Kansas

2021 Summary of Benefits

Blue Medicare Advantage (PPO)
Blue Medicare Advantage Comprehensive (PPO)

Topeka Region: Douglas, Jackson, Jefferson, Osage, Pottawatomie, Shawnee and Wabaunsee

Effective from January 1, 2021 through December 31, 2021

Section 1: Introduction

Introduction

This document is a summary of drug and health services covered by Blue Medicare Advantage (PPO) and Blue Medicare Advantage Comprehensive (PPO). The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

Blue Cross and Blue Shield of Kansas' Blue Medicare Advantage (PPO) and Blue Medicare Advantage Comprehensive (PPO) are PPOs with Medicare contracts. Enrollment in either plan depends on contract renewal.

This information is not a complete description of benefits. Call **1-800-222-7645 (TTY: 711)** for more information.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call **1-800-222-7645 (TTY: 711).**

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what Blue Medicare Advantage (PPO) and Blue Medicare Advantage Comprehensive (PPO) covers and what you pay. If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://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 https://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.

Who can join?

To join either Blue Medicare Advantage (PPO) or Blue Medicare Advantage Comprehensive (PPO), 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 counties in the state of Kansas: Douglas, Jackson, Jefferson, Osage, Pottawatomie, Shawnee, and Wabaunsee.

Hours of Operations

From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.

From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time. You may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day.

Phone Numbers and Website

If you have any questions, call toll-free at 1-866-626-0175(TTY:711) or visit our website at bcbsks.com/medicare/forms.

Which doctors, hospitals, and pharmacies can I use?

Blue Cross and Blue Shield of Kansas has a network of doctors, hospitals, pharmacies, and other providers. As a result, you may pay less for your covered benefits. However, you may also use providers that are not in our network.

Generally, you must use pharmacies in our network to fulfill your prescriptions for covered Part D Drugs.

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.

What drugs are covered?

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, bcbsks.com/medicare.

Or, call us and we will send you a copy of the Formulary.

How will I determine my drug costs?

Our plans group 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, day supply, 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. If you have questions about the different benefit stages, please contact the Plan for more information or access the Evidence of Coverage.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at **1-800-222-7645 (TTY: 711).**

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit bcbsks.com/medicare/forms or call **1-800-222-7645 (TTY: 711)** to view a copy of the EOC.

- ☐ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

- ☐ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.

- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

Section 2: Summary of Benefits

Notes: Services with a "[1]" may require prior authorization. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. Please see "Section 3: Optional Supplementals" for these additional benefits.

Category	Blue Medicare Advantage (PPO)	Blue Medicare Advantage Comprehensive (PPO)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services		
Monthly Plan Premium	You must continue to pay your Medicare Part B premium. $0 per month	You must continue to pay your Medicare Part B premium. $50 per month
Deductible	There is no annual deductible.	There is no annual deductible.
Maximum Out-of-Pocket (MOOP)	Your maximum out-of-pocket responsibility represents the most you will pay for copays, coinsurance, and other costs for Medicare-covered services throughout the year. This does not apply to prescription drugs and other select supplemental benefits (as noted). $6,700 annually for services you receive from in-network providers. $10,000 annually for services you receive from in and out-of-network providers combined. Your limit for services received from in-network providers will count toward this limit.	Your maximum out-of-pocket responsibility represents the most you will pay for copays, coinsurance, and other costs for Medicare-covered services throughout the year. This does not apply to prescription drugs and other select supplemental benefits (as noted). $6,200 annually for services you receive from in-network providers. $9,000 annually for services you receive from in and out-of-network providers combined. Your limit for services received from in-network providers will count toward this limit.
Inpatient Care		
Inpatient Hospital Care[1] **Prior Authorization may be required**	Our plan covers an unlimited number of days for an inpatient hospital stay. In-network: $300 copay per day for days 1 to 5. $0 copay per day for days 6 and beyond. Out-of-network: 40% coinsurance per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. In-network: $300 copay per day for days 1 to 5. $0 copay per day for days 6 and beyond. Out-of-network: 30% coinsurance per stay

