

Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO, Access PPO and Choice HMO-POS

2020

SUMMARY OF BENEFITS

January 1, 2020 – December 31, 2020

This information is not a complete description of benefits. Call 1-888-488-9850/TTY 711 for more information. A complete list of services is available in the Evidence of Coverage. You may review the Evidence of Coverage on-line or by calling Customer Service. (The website and phone numbers are printed on the back cover of this booklet).

To join **Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO**, **Blue Cross Blue Shield Nebraska Medicare Advantage Access PPO** and **Blue Cross Blue Shield Nebraska Medicare Advantage Choice HMO-POS**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

The service area for the **Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO** and the **Blue Cross Blue Shield Nebraska Medicare Advantage Access PPO** plans include these counties in Nebraska: Adams, Buffalo, Burt, Butler, Cass, Colfax, Cuming, Dodge, Douglas, Gage, Hall, Hamilton, Johnson, Lancaster, Madison, Merrick, Nemaha, Otoe, Platte, Polk, Saline, Sarpy, Saunders, Seward, Washington and York.

The service area for the **Blue Cross Blue Shield Nebraska Medicare Advantage Choice HMO-POS** plan includes these counties in Nebraska: Burt, Butler, Cass, Colfax, Cuming, Dodge, Douglas, Gage, Lancaster, Otoe, Saline, Sarpy, Saunders, Seward and Washington.

Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO, **Blue Cross Blue Shield Nebraska Medicare Advantage Access PPO** and **Blue Cross Blue Shield Nebraska Medicare Advantage Choice HMO-POS** have 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.

For more detailed information about our providers and our provider directory, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at medicare.nebraskablue.com.

Blue Cross and Blue Shield of Nebraska is an HMO, HMO-POS and PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of Nebraska Medicare Advantage depends on contract renewal.



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Additional Information about Medicare Advantage Choice (HMO-POS)

What does “point-of-service” mean?

This is an HMO-POS plan. HMO means Health Maintenance Organization; POS means Point-of-Service. You can use certain providers outside the Medicare Advantage Choice (HMO-POS) network when traveling, often for your in-network cost-sharing amount.

If you need care when you’re traveling outside of Nebraska, you can access the Point-of-Service (POS) benefit, offered through BlueCard® via the Blue Cross Blue Shield Association, which allows you to receive certain covered services from providers who participate with Medicare and Blues plans within the United States, the District of Columbia and Puerto Rico. Services in the District of Columbia and Puerto Rico are only covered if you go to a Medicare-approved provider. Dialysis services in the District of Columbia and Puerto Rico are only covered if you go to a Medicare-approved provider.

NOTE: POS is not the same as out-of-network; you pay all costs for services from out-of-network providers.

Premiums	Core HMO	Access PPO	Choice HMO-POS	What You Should Know
Monthly Plan Premium	You pay \$0	You pay \$26	You pay \$44	You must continue to pay your Medicare Part B premium.
Medical Benefits	Core HMO	Access PPO	Choice HMO-POS	What You Should Know
Deductible	You pay \$0			These plans do not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	\$6,250 annually	In-Network: \$4,500 annually Combined In-Network and Out-of-Network Services: \$6,900 annually	In-Network: \$5,700 annually Combined In-Network and BlueCard Coordinated Services: \$6,700 annually for services you receive from any provider both in-network and out-of-state using the POS benefit. Your limit for services received from in-network providers will count toward this limit.	<p>If you reach the limit on out-of-pocket costs, you keep getting Medicare-covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>You will still need to pay your monthly plan premiums, Medicare Part B premiums, and cost sharing for your Part D drugs.</p>

Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO

Out-of-network: Medical services are covered outside of our provider service area by Blue Cross Blue Shield Nebraska Medicare Advantage Core inside and outside of Nebraska.

Blue Cross Blue Shield Nebraska Medicare Advantage Access PPO

In-network and out-of-network: Benefits are the same unless specifically noted.

