A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

A Medicare Advantage HMO Plan

Baton Rouge (includes Ascension, East Baton Rouge, Livingston, St. Helena and West Baton Rouge parishes)

2016 SUMMARY OF BENEFITS

HMO Louisiana
A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

01MA1005 09/15  

H6453_15-044_MKLA CMS Accepted
Summary of Benefits
January 1, 2016 – December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn’t list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the “Evidence of Coverage.”

You have choices about how to get your Medicare benefits
- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Blue Advantage (HMO)).

Tips for comparing your Medicare choices
This Summary of Benefits booklet gives you a summary of what Blue Advantage (HMO) covers and what you pay.
- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet
- Things to Know About Blue Advantage (HMO)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-866-508-7145.

Things to Know About Blue Advantage (HMO)

Hours of Operation
- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time.

Blue Advantage (HMO) Phone Numbers and Website
- If you are a member of this plan, call toll-free 1-866-508-7145.
- If you are not a member of this plan, call toll-free 1-800-363-9152.
- Our website: http://www.bcbsla.com/blueadvantage

Who can join?
To join Blue Advantage (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following parishes in Louisiana: Ascension, East Baton Rouge, Livingston, St. Helena and West Baton Rouge.
Which doctors, hospitals, and pharmacies can I use?

Blue Advantage (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use the providers that are not in our network, the plan may not pay for these services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan’s provider and pharmacy directory at our website (www.bcbsla.com/blueadvantage). Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

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

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.bcbsla.com/blueadvantage.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

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

Blue Advantage from HMO Louisiana is an HMO plan with a Medicare contract.
## Summary of Benefits

**January 1, 2016 – December 31, 2016**

### Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

<table>
<thead>
<tr>
<th>How much is the monthly premium?</th>
<th>$0 per month. In addition, you must keep paying your Medicare Part B premium.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much is the deductible?</td>
<td>$95 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible.</td>
</tr>
</tbody>
</table>
| Is there any limit on how much I will pay for my covered services? | Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan:  
  - $6,700 for services you receive from in-network providers.  
If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.  
Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. |
| Is there a limit on how much the plan will pay? | Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply. |

### Covered Medical and Hospital Benefits

**Note:**

• Services with a " may require prior authorization.

#### Outpatient Care and Services

<table>
<thead>
<tr>
<th>Acupuncture</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>$245 co-pay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chiropractic Care</th>
<th>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 co-pay</th>
</tr>
</thead>
</table>

| Dental Services | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing. Preventive dental services:  
  - Cleaning (for up to 1 every year): $0 co-pay  
  - Dental x-ray(s) (for up to 1 every three years): $0 co-pay  
  - Fluoride treatment (for up to 1 every year): $0 co-pay  
  - Oral exam (for up to 1 every year): $0 co-pay  
The preventive dental x-ray coverage is for horizontal bite-wing x-rays only. |
|------------------|-------------------------------------------------|

| Diabetes Supplies and Services | Diabetes monitoring supplies: You pay nothing  
Diabetes self-management training: You pay nothing  
Therapeutic shoes or inserts: You pay nothing  
Authorization is required for diabetic shoes and inserts. |
|-----------------|-------------------------------------------------|