Category	Blue Medicare Advantage (PPO)	Blue Medicare Advantage Comprehensive (PPO)
Inpatient Mental Health Care[1] **Prior Authorization may be required**	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. In-network: $300 copay per day for days 1 to 5. $0 copay per day for days 6 to 90. Out-of-network: 40% coinsurance per stay	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. In-network: $300 copay per day for days 1 to 5. $0 copay per day for days 6 to 90. Out-of-network: 30% coinsurance per stay
Outpatient Care and Services		
Outpatient Surgery	In-network: $250 copay Out-of-network: $250 copay	In-network: $250 copay Out-of-network: $250 copay
Ambulatory Surgery Center	In-network: $250 copay Out-of-network: $250 copay	In-network: $250 copay Out-of-network: $250 copay
Doctor's Office Visits	**Primary Care Provider (PCP):** In-network: $10 copay Out-of-network: 40% coinsurance **Specialist:** In-network: $50 copay Out-of-network: 40% coinsurance	**Primary Care Provider (PCP):** In-network: $5 copay Out-of-network: 30% coinsurance **Specialist:** In-network: $40 copay Out-of-network: 30% coinsurance
Preventive Care	Our plan covers one annual physical exam per year, in addition to Medicare-covered preventive services In-network: $0 copay Out-of-network: 40% coinsurance	Our plan covers one annual physical exam per year, in addition to Medicare-covered preventive services In-network: $0 copay Out-of-network: 30% coinsurance
Telehealth	**Primary Care Provider (PCP):** In-network: $10 copay Out-of-network: 40% coinsurance **Specialist:** In-network: $50 copay Out-of-network: 40% coinsurance	**Primary Care Provider (PCP):** In-network: $5 copay Out-of-network: 30% coinsurance **Specialist:** In-network: $40 copay Out-of-network: 30% coinsurance

Category	Blue Medicare Advantage (PPO)	Blue Medicare Advantage Comprehensive (PPO)
Emergency Care	Services are available worldwide up to $50,000. You do not have to pay your Emergency Room copay if you are admitted to a hospital within 24 hours. In-network: $90 copay Out-of-network: $90 copay	Services are available worldwide up to $50,000. You do not have to pay your Emergency Room copay if you are admitted to a hospital within 24 hours. In-network: $80 copay Out-of-network: $80 copay
Urgently Needed Services	In-network: $30 copay Out-of-network: $30 copay	In-network: $25 copay Out-of-network: $25 copay
Diagnostic Services, Labs, and Imaging *(Costs for these services may vary based on place of service)* **Prior Authorization may be required for MRI's, CT Scans, etc.**	**Diagnostic Tests and Procedures:** In-network: $0 copay Out-of-network: 40% coinsurance **Lab Services:** In-network: $0 copay Out-of-network: 40% coinsurance **X-rays:** In-network: $0 copay Out-of-network: 40% coinsurance **Diagnostic Radiology Services (including MRIs, CT Scans, etc.) at a PCP or Specialist's Office:** In-network: $50 copay Out-of-network: 40% coinsurance **Diagnostic Radiology Services (including MRIs, CT Scans, etc.) at a Freestanding or Outpatient Facility:** In-network: $250 copay Out-of-network: 40% coinsurance **Therapeutic Radiology Services:** In-network: 20% coinsurance Out-of-network: 40% coinsurance	**Diagnostic Tests and Procedures:** In-network: $0 copay Out-of-network: 30% coinsurance **Lab Services:** In-network: $0 copay Out-of-network: 30% coinsurance **X-rays:** In-network: $0 copay Out-of-network: 30% coinsurance **Diagnostic Radiology Services (including MRIs, CT Scans, etc.) at a PCP or Specialist's Office:** In-network: $40 copay Out-of-network: 30% coinsurance **Diagnostic Radiology Services (including MRIs, CT Scans, etc.) at a Freestanding or Outpatient Facility:** In-network: $250 copay Out-of-network: 30% coinsurance **Therapeutic Radiology Services:** In-network: 20% coinsurance Out-of-network: 30% coinsurance

Category	Blue Medicare Advantage (PPO)	Blue Medicare Advantage Comprehensive (PPO)
Hearing Services	**Medicare-Covered Exams to Diagnose and Treat Hearing and Balance Issues:** In-network: $50 copay Out-of-network: 40% coinsurance **Routine Hearing Exams:** Our plan covers one routine hearing exam per year. In-network: $0 copay Out-of-network: 40% coinsurance **Hearing Aids:** You pay $699 or $999 per hearing aid for up to two TruHearing hearing aids every year (one per ear per year). Benefit is limited to the TruHearing Advanced and Premium hearing aids. You must see a TruHearing provider to use this benefit. ***Routine Hearing Exam and Hearing Aid cost-shares are not subject to the maximum out-of-pocket.***	**Medicare-Covered Exams to Diagnose and Treat Hearing and Balance Issues:** In-network: $40 copay Out-of-network: 30% coinsurance **Routine Hearing Exams:** Our plan covers one routine hearing exam per year. In-network: $0 copay Out-of-network: 30% coinsurance **Hearing Aids:** You pay $699 or $999 per hearing aid for up to two TruHearing hearing aids every year (one per ear per year). Benefit is limited to the TruHearing Advanced and Premium hearing aids. You must see a TruHearing provider to use this benefit. ***Routine Hearing Exam and Hearing Aid cost-shares are not subject to the maximum out-of-pocket.***

Category	Blue Medicare Advantage (PPO)	Blue Medicare Advantage Comprehensive (PPO)
Dental Services	**Medicare-Covered Dental Services:** In-network: $0 copay Out-of-network: 40% coinsurance Our plan pays up to $500 for preventive and comprehensive dental services every year for services received in-network or out-of-network. **Preventive Dental Services:** • Routine cleanings (up to 2 every year) • Bitewing x-rays (up to 2 every year) • Oral exams (up to 2 every year) In-network: $0 copay Out-of-network: 40% coinsurance **Comprehensive Dental Services:** Reference Evidence of Coverage for additional detail on covered comprehensive services / limitations. • Restorative • Endodontics • Periodontics • Extractions • Prosthodontics and Oral / Maxillofacial Services In-network: 50% coinsurance Out-of-network: 40% coinsurance ***Non Medicare-Covered Preventive Dental Service cost-shares are not subject to the maximum out-of-pocket.***	**Medicare-Covered Dental Services:** In-network:$0 copay Out-of-network: 30% coinsurance Our plan pays up to $800 for preventive and comprehensive dental services every year for services received in-network or out-of-network. **Preventive Dental Services:** • Routine cleanings (up to 2 every year) • Bitewing x-rays (up to 2 every year) • Oral exams (up to 2 every year) In-network: $0 copay Out-of-network: 30% coinsurance **Comprehensive Dental Services:** Reference Evidence of Coverage for additional detail on covered comprehensive services / limitations. • Restorative • Endodontics • Periodontics • Extractions • Prosthodontics and Oral / Maxillofacial Services In-network: 50% coinsurance Out-of-network: 30% coinsurance ***Non Medicare-Covered Preventive Dental Service cost-shares are not subject to the maximum out-of-pocket.***

Category	Blue Medicare Advantage (PPO)	Blue Medicare Advantage Comprehensive (PPO)
Vision Services	**Medicare-Covered Diabetic Eye Exams and Glaucoma Screenings:** In-network: $0 copay Out-of-network: 40% coinsurance **All Other Medicare-Covered Eye Exams:** In-network: $50 copay Out-of-network: 40% coinsurance **Medicare-Covered Eyewear:** In-network: $50 copay Out-of-network: 40% coinsurance **Routine Eye Exams:** Our plan covers one routine eye exam per year. In-network: $0 copay Out-of-network: You have an exam allowance of $85 every year. Any amount spent over $85 is your responsibility. **Frames, Lenses, and Contact Lenses:** You have an eyewear allowance of $150 every year. Any amount spent over $150 is your responsibility. ***Routine Eye Exam and Non-Medicare-Covered Eyewear cost-shares are not subject to the maximum out-of-pocket.***	**Medicare-Covered Diabetic Eye Exams and Glaucoma Screenings:** In-network: $0 copay Out-of-network: 30% coinsurance **All Other Medicare-Covered Eye Exams:** In-network: $40 copay Out-of-network: 30% coinsurance **Medicare-Covered Eyewear:** In-network: $40 copay Out-of-network: 30% coinsurance **Routine Eye Exams:** Our plan covers one routine eye exam per year. In-network: $0 copay Out-of-network: You have an exam allowance of $85 every year. Any amount spent over $85 is your responsibility. **Frames, Lenses, and Contact Lenses:** You have an eyewear allowance of $150 every year. Any amount spent over $150 is your responsibility. ***Routine Eye Exam and Non-Medicare-Covered Eyewear cost-shares are not subject to the maximum out-of-pocket.***