Blue Cross Blue Shield Nebraska Medicare Advantage Choice HMO-POS

Out-of-network: Inside Nebraska, medical services are not covered outside of our provider service area except for urgent and emergency care or unless authorized by Blue Cross Blue Shield Nebraska Medicare Advantage Choice HMO-POS. Outside of Nebraska, except for urgent or emergency care, medical services are coordinated through BlueCard services.



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Medical Benefits	Core HMO	Access PPO	Choice HMO-POS	What You Should Know
Inpatient Hospital Coverage	<p>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.</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p>			<p>Services may require prior authorization.</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p>
	<p>You pay \$395 copay per day for days 1 through 4</p> <p>You pay \$0 for additional days</p>	<p>You pay \$395 copay per day for days 1 through 4</p> <p>You pay \$0 for additional days</p>	<p>You pay \$380 copay per day for days 1 through 4</p> <p>You pay \$0 for additional days</p>	
Outpatient Hospital Coverage	<p>You pay \$395 copay for Medicare-covered outpatient hospital non-surgical services.</p> <p>You pay \$395 copay for Medicare-covered outpatient hospital surgical services.</p>	<p>You pay \$350 copay for Medicare-covered outpatient hospital nonsurgical services.</p> <p>You pay \$350 copay for Medicare-covered outpatient hospital surgical services.</p>	<p>You pay \$350 copay for Medicare-covered outpatient hospital non-surgical services.</p> <p>You pay \$350 copay for Medicare-covered outpatient hospital surgical services.</p>	<p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p>
<p>Doctor Visits</p> <ul style="list-style-type: none"> • Primary Care Providers • Specialists 	<p>You pay \$10 copay</p> <p>You pay \$45 copay</p>	<p>You pay \$5 copay in-network and \$15 copay out-of-network</p> <p>You pay \$30 copay in-network and \$40 copay out-of-network</p>	<p>You pay \$10 copay</p> <p>You pay \$40 copay</p>	

Medical Benefits	Core HMO	Access PPO	Choice HMO-POS	What You Should Know
Preventive Care	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive services.</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Annual physical exam • Annual wellness visit • Bone mass measurement • Breast cancer screenings (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Glaucoma screening • Health and wellness education programs • Hepatitis C screening • HIV screening • Immunizations (flu, pneumonia and Hepatitis B) • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • “Welcome to Medicare” preventive visit 			Any additional preventive services approved by Medicare during the contract year will be covered.



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Medical Benefits	Core HMO	Access PPO	Choice HMO-POS	What You Should Know
Emergency Care	You pay \$90 copay \$50,000 lifetime limit for emergency and urgent care received outside of the U.S.			If you are admitted to the hospital within 3 days for the same condition, you will pay a \$0 copay for the emergency room visit.
Urgently Needed Services	You pay \$55 copay			
Diagnostic Services/ Labs/Imaging				Services may require prior authorization.
• Diagnostic radiology service (e.g., MRI)	You pay \$150 copay	You pay \$100 copay	You pay \$150 copay	
• Lab services	You pay \$10 copay	You pay \$0 copay	You pay \$10 copay	
• Diagnostic tests and procedures	You pay \$20 copay	You pay \$20 copay	You pay \$20 copay	
• Outpatient X-rays	You pay \$20 copay	You pay \$15 copay	You pay \$20 copay	
• Therapeutic radiology services	You pay 20% of the approved amount	You pay 20% of the approved amount	You pay 20% of the approved amount	
Hearing Services				
• Medicare-covered	You pay \$10/\$45 copay	You pay \$5/\$30 copay in-network and \$15/\$40 copay out-of-network	You pay \$10/\$40 copay	One routine hearing exam per year is covered.
• Routine hearing exam	You pay \$10 copay	You pay \$0 copay	You pay \$0 copay	
• Hearing aid	\$500 allowance per ear toward one new standard (analog or basic digital) hearing aid every three years	\$500 allowance per ear toward one new standard (analog or basic digital) hearing aid every three years	\$500 allowance per ear toward one new standard (analog or basic digital) hearing aid every three years	
• Hearing aid fitting and evaluation	You pay \$0 once every three years	You pay \$0 once every three years	You pay \$0 once every three years	