| **Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for these services may vary based on place of service)** | Diagnostic radiology services (such as MRIs, CT scans): $150 co-pay  
Diagnostic tests and procedures: $10 co-pay  
Lab services: $10 co-pay  
Outpatient x-rays: $0-$35 co-pay, depending on the service  
Therapeutic radiology services (such as radiation treatment for cancer): $35 co-pay  
Authorization rules may apply for certain outpatient diagnostic procedures or tests.  
There is no co-pay for abdominal aneurysm screening, diabetes screening or prostate cancer screening when they are ordered as a preventive service. |
| --- | --- |
| **Doctor's Office Visits** | Primary care physician visit: $5 co-pay  
Specialist visit: $35 co-pay |
| **Durable Medical Equipment (wheelchairs, oxygen, etc.)** | 20% of the cost  
If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.  
Information on our network of Durable Medical Equipment (DME) providers is also included in our Provider Directory. |
| **Emergency Care** | $75 co-pay  
If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.  
Emergency Care is available worldwide. |
| **Foot Care (podiatry services)** | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $10 co-pay |
| **Hearing Services** | Exam to diagnose and treat hearing and balance issues: $10 co-pay  
Routine hearing exam (for up to 1 every year): $10 co-pay  
Hearing aid fitting/evaluation (for up to 1 every year): $0 co-pay  
Hearing aid: $0 co-pay  
Our plan pays up to $500 every year for hearing aids. |
| **Home Health Care †** | You pay nothing  
Authorization rules may apply for Home Health Services. |
| **Mental Health Care †** | Inpatient visit:  
Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. |
The co-pays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you’re admitted as an inpatient and ends when you haven’t received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There’s no limit to the number of benefit periods.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

- $60 co-pay per day for days 1 through 10
- You pay nothing per day for days 11 through 90

Outpatient group therapy visit: $35 co-pay
Outpatient individual therapy visit: $35 co-pay

<table>
<thead>
<tr>
<th>Outpatient Rehabilitation</th>
<th>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $20 co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Occupational therapy visit: $20 co-pay</td>
</tr>
<tr>
<td></td>
<td>Physical therapy and speech and language therapy visit: $20 co-pay</td>
</tr>
<tr>
<td></td>
<td>Co-pay for Cardiac Rehab Services applies per day. Authorization rules may apply for Outpatient Rehabilitation.</td>
</tr>
<tr>
<td></td>
<td>A separate co-pay for Occupational Therapy will apply if other outpatient therapy services are rendered on the same day.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Substance Abuse</th>
<th>Group therapy visit: $35 co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual therapy visit: $35 co-pay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Surgery</th>
<th>Ambulatory surgical center: $75 co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outpatient hospital: $100 co-pay or 20% of the cost, depending on the service</td>
</tr>
<tr>
<td></td>
<td>Authorization rules may apply for some Outpatient Hospital and Ambulatory Surgical Center services.</td>
</tr>
</tbody>
</table>

| Over-the-Counter Items | Not Covered |

<table>
<thead>
<tr>
<th>Prosthetic Devices (braces, artificial limbs, etc.)</th>
<th>Prosthetic devices: 20% of the cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Related medical supplies: 20% of the cost</td>
</tr>
<tr>
<td></td>
<td>Authorization rules may apply for some Prosthetics/Medical Supplies.</td>
</tr>
</tbody>
</table>

| Renal Dialysis | 20% of the cost |

<table>
<thead>
<tr>
<th>Transportation</th>
<th>You pay nothing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0 co-pay for up to 6 one-way trips to plan-approved locations every year.</td>
</tr>
<tr>
<td><strong>Urgently Needed Services</strong></td>
<td><strong>$35 co-pay</strong></td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------</td>
</tr>
</tbody>
</table>
| **Vision Services**       | **Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $10 co-pay**  
Routine eye exam (for up to 1 every year): $10 co-pay  
Contact lenses (for up to 1): $0 co-pay  
Eyeglass frames (for up to 1): $0 co-pay  
Eyeglasses lenses (for up to 1): $10 co-pay  
Eyeglasses or contact lenses after cataract surgery: $10 co-pay  
Our plan pays up to $100 every year for contact lenses, eyeglass lenses, and eyeglass frames. |

| **Preventive Care**       | **You pay nothing**  
Our plan covers many preventive services, including:  
- Abdominal aortic aneurysm screening  
- Alcohol misuse counseling  
- Bone mass measurement  
- Breast cancer screening (mammogram)  
- Cardiovascular disease (behavioral therapy)  
- Cardiovascular screenings  
- Cervical and vaginal cancer screening  
- Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)  
- Depression screening  
- Diabetes screenings  
- HIV screening  
- Medical nutrition therapy services  
- Obesity screening and counseling  
- Prostate cancer screenings (PSA)  
- Sexually transmitted infections screening and counseling  
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)  
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots  
- "Welcome to Medicare" preventive visit (one-time)  
- Yearly "Wellness" visit  
Any additional preventive services approved by Medicare during the contract year will be covered. |

| **Hospice**               | **You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.** |
Inpatient Care