Category	Blue Medicare Advantage (PPO)	Blue Medicare Advantage Comprehensive (PPO)
Mental Health Care[1]	**Outpatient Group Therapy Visit:** In-network: $40 copay Out-of-network: 40% coinsurance **Outpatient Individual Therapy Visit:** In-network: $40 copay Out-of-network: 40% coinsurance	**Outpatient Group Therapy Visit:** In-network: $40 copay Out-of-network: 30% coinsurance **Outpatient Individual Therapy Visit:** In-network: $40 copay Out-of-network: 30% coinsurance
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. In-network: $0 copay per day for days 1 to 20. $167.50 copay per day for days 21 to 100. Out-of-network: 40% coinsurance	Our plan covers up to 100 days in a SNF. In-network: $0 copay per day for days 1 to 20. $167.50 copay per day for days 21 to 100. Out-of-network: 30% coinsurance
Outpatient Rehabilitation	**Occupational Therapy Visit:** In-network: $40 copay Out-of-network: 40% coinsurance **Physical Therapy and Speech and Language Therapy Visit:** In-network: $40 copay Out-of-network: 40% coinsurance	**Occupational Therapy Visit:** In-network: $40 copay Out-of-network: 30% coinsurance **Physical Therapy and Speech and Language Therapy Visit:** In-network: $40 copay Out-of-network: 30% coinsurance
Ambulance	In-network: $250 copay per one-way ground or air trip Out-of-network: $250 copay per one-way ground or air trip	In-network: $250 copay per one-way ground or air trip Out-of-network: $250 copay per one-way ground or air trip
Transportation	Not covered	Not covered
Prescription Drugs		
Medicare-Covered Part B Drugs	**Chemotherapy Drugs:** In-network: 20% coinsurance Out-of-network: 40% coinsurance **Other Part B Drugs:** In-network: 20% coinsurance Out-of-network: 40% coinsurance	**Chemotherapy Drugs:** In-network: 20% coinsurance Out-of-network: 30% coinsurance **Other Part B Drugs:** In-network: 20% coinsurance Out-of-network: 30% coinsurance

Blue Medicare Advantage (PPO) and Blue Medicare Advantage Comprehensive (PPO) Outpatient Prescription Drugs – Short-Term Supply			
Phase 1: Deductible Stage	This plan does not have a pharmacy deductible.		
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. **Note:** Cost-shares may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. In addition, cost-shares may change depending on your Rx day supply or if you are in Long Term Care (LTC). For more information, please call us or access our Evidence of Coverage.		
	Standard Retail Rx 30-day Supply	Preferred Retail Rx 30-day Supply	Mail-Order Rx 30-day Supply
Tier 1: Preferred Generic	$10 copay	$3 copay	$3 copay
Tier 2: Generic	$12 copay	$5 copay	$5 copay
Tier 3: Preferred Brand	$45 copay	$45 copay	$45 copay
Tier 4: Non-Preferred Drug	$100 copay	$100 copay	$100 copay
Tier 5: Specialty Tier	30% coinsurance	30% coinsurance	30% coinsurance
Phase 3: Coverage Gap Stage	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 $4,130. Our plan offers additional drug coverage in the Coverage Gap Stage on Tier 1 and Tier 2 drugs. Tier 1 Preferred Generic drugs cost $3 for a 30-day supply when purchased through a Preferred Retail location or Mail-Order and $10 when purchased through a Standard Retail location. Tier 2 Generic drugs cost $5 for a 30-day supply when purchased through a Preferred Retail location or Mail-Order and $12 when purchased through a Standard Retail location. For all other formulary drugs, you pay 25% of the plan's cost for covered brand name and generic drugs until your costs total $6,550, which is the end of the coverage gap.		
Phase 4: Catastrophic Coverage	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: • 5% coinsurance, or • $3.70 copay for generic (including brand name drugs treated as generic) and a $9.20 copay for all other drugs.		

Category	Blue Medicare Advantage (PPO)	Blue Medicare Advantage Comprehensive (PPO)
Additional Covered Benefits		
Cardiac Rehabilitation Services	Limited to a maximum of two 1-hour sessions per day for up to 36 sessions or up to 36 weeks. In-network: $10 copay Out-of-network: 40% coinsurance	Limited to a maximum of two 1-hour sessions per day for up to 36 sessions or up to 36 weeks. In-network: $10 copay Out-of-network: 30% coinsurance
Chiropractic Care	Medicare-covered services are limited to manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). In-network: $20 copay Out-of-network: 40% coinsurance	Medicare-covered services are limited to manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). In-network: $20 copay Out-of-network: 30% coinsurance
Dialysis	In-network: 20% coinsurance Out-of-network: 20% coinsurance	In-network: 20% coinsurance Out-of-network: 20% coinsurance
Diabetic Supplies and Services[1]	In-network: 0% to 20% coinsurance Out-of-network: 40% coinsurance Diabetic Supplies are covered at 0% to 20% coinsurance, depending on the supplier. 0% coinsurance applies when supplies are manufactured by our preferred supplier, Ascensia. 20% coinsurance applies when Diabetic Supplies are received from all other suppliers at an in-network location. Diabetic Therapeutic Shoes and Inserts are covered in-network at 20% coinsurance.	In-network: 0% to 20% coinsurance Out-of-network: 30% coinsurance Diabetic Supplies are covered at 0% to 20% coinsurance, depending on the supplier. 0% coinsurance applies when supplies are manufactured by our preferred supplier, Ascensia. 20% coinsurance applies when Diabetic Supplies are received from all other suppliers at an in-network location. Diabetic Therapeutic Shoes and Inserts are covered in-network at 20% coinsurance.
Durable Medical Equipment (DME) & Prosthetic Devices	In-network: 20% coinsurance Out-of-network: 40% coinsurance	In-network: 20% coinsurance Out-of-network: 30% coinsurance

