limited to 1 per 5 years) • Removable dentures; complete, immediate, and partial (limited to 1 in any 5 year period)</p>	<p><u>In-Network:</u></p> <p>Medicare-covered: \$30 copay</p> <p>Our plan pays up to \$2,500 per year for combined preventive and comprehensive dental services. If the total covered cost for dental services is more than \$2,500 or if you exceed a service limit, you are required to pay the difference.</p> <p><u>Out-of-Network:</u></p> <p>Medicare-covered: 50% of the Medicare-allowed amount</p> <p>Our plan pays 50% of billed charges up to \$2,500. You pay 100% of any charges over \$2,500.</p>	<p><u>In-Network:</u></p> <p>Medicare-covered: \$30 copay</p> <p>Our plan pays up to \$2,500 per year for combined preventive and comprehensive dental services. If the total covered cost for dental services is more than \$2,500 or if you exceed a service limit, you are required to pay the difference.</p> <p><u>Out-of-Network:</u></p> <p>Medicare-covered: 50% of the Medicare-allowed amount</p> <p>Our plan pays 50% of billed charges up to \$2,500. You pay 100% of any charges over \$2,500.</p>
<p>Vision Services</p> <p>Members are encouraged to use the defined vision care network to obtain routine eye exam and eyewear benefit coverage.</p> <p>Routine eye exams and eyewear copays and coinsurance do not apply to</p>	<p><u>In- and Out-of-Network:</u></p> <p>Medicare-covered exam to diagnose and treat diseases and conditions of the eye: \$0 copay</p> <p>Routine eye exam (1 per year): \$0 copay</p> <p>Eyeglasses or contact lenses after cataract surgery: \$0 copay</p>	<p><u>In- and Out-of-Network:</u></p> <p>Medicare-covered exam to diagnose and treat diseases and conditions of the eye: \$0 copay</p> <p>Routine eye exam (1 per year): \$0 copay</p> <p>Eyeglasses or contact lenses after cataract surgery: \$0 copay</p>

HEALTH BENEFITS	Garnet Middle	Garnet West
<p>the maximum out-of-pocket.</p>	<p>Our plan pays a maximum of \$250 per year for routine eyewear.</p> <p>There is no copay for contact lenses or eyeglasses (frames and lenses). But, if your total cost is more than \$250, you will be required to pay the difference.</p> <p>For example: If your total cost for eyewear is \$300, the plan will pay \$250 and you will pay \$50.</p>	<p>Our plan pays a maximum of \$225 per year for routine eyewear.</p> <p>There is no copay for contact lenses or eyeglasses (frames and lenses). But, if your total cost is more than \$225, you will be required to pay the difference.</p> <p>For example: If your total cost for eyewear is \$300, the plan will pay \$225 and you will pay \$75.</p>
<p>Mental Health Services</p> <p>Prior authorization is required.</p>	<p><u>In-Network:</u> Outpatient group therapy visit: \$20 copay</p> <p>Individual therapy visit: \$30 copay</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>	<p><u>In-Network:</u> Outpatient group therapy visit: \$20 copay</p> <p>Individual therapy visit: \$30 copay</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>
<p>Skilled Nursing Facility (SNF)</p> <p>Prior authorization is required.</p> <p>The amounts apply per benefit period. Our plan covers up to 100 days in a SNF per benefit period. A benefit period begins the day you go into a SNF. The benefit period will accumulate one day for each day you are inpatient at a SNF. The benefit period ends when you haven't received any inpatient hospital care or skilled care</p>	<p><u>In-Network:</u> Days 1-20: \$0 copay per day Days 21-100: \$214 copay per day</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>	<p><u>In-Network:</u> Days 1-20: \$0 copay per day Days 21-100: \$214 copay per day</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>