Inpatient Hospital Care

The co-pays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you’re admitted as an inpatient and ends when you haven’t received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There’s no limit to the number of benefit periods.

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

- $60 co-pay per day for days 1 through 10
- You pay nothing per day for days 11 through 90
- $60 co-pay per day for days 91 through 100
- You pay nothing per day for days 101 and beyond

Inpatient Mental Health Care

For inpatient mental health care, see the "Mental Health Care" section of this booklet.

Skilled Nursing Facility (SNF)

Our plan covers up to 100 days in a SNF.

- You pay nothing per day for days 1 through 20
- $150 co-pay per day for days 21 through 100

No inpatient hospital stay is required prior to SNF admission.

Prescription Drug Benefits

How much do I pay?

For Part B drugs such as chemotherapy drugs:\n\[ \text{20\% of the cost} \]

Other Part B drugs:\n\[ \text{20\% of the cost} \]

Initial Coverage

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

<table>
<thead>
<tr>
<th>Standard Retail Cost-Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier</td>
</tr>
<tr>
<td>Tier 1 (Preferred Generic)</td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
</tr>
</tbody>
</table>
## Standard Mail Order Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>One-Month Supply</th>
<th>Two-Month Supply</th>
<th>Three-Month Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$3 co-pay</td>
<td>$6 co-pay</td>
<td>$9 co-pay</td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
<td>$10 co-pay</td>
<td>$20 co-pay</td>
<td>$30 co-pay</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$40 co-pay</td>
<td>$80 co-pay</td>
<td>$120 co-pay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>$85 co-pay</td>
<td>$170 co-pay</td>
<td>$255 co-pay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>31% of the cost</td>
<td>Not Offered</td>
<td>Not Offered</td>
</tr>
</tbody>
</table>

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

### Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug’s tier. See the chart that follows to find out how much it will cost you.

## Standard Retail Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>Drugs Covered</th>
<th>One-Month Supply</th>
<th>Two-Month Supply</th>
<th>Three-Month Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>All</td>
<td>$3 co-pay</td>
<td>$6 co-pay</td>
<td>$9 co-pay</td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
<td>All</td>
<td>$10 co-pay</td>
<td>$20 co-pay</td>
<td>$30 co-pay</td>
</tr>
</tbody>
</table>

## Standard Mail Order Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>Drugs Covered</th>
<th>One-Month Supply</th>
<th>Two-Month Supply</th>
<th>Three-Month Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>All</td>
<td>$3 co-pay</td>
<td>$6 co-pay</td>
<td>$9 co-pay</td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
<td>All</td>
<td>$10 co-pay</td>
<td>$20 co-pay</td>
<td>$30 co-pay</td>
</tr>
</tbody>
</table>
**Catastrophic Coverage**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of:

- 5% of the cost, or
- $2.95 co-pay for generic (including brand drugs treated as generic) and a $7.40 co-payment for all other drugs.

---

**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 1-866-508-7145. 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 1-866-508-7145. 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。如果需要此翻译服务，请致电1-866-508-7145。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1-866-508-7145。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 1-866-508-7145. 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 1-866-508-7145. 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 trình sức khỏe và chương trình thuốc men. Nếu có câu hỏi về chương trình, vui lòng gọi 1-866-508-7145. Chúng tôi sẽ giúp đỡ. Dịch vụ này miễn phí.


**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-508-7145. 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 1-866-508-7145. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.
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 1-866-508-7145. Someone who speaks English can help you. This is a free service.
Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract.