

Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO and Access PPO

2021

SUMMARY OF BENEFITS

Jan. 1, 2021 – Dec. 31, 2021

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** and **Blue Cross Blue Shield Nebraska Medicare Advantage Access PPO**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

There are two service areas for the **Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO** plan: Metro and Central. **Metro** includes these counties in Nebraska: Cass, Dodge, Douglas, Lancaster, Otoe, Sarpy, Saunders and Washington. **Central** includes these counties in Nebraska: Adams, Antelope, Arthur, Blaine, Boone, Buffalo, Burt, Butler, Chase, Clay, Colfax, Cuming, Custer, Dawson, Fillmore, Franklin, Frontier, Furnas, Gage, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Knox, Lincoln, Logan, Madison, McPherson, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Saline, Seward, Sherman, Stanton, Thayer, Thomas, Valley, Wayne, Webster, Wheeler and York.

The service area for the **Blue Cross Blue Shield Nebraska Medicare Advantage Access PPO** plan includes these counties in Nebraska: Adams, Antelope, Arthur, Blaine, Boone, Buffalo, Burt, Butler, Cass, Chase, Clay, Colfax, Cuming, Custer, Dawson, Dodge, Douglas, Fillmore, Franklin, Frontier, Furnas, Gage, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Knox, Lancaster, Lincoln, Logan, Madison, McPherson, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Saline, Sarpy, Saunders, Seward, Sherman, Stanton, Thayer, Thomas, Valley, Washington, Wayne, Webster, Wheeler and York.

Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO and **Blue Cross Blue Shield Nebraska Medicare Advantage Access PPO** 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 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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Premiums	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know
Monthly Plan Premium	You pay \$0	You pay \$26	You pay \$0	You must continue to pay your Medicare Part B premium.
Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	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	\$6,250 annually	If you reach the limit for Medicare-covered services on out-of-pocket costs, and you keep getting Medicare-covered hospital and medical services we will pay the full cost for the rest of the year. You will still need to pay your monthly plan premiums, Medicare Part B premiums, and cost sharing for your Part D drugs.

Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO Metro and Core HMO Central

As a supplemental benefit, medical services are covered at in-network cost shares outside of the service area and within the U.S. and territories. With limited exceptions, there is no medical coverage for services provided by an out-of-network provider within service area.

Blue Cross Blue Shield of Nebraska Medicare Advantage Access PPO

As a supplemental benefit, medical services are covered at in-network cost shares outside of the service area and within the U.S. and territories. Out-of-network cost shares apply to covered medical services provided by an out-of-network provider within service area. Out-of-network cost shares are the same as in-network cost shares unless specifically noted.

Please contact the plan for assistance in locating a provider outside of the service area.

Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know
Inpatient Hospital Coverage	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.			Services may require prior authorization.
	Our plan covers an unlimited number of days for an inpatient hospital stay.			
	You pay a \$420 copay per day for days 1 through 4			
	You pay a \$0 for additional days			
Outpatient Hospital Coverage	<p>You pay a \$395 copay for Medicare-covered outpatient hospital non-surgical services.</p> <p>You pay a \$395 copay for Medicare-covered outpatient hospital surgical services.</p>	<p>You pay a \$350 copay for Medicare-covered outpatient hospital nonsurgical services.</p> <p>You pay a \$350 copay for Medicare-covered outpatient hospital surgical services.</p>	<p>You pay a \$395 copay for Medicare-covered outpatient hospital non-surgical services.</p> <p>You pay a \$395 copay for Medicare-covered outpatient hospital surgical services.</p>	<p>Services may require prior authorization.</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 a \$10 copay, in-person and by telehealth</p> <p>You pay a \$45 copay, in-person and by telehealth</p>	<p>You pay a \$5 copay in-network, in-person and by telehealth, and \$15 copay out-of-network, in-person and by telehealth</p> <p>You pay a \$30 copay in-network, in-person and by telehealth, and \$40 copay out-of-network, in-person and by telehealth</p>	<p>You pay a \$5 copay, in-person and by telehealth</p> <p>You pay a \$45 copay, in-person and by telehealth</p>	



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 email: **getstarted@nebraskablue.com**. or visit **Medicare.NebraskaBlue.com**.

Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	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.
Emergency Care	<p style="text-align: center;">Within U.S.</p> <p style="text-align: center;">You pay a \$90 copay</p> <p style="text-align: center;">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.</p> <p style="text-align: center;">Outside of the U.S.</p> <p style="text-align: center;">You pay a \$90 copay</p> <p style="text-align: center;">\$50,000 lifetime limit inclusive of emergency, urgent care and transportation outside of the U.S.</p>			

Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know
Urgently Needed Services	<p>Within U.S. You pay a \$65 copay, in-person and telehealth services</p> <p>Outside of the U.S. You pay a \$90 copay \$50,000 lifetime limit inclusive worldwide emergency, urgent care and transportation</p>			
Diagnostic Services/ Labs/Imaging <ul style="list-style-type: none"> • Diagnostic radiology service (e.g., MRI) • Lab services • Diagnostic tests and procedures • Outpatient X-rays • Therapeutic radiology services 	You pay a \$150 copay You pay a \$10 copay You pay a \$20 copay You pay a \$20 copay You pay 20% of the approved amount	You pay a \$100 copay You pay a \$0 copay in-network; \$20 out-of-network You pay a \$20 copay You pay a \$15 copay in-network; \$30 copay out-of-network You pay 20% of the approved amount	You pay a \$150 copay You pay a \$10 copay You pay a \$20 copay You pay a \$20 copay You pay 20% of the approved amount	Services may require prior authorization. For Medicare-covered diagnostic radiological services, Medicare-covered diagnostic tests and procedures and Medicare-covered X-ray services performed in an outpatient setting, refer to Outpatient Surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.
Hearing Services <ul style="list-style-type: none"> • Medicare-covered • Routine hearing exam • Hearing aid • Hearing aid fitting and evaluation 	You pay a \$10 copay (Primary Care Provider) and a \$45 copay (Specialist) copay You pay a \$10 copay \$500 allowance per ear toward one new standard (analog or basic digital) hearing aid every three years You pay a \$0 copay once every three years	You pay a \$5 copay (Primary Care Provider) and a \$30 copay (Specialist) copay in-network and \$15 copay (Primary Care Provider) and a \$40 copay (Specialist) copay out-of-network You pay a \$0 copay \$500 allowance per ear toward one new standard (analog or basic digital) hearing aid every three years You pay a \$0 copay once every three years	You pay a \$5 copay (Primary Care Provider) and a \$45 copay (Specialist) copay You pay a \$10 copay \$500 allowance per ear toward one new standard (analog or basic digital) hearing aid every three years You pay a \$0 copay once every three years	One routine hearing exam per year is covered.