Medical Benefits	Core HMO	Access PPO	Choice HMO-POS	What You Should Know
Dental Services <ul style="list-style-type: none"> • Medicare-covered • Supplemental Preventive Dental 	You pay \$45 copay	You pay \$40 copay	You pay \$40 copay	Preventive and Comprehensive Dental Services are covered as a member reimbursed benefit. Dental forms can be downloaded at medicare.nebraskablue.com/MedicareAdvantage/Resources .
	The Preventive Dental Services benefit provides a \$500 max benefit every plan year and may be used for: (a) 2 Oral Exams, (b) 2 Prophylaxis (cleaning), and / or (c) Dental X-rays. Routine cleanings and periodontal maintenance are covered under prophylaxis (cleaning). Emergency Dental exams are covered as Preventive Dental Services oral exams. Preventive Dental Services must be provided by a licensed Dental provider.			
Vision Services <ul style="list-style-type: none"> • Medicare-covered • Medicare-covered Diabetic Retinopathy exam • Supplemental eyewear www.VSP.com • Routine eye exam when provided by a VSP provider • Eyeglasses or contact lenses after cataract surgery • Glaucoma Screening 	You pay \$45 copay You pay \$10 copay for a non-VSP specialist office visit \$100 plan coverage limit for supplemental eyewear every two years. Must be provided by a VSP provider. You pay \$10 copay You pay \$0 You pay \$0	You pay \$30 copay in-network and \$40 copay out-of-network You pay \$0 copay for a non-VSP specialist office visit \$200 plan coverage limit for supplemental eyewear every two years. Must be provided by a VSP provider in-network. You pay 40% of the approved amount out-of-network with a non-VSP provider. You pay \$0 in-network and 40% of the approved amount out-of-network You pay \$0 You pay \$0	You pay \$40 copay You pay \$0 copay for a non-VSP specialist office visit \$100 plan coverage limit for supplemental eyewear every two years. Must be provided by a VSP provider. You pay \$0 You pay \$0 You pay \$0	One routine eye exam per year is covered. Routine eye exams must be provided by a VSP provider. One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens is covered. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)



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Medical Benefits	Core HMO	Access PPO	Choice HMO-POS	What You Should Know
Mental Health Services	<p>The copays for inpatient psychiatric hospital care 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 for 60 days in a row. If you go into a hospital 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.</p> <p>Our plan covers 90 days for a benefit period.</p>			<p>In addition to the 90 days of coverage in each benefit period, the beneficiary receives 100 lifetime reserve days for inpatient hospital psychiatric stays. 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 health services provided in a general hospital.</p> <p>Services may require prior authorization.</p>
• Inpatient visit	<p>You pay \$395 copay per day for days 1 through 4</p> <p>You pay \$0 per day for days 5 through 90</p> <p>You pay \$0 for days 91-190 until lifetime limitation is exhausted</p>	<p>You pay \$395 copay per day for days 1 through 4</p> <p>You pay \$0 per day for days 5 through 90</p> <p>You pay \$0 for days 91-190 until lifetime limitation is exhausted</p>	<p>You pay \$380 copay per day for days 1 through 4</p> <p>You pay \$0 per day for days 5 through 90</p> <p>You pay \$0 for days 91-190 until lifetime limitation is exhausted</p>	
• Outpatient therapy visit	<p>You pay \$40 copay for outpatient group/individual therapy visit</p>	<p>You pay \$40 copay for outpatient group/individual therapy visit</p>	<p>You pay \$40 copay for outpatient group/individual therapy visit</p>	
Skilled Nursing Facility (SNF)	<p>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.</p> <p>Our plan covers 100 days for a benefit period.</p>			<p>Services may require prior authorization.</p>
	<p>You pay \$0 per day for days 1 through 20</p> <p>\$172 copay per day for days 21 through 59</p> <p>\$0 copay per day for days 60 through 100</p>	<p>You pay \$0 per day for days 1 through 20</p> <p>\$169 copay per day for days 21 through 48</p> <p>\$0 copay per day for days 49 through 100</p>	<p>You pay \$0 per day for days 1 through 20</p> <p>\$169 copay per day for days 21 through 55</p> <p>\$0 copay per day for days 56 through 100</p>	
Physical Therapy	You pay \$40 copay			
Ambulance (Air and Ground)	You pay \$300 copay	You pay \$250 copay	You pay \$300 copay	Copay is for each one-way trip for Medicare-covered services.
Transportation	Not covered			
Medicare Part B Drugs	You pay 20% of the approved amount for Part B drugs			Some drugs may require prior authorization.

