South Dakota
2026

Wellmark Advantage Health Plan

Wellmark Advantage Health Plan, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

Blue Medicare Advantage Valor PPO
Blue Medicare Advantage Classic PPO
Blue Medicare Advantage Enhanced PPO

Jan. 1 – Dec. 31, 2026

Summary of Benefits

Blue Medicare Advantage is a preferred provider organization (PPO). To join a Wellmark Advantage Health Plan, you must meet all of the following requirements:

- Have both Medicare Part A and Medicare Part B.
- Be a United States citizen or lawfully present in the United States.
- Live in our geographic service area. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

Our service area for Blue Medicare Advantage Classic PPO includes the following counties in South Dakota: Butte, Custer, Fall River, Haakon, Jackson, Lawrence, Meade and Pennington.

Our service area for Blue Medicare Advantage Valor PPO or Blue Medicare Advantage Enhanced PPO includes the following counties in South Dakota: Aurora, Bon Homme, Brookings, Butte, Campbell, Charles Mix, Clark, Clay, Corson, Custer, Davison, Day, Deuel, Dewey, Douglas, Edmunds, Fall River, Haakon, Hanson, Harding, Hutchinson, Jackson, Jerauld, Kingsbury, Lake, Lawrence, Lincoln, Marshall, McCook, McPherson, Meade, Miner, Minnehaha, Moody, Pennington, Perkins, Roberts, Sanborn, Turner, Union, Walworth, Yankton and Ziebach.

Each Wellmark Advantage Health Plan has a network of doctors, hospitals, pharmacies and other providers. If you use the providers in our network, you may pay less for your covered services. You can also use providers that are not in our network. For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at **www.Wellmark.com/Finder-Medicare**.

Out-of-network/non-contracted providers are under no obligation to treat Wellmark Advantage Health Plan 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.

www.WellmarkAdvantageHealthPlan.com

Wellmark Advantage Health Plan is a PPO plan with a Medicare contract. Enrollment in Wellmark Advantage Health Plan depends on contract renewal.

Premium/Cost-sharing Table

You must continue to pay your Medicare Part B premium.

Monthly plan premiums, deductibles and limits on how much you pay for covered services	Blue Medicare Advantage Valor PPO	Blue Medicare Advantage Classic PPO	Blue Medicare Advantage Enhanced PPO
Premium	$0	$55	$80
Deductible	This plan does not have a deductible for hospital and medical services. This plan does not include Part D prescription drug coverage.	This plan does not have a deductible for hospital and medical services. No deductible on Part D prescription drugs on Tiers 1 and 2. $300 deductible for Part D prescription drugs in Tiers 3, 4, and 5. Deductible does not apply to insulins.	This plan does not have a deductible for hospital and medical services. No deductible on Part D prescription drugs on Tiers 1 and 2. $300 deductible for Part D prescription drugs in Tiers 3, 4, and 5. Deductible does not apply to insulins.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**In-Network** $6,750 annually **Combined In- and Out-of-Network** $6,750 annually	**In-Network** $5,500 annually **Combined In- and Out-of-Network** $6,500 annually	**In-Network** $4,200 annually **Combined In- and Out-of-Network** $5,000 annually
	The most you pay for copays, coinsurance and other costs for medical services for the year. 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. You will still need to pay your monthly plan premiums, Medicare Part B premiums and cost sharing for your Part D drugs.		

Benefits	Blue Medicare Advantage Valor PPO **$0 monthly premium** Medical coverage only	Blue Medicare Advantage Classic PPO **$55 monthly premium** Medical & Part D drug coverage	Blue Medicare Advantage Enhanced PPO **$80 monthly premium** Medical & Part D drug coverage
Inpatient Hospital Coverage Our plan covers an unlimited number of days for an inpatient hospital stay.	*Authorization rules may apply; your plan provider will arrange for this authorization, if needed.* The copays 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.		
	In-Network $380 copay per day for days 1 through 6 $0 copay for additional days **Out-of-Network** 40% coinsurance per stay	**In- and Out-of-Network** $390 copay per day for days 1 through 6 $0 copay for additional days **Out-of-Network** 40% coinsurance per stay	**In-Network** $460 copay per stay **Out-of-Network** $600 copay per stay
Outpatient Hospital Coverage	*Authorization rules may apply; your plan provider will arrange for this authorization, if needed.*		
	In-Network $50 copay for non-surgical services $400 copay for surgical services **Out-of-Network** $75 copay for non-surgical services $500 copay for surgical services	**In-Network** $50 copay for non-surgical services $400 copay for surgical services **Out-of-Network** $60 copay for non-surgical services $450 copay for surgical services	**In-Network** $30 copay for non-surgical services $200 copay for surgical services **Out-of-Network** $40 copay for non-surgical services $300 copay for surgical services