HEALTH BENEFITS	Garnet Middle	Garnet West
<p>in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins.</p> <p>There is no limit to the number of benefit periods.</p>		
<p>Outpatient Rehabilitation Services (Physical Therapy)</p> <p>Prior authorization is required.</p>	<p><u>In-Network:</u></p> <p>Occupational therapy visit: \$15 copay</p> <p>Physical therapy visit: \$15 copay</p> <p>Speech and language therapy visit: \$15 copay</p> <p><u>Out-of-Network:</u></p> <p>Occupational therapy visit: 50% of the Medicare-allowed amount</p> <p>Physical therapy visit: 50% of the Medicare-allowed amount</p> <p>Speech and language therapy visit: 50% of the Medicare-allowed amount</p>	<p><u>In-Network:</u></p> <p>Occupational therapy visit: \$15 copay</p> <p>Physical therapy visit: \$15 copay</p> <p>Speech and language therapy visit: \$15 copay</p> <p><u>Out-of-Network:</u></p> <p>Occupational therapy visit: 50% of the Medicare-allowed amount</p> <p>Physical therapy visit: 50% of the Medicare-allowed amount</p> <p>Speech and language therapy visit: 50% of the Medicare-allowed amount</p>
<p>Ambulance</p> <p>Prior authorization is required for all non-emergency ambulance transport.</p>	<p><u>Domestic:</u></p> <p>Ground Ambulance: \$295 copay per one-way trip</p> <p>Air Ambulance: 20% of the Medicare-allowed amount per one-way trip</p> <p><u>Worldwide:</u></p> <p>Ground Ambulance: \$295 copay per one-way trip</p> <p>Air Ambulance: 20% of the Plan-allowed amount per one-way trip</p>	<p><u>Domestic:</u></p> <p>Ground Ambulance: \$295 copay per one-way trip</p> <p>Air Ambulance: 20% of the Medicare-allowed amount per one-way trip</p> <p><u>Worldwide:</u></p> <p>Ground Ambulance: \$295 copay per one-way trip</p> <p>Air Ambulance: 20% of the Plan-allowed amount per one-way trip</p>

HEALTH BENEFITS	Garnet Middle	Garnet West
Transportation	Not covered	Not covered
Medicare Part B Drugs Prior authorization may be required.	<p><u>In-Network:</u></p> <p>For Part B drugs such as chemotherapy drugs: 20% of the Plan-allowed amount</p> <p>Other Part B drugs: 20% of the Plan-allowed amount</p> <p>Part B insulin: 20% of the Plan-allowed amount, with a \$35 maximum copay for a one-month supply of each covered insulin product</p> <p><u>Out-of-Network:</u></p> <p>For Part B drugs such as chemotherapy drugs: 50% of the Medicare-allowed amount</p> <p>Other Part B drugs: 50% of the Medicare-allowed amount</p> <p>Part B insulin: 20% of the Medicare-allowed amount, with a \$35 maximum copay for a one-month supply of each covered insulin product</p>	<p><u>In-Network:</u></p> <p>For Part B drugs such as chemotherapy drugs: 20% of the Plan-allowed amount</p> <p>Other Part B drugs: 20% of the Plan-allowed amount</p> <p>Part B insulin: 20% of the Plan-allowed amount, with a \$35 maximum copay for a one-month supply of each covered insulin product</p> <p><u>Out-of-Network:</u></p> <p>For Part B drugs such as chemotherapy drugs: 50% of the Medicare-allowed amount</p> <p>Other Part B drugs: 50% of the Medicare-allowed amount</p> <p>Part B insulin: 20% of the Medicare-allowed amount, with a \$35 maximum copay for a one-month supply of each covered insulin product</p>

PRESCRIPTION DRUG BENEFITS

Deductible

Prescription Drug Deductible: **No deductible**

Initial Coverage

You pay the following until your total yearly drug costs reach **\$2,000**.

Total yearly drug costs are the drug costs paid by both you and our Part D plan.

	Garnet – Middle	Garnet – West
Preferred Pharmacies	Retail and Mail Order	Retail and Mail Order
Tier	30 / 100 Day Supply	30 / 100 Day Supply
Tier 1: Preferred Generic	\$0 / \$0	\$0 / \$0
Tier 2: Generic	\$10 / \$10	\$10 / \$10
	30 / 90 Day Supply	30 / 90 Day Supply
Tier 3: Insulins	\$35 / \$105	\$35 / \$105
Tier 3: Preferred Brand	\$42 / \$105	\$42 / \$105
Tier 4: Non-Preferred Drugs	50% coinsurance	50% coinsurance
Tier 5: Specialty Drugs (limited to a 30-day supply)	33% coinsurance	33% coinsurance
Standard Pharmacies	Retail and Mail Order	Retail and Mail Order
Tier	30 / 100 Day Supply	30 / 100 Day Supply
Tier 1: Preferred Generic	\$6 / \$15	\$6 / \$15
Tier 2: Generic	\$15 / \$35	\$15 / \$35
	30 / 90 Day Supply	30 / 90 Day Supply
Tier 3: Insulins	\$35 / \$105	\$35 / \$105
Tier 3: Preferred Brand	\$47 / \$135	\$47 / \$135
Tier 4: Non-Preferred Drugs	50% coinsurance	50% coinsurance
Tier 5: Specialty Drugs (limited to a 30-day supply)	33% coinsurance	33% coinsurance

You won't pay more than **\$35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach the **\$2,000** limit for the calendar year, your Part D-covered prescription drugs will be covered at no cost to you, except for the four drugs on the additional covered drug list.

Additional Covered Drugs

Our plan has additional coverage for the prescription drugs listed below. They're covered at a Tier 2 cost share. They're not normally covered in a Medicare Advantage plan with prescription drug coverage. The amount you pay for these drugs doesn't count toward your total drug costs or help you qualify for catastrophic coverage. If you get "Extra Help" to pay for your prescriptions, it doesn't apply to these drugs.