Category	Blue Medicare Advantage (PPO)	Blue Medicare Advantage Comprehensive (PPO)
Foot Care	Medicare-covered podiatry services are limited to foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. In-network: $50 copay Out-of-network: 40% coinsurance	Medicare-covered podiatry services are limited to foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. In-network: $40 copay Out-of-network: 30% coinsurance
Home Health Care	In-network: $0 copay Out-of-network: 40% coinsurance	In-network: $0 copay Out-of-network: 30% coinsurance
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. Please see the Evidence of Coverage for more information about hospice care and coverage.	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. Please see the Evidence of Coverage for more information about hospice care and coverage.
Meals	Not covered	Our plan covers up to 14 home delivered meals by Nutrisystem over a 7-day period after an inpatient hospital discharge. In-network: $0 copay
Opioid Treatment Services	In-network: $10 copay Out-of-network: 40% coinsurance	In-network: $5 copay Out-of-network: 30% coinsurance
Outpatient Substance Abuse	**Group Therapy Visit:** In-network: $50 copay Out-of-network: 40% coinsurance **Individual Therapy Visit:** In-network: $50 copay Out-of-network: 40% coinsurance	**Group Therapy Visit:** In-network: $40 copay Out-of-network: 30% coinsurance **Individual Therapy Visit:** In-network: $40 copay Out-of-network: 30% coinsurance
Over-the-Counter (OTC) Drugs	Our plan covers up to $40 allowance every 3 months for the purchase of over-the-counter drugs.	Our plan covers up to $90 allowance every 3 months for the purchase of over-the-counter drugs.

Category	Blue Medicare Advantage (PPO)	Blue Medicare Advantage Comprehensive (PPO)
Wellness Programs	Health Club Membership/Fitness classes at participating SilverSneakers® locations. In-network: $0 copay	Health Club Membership/Fitness classes at participating SilverSneakers® locations. In-network: $0 copay

Section 3: Optional Supplementals

Optional Supplemental Dental Package

For an additional $21 per month, you can purchase an optional supplemental dental package. You must keep paying your Medicare Part B premium and either your $0 premium for your Blue Medicare Advantage (PPO) plan or $50 for your Blue Medicare Advantage Comprehensive (PPO) plan.

The supplemental dental package pays up to **$1,000 of services per year.**
This package covers comprehensive dental services such as:

Covered Services	In-Network Cost Share	Out-of-Network Cost Share
Restorative Services		
Amalgam and Resin Fillings (1 per tooth per surface every 2 years)	50% coinsurance	50% coinsurance
Crowns (1 per tooth every 5 years)	50% coinsurance	50% coinsurance
Endodontics		
Root Canal (1 per tooth per lifetime)	50% coinsurance	50% coinsurance
Periodontics		
Scaling/Root Planning(2 quadrants per visit, once per quadrant every 24 months)	50% coinsurance	50% coinsurance
Extractions		
Extractions (1 extraction per tooth per year)	50% coinsurance	50% coinsurance
Prosthodontics and Maxillofacial Services		
Dentures (complete and partial) and Bridges (1 every 5 years)	50% coinsurance	50% coinsurance

Members are responsible for the difference between the allowed amount and the billed amount.
For more information, please review the Evidence of Coverage.

Blue Cross and Blue Shield Medicare Advantage Member Services Contact Information

Call

1-800-222-7645

Calls to this number are free. Hours are 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on Thanksgiving, Christmas, and holidays and weekends from April 1 through September 30. Please leave a message and your call will be returned the next business day.

Customer Service also has free language interpreter services available for non-English speakers.

TTY

711

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free. Hours are 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on Thanksgiving, Christmas, and holidays and weekends from April 1 through September 30. Please leave a message and your call will be returned the next business day.

Fax

1-800-426-6535

Write

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Website

https://secure.healthx.com/bcbsks.member

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