Medical Benefits	Core HMO	Access PPO	Choice HMO-POS	What You Should Know
Chiropractic Care <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation • Routine office visits • One set of X-rays (up to 3 views) 	You pay \$20 copay for each Medicare-covered visit You pay \$20 copay for all routine care visits You pay \$0 copay for one annual set of X-rays (up to 3 views) when performed by a chiropractor			
Foot Care (podiatry services) <ul style="list-style-type: none"> • Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions 	You pay \$45 copay	You pay \$30 copay for In-Network Medicare-covered visits You pay \$40 copay for Out-of-Network Medicare-covered visits	You pay \$40 copay	Medicare-covered podiatry benefits are for medically necessary foot care.
Home Health Care	You pay \$0			A doctor must certify that you need home health services and will order home health services to be provided by a home health agency.
Hospice	You pay \$0 for hospice care from a Medicare-certified hospice program. Hospice is covered outside of our plan. Please contact Customer Service for more details (phone numbers are on the back of this booklet).			
Medical Equipment/Supplies <ul style="list-style-type: none"> • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetes supplies (e.g., monitoring, shoes or inserts) 	You pay 20% of the approved amount You pay 20% of the approved amount You pay 20% of the approved amount	You pay 20% of the approved amount You pay 20% of the approved amount You pay \$0 for our preferred brand of diabetic supplies	You pay 20% of the approved amount You pay 20% of the approved amount You pay 20% of the approved amount	Medical equipment/supplies may require prior authorization.
Outpatient Substance Abuse <ul style="list-style-type: none"> • Outpatient therapy visit 	You pay \$40 copay for group/individual therapy visit			



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Medical Benefits	Core HMO	Access PPO	Choice HMO-POS	What You Should Know
Outpatient Surgery <ul style="list-style-type: none"> • Ambulatory surgical center • Outpatient hospital 	You pay \$300 copay for Medicare-covered outpatient surgical services You pay \$395 copay for Medicare-covered outpatient surgical services	You pay \$200 copay for Medicare-covered outpatient surgical services You pay \$350 copay for Medicare-covered outpatient surgical services	You pay \$200 copay for Medicare-covered outpatient surgical services You pay \$350 copay for Medicare-covered outpatient surgical services	Services may require prior authorization.
Rehabilitation Services <ul style="list-style-type: none"> • Pulmonary • Cardiac • Intensive cardiac • Occupational, speech and language therapy 	You pay \$30 copay each visit You pay \$45 copay each visit You pay \$45 copay each visit You pay \$40 copay each visit	You pay \$30 copay each visit You pay \$40 copay each visit You pay \$40 copay each visit You pay \$40 copay each visit	You pay \$30 copay each visit You pay \$45 copay each visit You pay \$45 copay each visit You pay \$40 copay each visit	
Renal Dialysis	You pay 20% of the approved amount			
Wellness Programs (e.g., fitness)	All members can join the SilverSneakers® Fitness program at no cost. SilverSneakers is a leading fitness program for people with Medicare. <ul style="list-style-type: none"> • Locations nationwide • Low-impact classes to improve strength and balance • Health education events • SilverSneakers Steps Kit You must use network facilities to obtain this benefit. <p>Tivity Health™ is an independent company not associated with the Blue Cross Blue Shield Association. Blue Cross Blue Shield of Nebraska contracts with Tivity Health to offer the SilverSneakers fitness program benefit. SilverSneakers® is a registered trade mark of Tivity Health, Inc. © 2019 Tivity Health, Inc. All rights reserved.</p>			To locate a participating fitness center near you, call 1-866-678-0828, 8 a.m. to 8 p.m. Central time Monday through Friday. TTY users call 711. Or visit SilverSneakers.com.