Respiratory and Allergy, Vitamins, and Erectile Dysfunction

Additional Benefits/Services	Garnet Middle	Garnet West
24/7 NurseLine	<u>In-Network:</u> <u>Out-of-Network:</u> Not covered	<u>In-Network:</u> <u>Out-of-Network:</u> Not covered
Acupuncture Prior authorization is required.	<u>In-Network:</u> \$20 copay <u>Out-of-Network:</u> 50% of the Medicare-allowed amount	<u>In-Network:</u> \$20 copay <u>Out-of-Network:</u> 50% of the Medicare-allowed amount
Chiropractic Care Prior authorization is required.	Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position) <u>In-Network:</u> \$20 copay per visit <u>Out-of-Network:</u> 50% of the Medicare-allowed amount	Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position) <u>In-Network:</u> \$20 copay per visit <u>Out-of-Network:</u> 50% of the Medicare-allowed amount
Diabetic Supplies and Services Prior authorization may be required.	Diabetes self-management training <u>In-Network:</u> \$0 copay <u>Out-of-Network:</u> 20% of the Medicare-allowed amount Diabetes monitoring supplies <u>In-Network:</u> Preferred: \$0 copay Non-Preferred: 20% of the Plan-allowed amount <u>Out-of-Network:</u> 50% of the Medicare-allowed amount Therapeutic shoes/inserts <u>In-Network:</u> \$10 copay	Diabetes self-management training <u>In-Network:</u> \$0 copay <u>Out-of-Network:</u> 20% of the Medicare-allowed amount Diabetes monitoring supplies <u>In-Network:</u> Preferred: \$0 copay Non-Preferred: 20% of the Plan-allowed amount <u>Out-of-Network:</u> 50% of the Medicare-allowed amount Therapeutic shoes/inserts <u>In-Network:</u> \$10 copay

Additional Benefits/Services	Garnet Middle	Garnet West
	<u>Out-of-Network:</u> 50% of the Medicare-allowed amount	<u>Out-of-Network:</u> 50% of the Medicare-allowed amount
Durable Medical Equipment Prior authorization may be required.	<u>In-Network:</u> 20% of the Plan-allowed amount <u>Out-of-Network:</u> 50% of the Medicare- allowed amount	<u>In-Network:</u> 20% of the Plan-allowed amount <u>Out-of-Network:</u> 50% of the Medicare- allowed amount
Home Health Care Prior authorization is required.	<u>In-Network:</u> \$0 copay <u>Out-of-Network:</u> 50% of the Medicare-allowed amount	<u>In-Network:</u> \$0 copay <u>Out-of-Network:</u> 50% of the Medicare-allowed amount
Meal Benefit	<u>In-Network:</u> \$0 copay Meal benefit includes 14 meals following an acute inpatient, SNF discharge, or observation stay to a home setting. There is not a limit to the number of discharges for meals. Must use designated Vendor. <u>Out-of-Network:</u> Not covered	<u>In-Network:</u> \$0 copay Meal benefit includes 14 meals following an acute inpatient, SNF discharge, or observation stay to a home setting. There is not a limit to the number of discharges for meals. Must use designated Vendor. <u>Out-of-Network:</u> Not covered
Outpatient Rehabilitation (Cardiac and Pulmonary) Prior authorization is required.	Cardiac (heart) rehab services <u>In Network:</u> \$20 copay <u>Out-of-Network:</u> 50% of the Medicare- allowed amount Pulmonary (lung) rehab services <u>In Network:</u> \$15 copay <u>Out-of-Network:</u> 50% of the Medicare- allowed amount	Cardiac (heart) rehab services <u>In Network:</u> \$20 copay <u>Out-of-Network:</u> 50% of the Medicare- allowed amount Pulmonary (lung) rehab services <u>In Network:</u> \$15 copay <u>Out-of-Network:</u> 50% of the Medicare- allowed amount