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Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know
<p>Dental Services</p> <ul style="list-style-type: none"> • Medicare-covered • Supplemental Preventive and Comprehensive Dental Services 	<p>You pay a \$45 copay</p> <p>The Dental Services benefit provides a combined Preventive and Comprehensive \$650 max benefit every plan year and may be used for: (a) 2 Oral Exams, (b) 2 Prophylaxis (cleaning), and / or (c) Dental X-rays.</p> <p>The Preventive Dental Services benefit provides routine cleanings and periodontal maintenance are covered under prophylaxis (cleaning). Emergency Dental exams are covered as Preventive Dental Services oral exams.</p> <p>The Comprehensive Dental Services benefit provides diagnostic services restorative services, endodontics, periodontics, extractions and prosthodontics.</p> <p>Preventive and comprehensive dental services must be provided by a licensed dental provider.</p>	<p>You pay a \$40 copay</p> <p>The Dental Services benefit provides a combined Preventive and Comprehensive \$1350 max benefit every plan year and may be used for: (a) 2 Oral Exams, (b) 2 Prophylaxis (cleaning), and / or (c) Dental X-rays.</p> <p>The Preventive Dental Services benefit provides routine cleanings and periodontal maintenance are covered under prophylaxis (cleaning). Emergency Dental exams are covered as Preventive Dental Services oral exams.</p> <p>The Comprehensive Dental Services benefit provides diagnostic services restorative services, endodontics, periodontics, extractions and prosthodontics.</p> <p>Preventive and comprehensive dental services must be provided by a licensed dental provider.</p>	<p>You pay a \$45 copay</p> <p>The Dental Services benefit provides a combined Preventive and Comprehensive \$900 max benefit every plan year and may be used for: (a) 2 Oral Exams, (b) 2 Prophylaxis (cleaning), and / or (c) Dental X-rays.</p> <p>The Preventive Dental Services benefit provides routine cleanings and periodontal maintenance are covered under prophylaxis (cleaning). Emergency Dental exams are covered as Preventive Dental Services oral exams.</p> <p>The Comprehensive Dental Services benefit provides diagnostic services restorative services, endodontics, periodontics, extractions and prosthodontics.</p> <p>Preventive and comprehensive dental services must be provided by a licensed dental provider.</p>	<p>Preventive and Comprehensive Dental Services are covered as a member-reimbursed benefit. Dental forms can be downloaded at Medicare. NebraskaBlue.com/MedicareAdvantage/Resources.</p>
<p>Vision Services</p> <ul style="list-style-type: none"> • Medicare-covered • Medicare-covered Diabetic Retinopathy exam 	<p>You pay a \$45 copay</p> <p>You pay a \$10 copay for a non-VSP specialist office visit (a Medicare-covered Diabetic Retinopathy exam is included in the routine eye exam provided by a VSP provider)</p>	<p>You pay a \$30 copay in-network and a \$40 copay out-of-network</p> <p>You pay a \$0 copay for a non-VSP specialist office visit (a Medicare-covered Diabetic Retinopathy exam is included in the routine eye exam provided by a VSP provider)</p>	<p>You pay a \$45 copay</p> <p>You pay a \$10 copay for a non-VSP specialist office visit (a Medicare-covered Diabetic Retinopathy exam is included in the routine eye exam provided by a VSP provider)</p>	<p>One routine eye exam per year is covered. Routine eye exams must be provided by a VSP provider.</p> <p>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</p>

Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know
<p>Vision Services (continued)</p> <ul style="list-style-type: none"> • Supplemental eyewear when provided by a VSP provider www.VSP.com • Supplemental eyewear when provided by a non-VSP provider • Routine eye exam when provided by a VSP provider • Eyeglasses or contact lenses after cataract surgery • Glaucoma Screening 	<p>\$100 plan coverage limit every 24 months for elective contact lenses or eyeglass frames through VSP provider. Standard lenses for glasses are covered in full.</p> <p>You pay a \$10 copay</p> <p>You pay a \$0 copay</p> <p>You pay a \$0 copay</p>	<p>\$200 plan coverage limit every 24 months and is inclusive of both in-network and out-of-network. Coverage for elective contact lenses or eyeglass frames. Standard lenses for glasses are covered in full.</p> <p>Coverage every 24 months through non-VSP provider. Non-VSP Coverage at 50% with specific benefit limits including Exam \$58, Lenses (Single \$30, Bifocal \$50, Trifocal \$65, Lenticular \$100), Frame \$100, Elective contacts \$100, Medically Necessary contacts \$210).</p> <p>You pay a \$0 in-network copay and 50% of the approved amount out-of-network (limit \$58)</p> <p>You pay a \$0 copay</p> <p>You pay a \$0 copay</p>	<p>\$100 plan coverage limit every 24 months for elective contact lenses or eyeglass frames through VSP provider. Standard lenses for glasses are covered in full.</p> <p>You pay a \$10 copay</p> <p>You pay a \$0 copay</p> <p>You pay a \$0 copay</p>	<p>purchase two eyeglasses after the second surgery.)</p>