Blue Cross Blue Shield Nebraska – Core HMO

Outpatient Prescription Drugs – Short-Term Supply				
PHASE 1: Deductible Stage	\$250 which applies to Tiers 3 through 5 only			
PHASE 2: Initial Coverage Stage	You pay the following until your total yearly drug costs reach \$4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us at 1-855-457-1349 or access our <i>Evidence of Coverage</i> online at medicare.nebraskablue.com/medicareadvantage/plandetails .
	Standard Retail RX 30-day supply	Preferred Retail and Mail-Order RX 30-day supply	Long Term Care RX 31-day supply	
TIER 1 Preferred generic	You pay \$14	You pay \$3 for 30-day Preferred Retail You pay \$4 for 30-day Mail-Order	You pay \$3	
TIER 2 Generic	You pay \$18	You pay \$8	You pay \$8	
TIER 3 Preferred brand	You pay \$47	You pay \$37	You pay \$37	
TIER 4 Non-preferred	You pay 45%	You pay 45%	You pay 45%	
TIER 5 Specialty	You pay 28%	You pay 28%	You pay 28%	
PHASE 3: Coverage Gap Stage	You pay 25% for generic and brand drugs.			
PHASE 4: Catastrophic Coverage Stage	You pay the greater of \$3.60 generic/\$8.95 brand or 5%			



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Blue Cross Blue Shield Nebraska – Core HMO

Outpatient Prescription Drugs – Long-Term Supply					
PHASE 1: Deductible Stage	\$250 which applies to Tiers 3 through 5 only				
PHASE 2: Initial Coverage Stage	You pay the following until your total yearly drug costs reach \$4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.				
	Standard Retail RX 60-day supply	Preferred Retail and Mail-Order RX 60-day supply	Standard Retail RX 90-day supply	Preferred Retail and Mail-Order Rx 90-day supply	
TIER 1 Preferred generic	You pay \$28	You pay \$6 for 60-day Preferred Retail You pay \$8 for 60-day Mail-Order	You pay \$42	You pay \$9 for 90-day Preferred Retail You pay \$0 for 90-day Mail-Order	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us at 1-855-457-1349 or access our <i>Evidence of Coverage</i> online at medicare.nebraskablue.com/medicareadvantage/plandetails .
TIER 2 Generic	You pay \$36	You pay \$16	You pay \$54	You pay \$24 for 90-day Preferred Retail You pay \$0 for 90-day Mail-Order	
TIER 3 Preferred brand	You pay \$94	You pay \$74	You pay \$141	You pay \$111	
TIER 4 Non-preferred	You pay 45%	You pay 45%	You pay 45%	You pay 45%	
TIER 5 Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	
PHASE 3: Coverage Gap Stage	You pay 25% for generic and brand drugs.				
PHASE 4: Catastrophic Coverage Stage	You pay the greater of \$3.60 generic/\$8.95 brand or 5%				

Blue Cross Blue Shield Nebraska – Access PPO

Outpatient Prescription Drugs – Short-Term Supply				
PHASE 1: Deductible Stage	\$100 which applies to Tiers 3 through 5 only			
PHASE 2: Initial Coverage Stage	You pay the following until your total yearly drug costs reach \$4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			
	Standard Retail RX 30-day supply	Preferred Retail and Mail-Order RX 30-day supply	Long Term Care RX 31-day supply	
TIER 1 Preferred generic	You pay \$12	You pay \$0 for 30-day Preferred Retail You pay \$2 for 30-day Mail-Order	You pay \$0	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us at 1-855-457-1349 or access our <i>Evidence of Coverage</i> online at medicare.nebraskablue.com/medicareadvantage/plandetails .
TIER 2 Generic	You pay \$18	You pay \$8	You pay \$8	
TIER 3 Preferred brand	You pay \$47	You pay \$37	You pay \$37	
TIER 4 Non-preferred	You pay 45%	You pay 45%	You pay 45%	
TIER 5 Specialty	You pay 31%	You pay 31%	You pay 31%	
PHASE 3: Coverage Gap Stage	You pay 25% for generic and brand drugs.			
PHASE 4: Catastrophic Coverage Stage	You pay the greater of \$3.60 generic/\$8.95 brand or 5%			



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Blue Cross Blue Shield Nebraska – Access PPO

Outpatient Prescription Drugs – Long-Term Supply					
PHASE 1: Deductible Stage	\$100 which applies to Tiers 3 through 5 only				
PHASE 2: Initial Coverage Stage	You pay the following until your total yearly drug costs reach \$4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.				
	Standard Retail RX 60-day supply	Preferred Retail and Mail-Order RX 60-day supply	Standard Retail RX 90-day supply	Preferred Retail and Mail-Order Rx 90-day supply	
TIER 1 Preferred generic	You pay \$24	You pay \$0 for 60-day Preferred Retail You pay \$4 for 60-day Mail-Order	You pay \$36	You pay \$0	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us at 1-855-457-1349 or access our <i>Evidence of Coverage</i> online at medicare.nebraskablue.com/medicareadvantage/plandetails .
TIER 2 Generic	You pay \$36	You pay \$16	You pay \$54	You pay \$24 for 90-day Preferred Retail You pay \$0 for 90-day Mail-Order	
TIER 3 Preferred brand	You pay \$94	You pay \$74	You pay \$141	You pay \$111	
TIER 4 Non-preferred	You pay 45%	You pay 45%	You pay 45%	You pay 45%	
TIER 5 Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	
PHASE 3: Coverage Gap Stage	You pay 25% for generic and brand drugs.				
PHASE 4: Catastrophic Coverage Stage	You pay the greater of \$3.60 generic/\$8.95 brand or 5%				

Blue Cross Blue Shield Nebraska – Choice HMO-POS

Outpatient Prescription Drugs – Short-Term Supply				
PHASE 1: Deductible Stage	\$150 which applies to Tiers 3 through 5 only			
PHASE 2: Initial Coverage Stage	You pay the following until your total yearly drug costs reach \$4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us at 1-855-457-1349 or access our <i>Evidence of Coverage</i> online at medicare.nebraskablue.com/medicareadvantage/plandetails .
	Standard Retail RX 30-day supply	Preferred Retail and Mail-Order RX 30-day supply	Long Term Care RX 31-day supply	
TIER 1 Preferred generic	You pay \$12	You pay \$2	You pay \$2	
TIER 2 Generic	You pay \$18	You pay \$8	You pay \$8	
TIER 3 Preferred brand	You pay \$47	You pay \$37	You pay \$37	
TIER 4 Non-preferred	You pay 45%	You pay 45%	You pay 45%	
TIER 5 Specialty	You pay 30%	You pay 30%	You pay 30%	
PHASE 3: Coverage Gap Stage	You pay 25% for generic and brand drugs.			
PHASE 4: Catastrophic Coverage Stage	You pay the greater of \$3.60 generic/\$8.95 brand or 5%			



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Blue Cross Blue Shield Nebraska – Choice HMO-POS

Outpatient Prescription Drugs – Long-Term Supply					
PHASE 1: Deductible Stage	\$150 which applies to Tiers 3 through 5 only				
PHASE 2: Initial Coverage Stage	You pay the following until your total yearly drug costs reach \$4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.				
	Standard Retail RX 60-day supply	Preferred Retail and Mail-Order RX 60-day supply	Standard Retail RX 90-day supply	Preferred Retail and Mail-Order Rx 90-day supply	
TIER 1 Preferred generic	You pay \$24	You pay \$4	You pay \$36	You pay \$6 for 90-day Preferred Retail You pay \$0 for 90-day Mail-Order	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us at 1-855-457-1349 or access our <i>Evidence of Coverage</i> online at medicare.nebraskablue.com/medicareadvantage/plandetails .
TIER 2 Generic	You pay \$36	You pay \$16	You pay \$54	You pay \$24 for 90-day Preferred Retail You pay \$0 for 90-day Mail-Order	
TIER 3 Preferred brand	You pay \$94	You pay \$74	You pay \$141	You pay \$111	
TIER 4 Non-preferred	You pay 45%	You pay 45%	You pay 45%	You pay 45%	
TIER 5 Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	
PHASE 3: Coverage Gap Stage	You pay 25% for generic and brand drugs.				
PHASE 4: Catastrophic Coverage Stage	You pay the greater of \$3.60 generic/\$8.95 brand or 5%				

Discrimination is Against the Law

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

Blue Cross and Blue Shield of Nebraska:

- 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 Customer Service at 1-888-488-9850, TTY 711.

If you believe that Blue Cross and Blue Shield of Nebraska 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:

Manager, Corporate Compliance
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001
1-888-488-9850, TTY: 711
Fax: 1-402-392-4130
civilrights@nebraskablue.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Manager, Corporate Compliance, 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>.

Multi-language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-899-6060 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-899-6060 (TTY: 711).

Chinese: 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 1-844-899-6060 (TTY: 711)。

Arabic: ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-899-6060 (رقم هاتف الصم والبكم: 711).

Karen: ၵၢ်သ့ၵ်ၵ်း- နမ့ၢ်ကတိၢ် ကညီ ကျိၣ်အသိၣ်, နမ့ၢ်န့ၢ် ကျိၣ်အတၢ်မၤတၢ်လၢ တလၢၣ်တၢ်တၢ်တၢ်န့ၢ်လၢန့ၢ်လၢ. ကိး
1-844-899-6060 (TTY: 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-899-6060 (ATS: 711).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-899-6060 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-899-6060 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-844-899-6060 (TTY: 711) 번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: यदि तपाईंले नेपाली बोल्नुहुन्छ भने, तपाईंको लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। 1-844-899-6060 (TTY: 711) मा फोन गर्नुहोस्।

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-899-6060 (телетайп: 711).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ແຈ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-844-899-6060 (TTY: 711).

Kurdish: ئاگاداری: ئهگهر به زمانی کوردی قهسه، دهکهییت خزمهتگوزاریهکانی یارمهتی، زمان بهخۆراییی یۆ تو بهردهسته. پهیههندی به 1-844-899-6060 (TTY: 711) بکه.

Persian: توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات و کمک‌های زبانی رایگان برای شما موجود است. برای کسب اطلاعات بیشتر، با شماره 1-844-899-6060 (TTY: 711) تماس بگیرید.

Japanese: 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。
1-844-899-6060 (TTY: 711) まで、お電話にてご連絡ください。

Need more information?

For more information, please call us at the phone number below or visit us at [medicare.nebraskablue.com](https://www.medicare.nebraskablue.com).

If you are a member of this plan, call toll-free **1-888-488-9850 (TTY users should call 711)**.

If you are not a member of this plan, call toll-free **1-844-899-6060 (TTY users should call 711)**.

- From October 1 to March 31, you can call us 7 days a week, 8:00 a.m. to 8:00 p.m. Central time.
- From April 1 to September 30, you can call us Monday through Friday, 8:00 a.m. to 8:00 p.m. Central time.

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 large print by calling the customer service phone number.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO, Choice HMO-POS and Access PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.



An independent licensee of the Blue Cross and Blue Shield Association