Additional Benefits/Services	Garnet Middle	Garnet West
Over-the-Counter (OTC) Items	<p><u>In-Network:</u> The plan pays \$60 per quarter (no roll-over) for certain OTC items such as vitamins, cough/cold/allergy medicines, dental products and skin care items. Must use designated vendor.</p> <p><u>Out-of-Network:</u> Not covered</p>	<p><u>In-Network:</u> The plan pays \$55 per quarter (no roll-over) for certain OTC items such as vitamins, cough/cold/allergy medicines, dental products and skin care items. Must use designated vendor.</p> <p><u>Out-of-Network:</u> Not covered</p>
Prosthetic Devices & Related Medical Supplies Prior authorization may be required.	<p><u>In-Network:</u> 20% of the Plan-allowed amount</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>	<p><u>In-Network:</u> 20% of the Plan-allowed amount</p> <p><u>Out-of-Network:</u> 50% of the Medicare-allowed amount</p>
Renal Dialysis	<p><u>In-Network:</u> 20% of the Plan-allowed amount</p> <p><u>Out-of-Network:</u> 20% of the Medicare-allowed amount</p>	<p><u>In-Network:</u> 20% of the Plan-allowed amount</p> <p><u>Out-of-Network:</u> 20% of the Medicare- allowed amount</p>
Fitness Program This plan includes a free standard fitness center membership, tools and online resources.	<p><u>In-Network:</u> You pay nothing.</p> <p><u>Out-of-Network:</u> Not covered</p>	<p><u>In-Network:</u> You pay nothing.</p> <p><u>Out-of-Network:</u> Not covered</p>

DISCLAIMERS

This is a summary of drugs and health services covered by BlueAdvantage Preferred Provider Organization (PPO) Garnet Middle and Garnet West health plans January 1, 2025 through December 31, 2025.

BlueAdvantage is a PPO plan with a Medicare contract. Enrollment in BlueAdvantage depends on contract renewal.

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, go to **bcbstmedicare.com** or call us and ask for the “**Evidence of Coverage.**”

To join BlueAdvantage Garnet, 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:

Middle Tennessee: Bedford, Cheatham, Coffee, Davidson, Dickson, Giles, Hickman, Houston, Humphreys, Lawrence, Lewis, Lincoln, Marshall, Maury, Montgomery, Moore, Perry, Robertson, Rutherford, Stewart, Sumner, Trousdale, Wayne, Williamson and Wilson

West Tennessee: Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton and Weakley

This document is available in other alternate formats.

This document may be available in a non-English language. For additional information, call us at **1-800-831-2583, TTY 711.**

Out-of-network/non-contracted providers are under no obligation to treat BlueCross BlueShield of Tennessee 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 Member Service or see the "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services.

**If you have any questions about this plan's benefits or costs,
please contact BlueCross BlueShield of Tennessee.**

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 our representative at **1-800-292-5146, TTY 711.**

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 **bcbstmedicare.com** or call **1-800-292-5146, TTY 711**, to view a copy of the EOC.
- Review the provider directory (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

- 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/coinsurance may change on January 1, 2026.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, 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 copay for services received by non-contracted providers.
- 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.

*BlueAdvantage Sapphire (PPO)SM and BlueAdvantage Garnet (PPO)SM plans have a \$0 plan premium.

Note: For BlueAdvantage Prime (PPO)SM there are limited times when you can add or remove the Optional Supplemental Benefits: Dental and Vision package.

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries SecurityCare of Tennessee, Inc. and Volunteer State Health Plan, Inc. also doing business as BlueCare Tennessee, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.

Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Service at the number on the back of your Member ID card or call **1-800-831-2583**, TTY **711**. From **Oct. 1 to March 31**, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

If you believe that BlueCross 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 (“Nondiscrimination Grievance”). For help with preparing and submitting your Nondiscrimination Grievance, contact Member Service at the number on the back of your Member ID card or call **1-800-831-2583**, TTY **711**. They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

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 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, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD), 8:30 a.m. to 8 p.m. ET. Complaint forms are available at hhs.gov/ocr/office/file/index.html.

You can contact BlueCross’s Nondiscrimination Coordinator at 423-535-1010 (phone), Nondiscrimination_CoordinatorGM@bcbst.com (email), or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross’s website: **bcbst.com**.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

Multi-language Interpreter Services

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 1-800-831-2583, TTY 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 1-800-831-2583, TTY 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 1-800-831-2583, TTY 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 1-800-831-2583, TTY 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 1-800-831-2583, TTY 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 1-800-831-2583, TTY 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 quý vị cần thông dịch viên xin gọi 1-800-831-2583, TTY 711 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-831-2583, TTY 711. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-831-2583, TTY 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 1-800-831-2583, TTY 711. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-831-2583, TTY 711. 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 1-800-831-2583, TTY 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 1-800-831-2583, TTY 711. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: 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 1-800-831-2583, TTY 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 1-800-831-2583, TTY 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 1-800-831-2583, TTY 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。通訳をご用命になるには、1-800-831-2583, TTY 711 にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。

We're right here when you need us.



bcbstmedicare.com



If you are a member, call toll-free
1-800-831-2583, TTY **711**.

If you are not a member, call toll-free
1-800-292-5146, TTY **711**.

OCT. 1 TO MARCH 31, SEVEN DAYS A WEEK
FROM 8 A.M. TO 9 P.M. ET. FROM **APRIL 1**
TO SEPT. 30, M-F FROM 8 A.M. TO 9 P.M. ET.