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Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know			
<p>Mental Health Services</p> <ul style="list-style-type: none"> • Inpatient visit • Outpatient therapy visit 	<p>The copays for Medicare-covered 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>You pay a \$420 copay per day for days 1 through 4 You pay \$0 per day for days 5 through 90 You pay \$0 for days 91 through 190 until lifetime limitation is exhausted You pay a \$40 copay for outpatient group/individual therapy visit, in-person and by telehealth</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>Skilled Nursing Facility (SNF)</p>	<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> <table border="1" data-bbox="407 1146 1275 1750"> <tr> <td data-bbox="407 1146 699 1750"> <p>You pay a \$0 copay per day for days 1 through 20 \$184 copay per day for days 21 through 54 \$0 copay per day for days 55 through 100</p> </td> <td data-bbox="699 1146 991 1750"> <p>In-Network: You pay a \$0 copay per day for days 1 through 20 \$179 copay per day for days 21 through 46 \$0 copay per day for days 47 through 100</p> <p>Out-of-Network: You pay a \$0 copay per day for days 1 through 20 \$179 copay per day for days 21 through 59 \$0 copay per day for days 60 through 100</p> </td> <td data-bbox="991 1146 1275 1750"> <p>You pay a \$0 copay per day for days 1 through 20 \$184 copay per day for days 21 through 54 \$0 copay per day for days 55 through 100</p> </td> </tr> </table>			<p>You pay a \$0 copay per day for days 1 through 20 \$184 copay per day for days 21 through 54 \$0 copay per day for days 55 through 100</p>	<p>In-Network: You pay a \$0 copay per day for days 1 through 20 \$179 copay per day for days 21 through 46 \$0 copay per day for days 47 through 100</p> <p>Out-of-Network: You pay a \$0 copay per day for days 1 through 20 \$179 copay per day for days 21 through 59 \$0 copay per day for days 60 through 100</p>	<p>You pay a \$0 copay per day for days 1 through 20 \$184 copay per day for days 21 through 54 \$0 copay per day for days 55 through 100</p>	<p>Services may require prior authorization.</p>
<p>You pay a \$0 copay per day for days 1 through 20 \$184 copay per day for days 21 through 54 \$0 copay per day for days 55 through 100</p>	<p>In-Network: You pay a \$0 copay per day for days 1 through 20 \$179 copay per day for days 21 through 46 \$0 copay per day for days 47 through 100</p> <p>Out-of-Network: You pay a \$0 copay per day for days 1 through 20 \$179 copay per day for days 21 through 59 \$0 copay per day for days 60 through 100</p>	<p>You pay a \$0 copay per day for days 1 through 20 \$184 copay per day for days 21 through 54 \$0 copay per day for days 55 through 100</p>					
<p>Physical Therapy</p>	<p>You pay a \$40 copay</p>						

Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know
Ambulance (Air and Ground)	<p>In U.S., including the District of Columbia and Puerto Rico:</p> <p>\$325 copay for each Medicare-covered, one-way ground or air ambulance trip.</p> <p>Outside U.S.:</p> <p>\$90 copay for worldwide emergency transportation, one-way ground or air ambulance trip.</p> <p>\$50,000 lifetime limit for worldwide coverage inclusive of emergency, urgent care and transportation.</p>			<p>Non-emergency ambulance trips may require prior authorization.</p> <p>Copay is for each one-way trip for Medicare-covered services.</p>
Transportation	Not covered			
Medicare Part B Drugs	You pay 20% of the approved amount for Part B drugs			Some drugs may require prior authorization.
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) when performed by a chiropractor. 	<p>You pay a \$20 copay for each Medicare-covered visit</p> <p>You pay a \$20 copay for routine care visits</p> <p>You pay a \$0 copay for one annual set of X-rays (up to 3 views) when performed by a chiropractor</p>			



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Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know
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 a \$45 copay for Medicare-covered, in-person and by telehealth	You pay a \$30 copay for in-network Medicare-covered visits, in-person and by telehealth You pay a \$40 copay for out-of-network Medicare-covered visits, in-person and by telehealth	You pay a \$45 copay for Medicare-covered, in-person and by telehealth	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 a \$0 copay 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 a \$0 copay for Contour/Breeze/Ascensia blood glucose monitors, blood glucose test strips, lancet devices, and lancets. You pay a \$0 copay for solutions and urine/ketone tests.			Medical equipment/supplies may require prior authorization.
Outpatient Substance Abuse <ul style="list-style-type: none"> • Outpatient therapy visit 	You pay a \$40 copay for Medicare-covered group/individual therapy visit, in-person and by telehealth			
Outpatient Surgery <ul style="list-style-type: none"> • Ambulatory surgical center • Outpatient hospital 	You pay a \$300 copay for Medicare-covered outpatient surgical services You pay a \$395 copay for Medicare-covered outpatient surgical services	You pay a \$200 copay for Medicare-covered outpatient surgical services You pay a \$350 copay for Medicare-covered outpatient surgical services	You pay a \$300 copay for Medicare-covered outpatient surgical services You pay a \$395 copay for Medicare-covered outpatient surgical services	Services may require prior authorization.

Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know
Rehabilitation Services <ul style="list-style-type: none"> • Pulmonary • Cardiac • Intensive cardiac • Occupational, speech and language therapy 	You pay a \$30 copay each visit You pay a \$50 copay each visit You pay a \$50 copay each visit You pay a \$40 copay each visit	You pay a \$30 copay each visit You pay a \$45 copay each visit You pay a \$45 copay each visit You pay a \$40 copay each visit	You pay a \$30 copay each visit You pay a \$50 copay each visit You pay a \$50 copay each visit You pay a \$40 copay each visit	Services may require prior authorization.
Renal Dialysis	You pay 20% of the approved amount			
Wellness Programs (e.g., fitness)	<p>SilverSneakers® is a comprehensive program that can improve overall well-being and social connections. Designed for all levels and abilities, SilverSneakers provides convenient access to our nationwide fitness network, a variety of programming options and activities beyond the gym that incorporate physical well-being and social interaction.</p> <ul style="list-style-type: none"> • A no-added-cost fitness benefit with access to thousands of locations nationwide both in person and virtual • SilverSneakers FLEX classes offered outside the traditional gym setting • SilverSneakers.com online resources including, SilverSneakers Live classes & Live workshops, On-Demand, fitness location directory, articles, and more • Guidance from dedicated fitness staff • Adjustable workout programs tailored to individual fitness levels, schedule reminders for favorite activities, find convenient locations and more with the SilverSneakers GOTM app • Signature SilverSneakers classes designed for all fitness levels and led by trained instructors • The ability to enroll at multiple locations at any time - national reciprocity • Social connections through events such as shared meals, holiday celebrations, and class socials <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. © 2020 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.



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Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know
Acupuncture	You pay \$20 for up to 20 Medicare-covered acupuncture treatments annually for chronic lower back pain.			<p>Services may require prior authorization.</p> <p>Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: Lasting 12 weeks or longer; nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); not associated with surgery; and not associated with pregnancy.</p> <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p>
Nurse Hotline	You pay \$0 for calls to the Nurse Hotline.			Available 24 hours a day, 7 days a week.

Medical Benefits	Core HMO Metro	Access PPO	Core HMO Central	What You Should Know
<p>Telehealth</p> <ul style="list-style-type: none"> • Urgently needed services • Visits with a Primary Care Physician • Visits with a specialist • Individual and group mental health and psychiatric services • Podiatry services • Opioid treatment • Individual and group outpatient substance abuse services • Kidney disease education services • Other Health Care Professionals 	<p>\$65 copay</p> <p>\$10 copay</p> <p>\$45 copay</p> <p>\$40 copay</p> <p>\$45 copay</p> <p>\$45 copay</p> <p>\$40 copay</p> <p>\$0 copay</p> <p>\$10-\$45 copay</p>	<p>\$65 copay</p> <p>\$5 copay in-network/\$15 copay out-of-network</p> <p>\$30 copay in-network/\$40 copay out-of-network</p> <p>\$40 copay</p> <p>\$30 copay in-network/\$40 copay out-of-network</p> <p>\$30 copay in-network/\$40 copay out-of-network</p> <p>\$40 copay</p> <p>\$0 copay</p> <p>\$5-\$30 copay in-network/\$15-\$40 copay out-of-network</p>	<p>\$65 copay</p> <p>\$5 copay</p> <p>\$45 copay</p> <p>\$40 copay</p> <p>\$45 copay</p> <p>\$45 copay</p> <p>\$40 copay</p> <p>\$0 copay</p> <p>\$5-\$45 copay</p>	<p>Telehealth visits are medical visits delivered to you by a provider that uses compliant technology capabilities.</p> <p>Not all medical conditions can be treated through Telehealth visits. The Telehealth doctor will identify if you need to see an in-person doctor for treatment.</p> <p>If you choose to receive one of these services via Telehealth, then you must use a provider that currently offers the service via Telehealth.</p>
Over-the-Counter (OTC) items	\$25 quarterly allowance that does not rollover each quarter.	\$50 quarterly allowance that does not rollover each quarter.	\$25 quarterly allowance that does not rollover each quarter.	Members may obtain authorized OTC items using a prepaid card and from vendor at retail locations and via mail, phone and website. Members may access their OTC benefit through a program that delivers to their home.



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Blue Cross Blue Shield Nebraska – Core HMO Metro

Outpatient Prescription Drugs – Short-Term Supply				
PHASE 1: Deductible Stage	\$0 for Tiers 1 and 2			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.
	\$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 \$4,130. 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 \$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 \$100	You pay \$100	You pay \$100	
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	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of \$3.70 generic/\$9.20 brand or 5%			

Blue Cross Blue Shield Nebraska – Core HMO Metro

Outpatient Prescription Drugs – Long-Term Supply						
PHASE 1: Deductible Stage	\$0 for Tiers 1 and 2					
	\$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 \$4,130. 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 \$200	You pay \$200	You pay \$300	You pay \$300		
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	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of \$3.70 generic/\$9.20 brand or 5%					



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email: getstarted@nebraskablue.com. or visit [Medicare.NebraskaBlue.com](https://www.Medicare.NebraskaBlue.com).

Blue Cross Blue Shield Nebraska – Access PPO

Outpatient Prescription Drugs – Short-Term Supply				
PHASE 1: Deductible Stage	\$0 for Tiers 1 and 2			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.
	\$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 \$4,130. 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	
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 \$100	You pay \$100	You pay \$100	
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	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of \$3.70 generic/\$9.20 brand or 5%			

Blue Cross Blue Shield Nebraska – Access PPO

Outpatient Prescription Drugs – Long-Term Supply						
PHASE 1: Deductible Stage	\$0 for Tiers 1 and 2					
	\$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 \$4,130. 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 \$200	You pay \$200	You pay \$300	You pay \$300		
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	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of \$3.70 generic/\$9.20 brand or 5%					



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Blue Cross Blue Shield Nebraska – Core HMO Central

Outpatient Prescription Drugs – Short-Term Supply				
PHASE 1: Deductible Stage	\$0 for Tiers 1 and 2			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.
	\$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 \$4,130. 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 \$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 \$100	You pay \$100	You pay \$100	
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	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of \$3.70 generic/\$9.20 brand or 5%			

Blue Cross Blue Shield Nebraska – Core HMO Central

Outpatient Prescription Drugs – Long-Term Supply						
PHASE 1: Deductible Stage	\$0 for Tiers 1 and 2					
	\$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 \$4,130. 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 \$200	You pay \$200	You pay \$300	You pay \$300		
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	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of \$3.70 generic/\$9.20 brand or 5%					



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email: getstarted@nebraskablue.com. or visit [Medicare.NebraskaBlue.com](https://www.Medicare.NebraskaBlue.com).

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: ၵၢၢ်သ့ၵၢၢ်လၢသး- နမ့ၢ်ကတိၤ ကညိၣ် ကျိၣ်အလိၣ်, နမ့ၢ်န့ၢ် ကျိၣ်အတၢ်မၤတၢ်လၢ တလၢၢ်ဘၣ်လၢၢ်တ့ၢ် နိတမံၤဘၣ်သ့ၵၢၢ်လိၣ်. 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 नि:शुल्क 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-844-899-6060 (TTY: 711).

Kurdish: ناگاداری: ئه‌گهر به زمانى كوردى قهسه، ده‌كهیت خزمهتگوزاریه‌كانى یارمهتی، زمان به‌خوێراى بۆ تو به‌دهسته. په‌یۆندی 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**.

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 Oct. 1 to Mar. 31, you can call us 7 days a week, 8:00 a.m. to 8:00 p.m. CT.
- From Apr. 1 to Sept. 30, you can call us Monday through Friday, 8:00 a.m. to 8:00 p.m. CT.

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 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