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Ambulatory Surgical Center (ASC) Services	*Authorization rules may apply; your plan provider will arrange for this authorization, if needed.*		
	In-Network $300 copay **Out-of-Network** $500 copay	**In-Network** $250 copay **Out-of-Network** $400 copay	**In-Network** $175 copay **Out-of-Network** $250 copay
Doctor Visits			
• Primary care providers	**In-Network** $0 copay **Out-of-Network** $25 copay	**In-Network** $0 copay **Out-of-Network** $35 copay	**In-Network** $0 copay **Out-of-Network** $10 copay
• Specialists	**In-Network** $50 copay **Out-of-Network** $75 copay	**In-Network** $50 copay **Out-of-Network** $60 copay	**In-Network** $30 copay **Out-of-Network** $40 copay

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Preventive Care Any additional preventive services approved by Medicare during the contract year will be covered.	**In- and Out-of-Network** $0 copay Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual physical exam • Annual wellness visit (once per plan year) • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening (colonoscopy, flexible sigmoidoscopy, guaiac-based fecal occult blood test, fecal immunochemical test, or DNA based colorectal screening) • Depression screening • Diabetes screening • Diabetes self-management training		• Glaucoma screening • HIV screening • COVID-19, flu, Hepatitis B and pneumonia immunizations • Intensive behavioral therapy for obesity • Medical nutrition therapy services • Medicare Diabetes Prevention Program • Prostate cancer screenings • Screening for lung cancer with low dose computed tomography • Screening for sexually transmitted infections and counseling to prevent STIs • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • “Welcome to Medicare” preventive visit (one time)

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Emergency Care	**Note:** If you are admitted to the hospital within one day, 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.		
	In-Network $125 copay	**In-Network** $130 copay	**In-Network** $120 copay
	Outside the U.S. and its territories: You have coverage for worldwide emergency care. See Worldwide Emergency Coverage later in this chart.		
Urgently Needed Services	**In-Network** $50 copay	**In-Network** $50 copay	**In-Network** $45 copay
	In-Network $0 copay for urgent care services via Doctor on Demand Visit **DoctorOnDemand.com/WellmarkMA** or call 1-800-997-6196. TTY users call 711. **Outside the U.S. and its territories** You have coverage for worldwide urgently needed services. See Worldwide Emergency Coverage later in this chart.		
Diagnostic Services/Labs/ Imaging • Outpatient therapeutic radiological services	**In- and Out-of-Network** 20% coinsurance	**In- and Out-of-Network** 20% coinsurance	**In- and Out-of-Network** 20% coinsurance
• Outpatient lab services	**In-Network** $15 copay **Out-of-Network** $20 copay	**In-Network** $5 copay **Out-of-Network** $10 copay	**In-Network** $0 copay **Out-of-Network** $5 copay

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Diagnostic Services/Labs/ Imaging (continued)	*Authorization rules may apply; your plan provider will arrange for this authorization, if needed.*		
• Outpatient diagnostic tests and procedures	**In-Network** $50 copay **Out-of-Network** $75 copay	**In-Network** $50 copay **Out-of-Network** $60 copay	**In-Network** $30 copay **Out-of-Network** $40 copay
• Outpatient high-tech diagnostic radiological services (for example, CT, MRI, MRA and PET)	**In-Network** $225 copay **Out-of-Network** $300 copay	**In-Network** $150 copay **Out-of-Network** $250 copay	**In-Network** $125 copay **Out-of-Network** $175 copay
• Outpatient X-rays and low-tech diagnostic radiological services (for example, ultrasounds)	**In-Network** $20 copay **Out-of-Network** $30 copay	**In-Network** $20 copay **Out-of-Network** $30 copay	**In-Network** $10 copay **Out-of-Network** $20 copay

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Hearing Services **Original Medicare covers limited hearing services** Hearing exam to diagnose and treat hearing and balance issues	**In-Network** $0 copay for hearing exams from primary care providers $50 copay for hearing exams from specialists **Out-of-Network** $25 copay for hearing exams from primary care providers $75 copay for hearing exams from specialists	**In-Network** $0 copay for hearing exams from primary care providers $50 copay for hearing exams from specialists **Out-of-Network** $35 copay for hearing exams from primary care providers $60 copay for hearing exams from specialists	**In-Network** $0 copay for hearing exams from primary care providers $30 copay for hearing exams from specialists **Out-of-Network** $10 copay for hearing exams from primary care providers $40 copay for hearing exams from specialists
Hearing benefits beyond Original Medicare • Routine hearing exam once every year	**In- and Out-of-Network** $0 copay		

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Dental Services **Original Medicare covers limited dental services** **Enhanced dental services (Preventive and Comprehensive)** Preventive Services include oral exams, routine cleanings, certain dental X-rays, brush biopsies and fluoride treatment	**In-Network** $50 copay **Out-of-Network** $75 copay **In- and Out-of-Network** $0 copay for an office visit that may include: • Cleanings (including periodontal cleanings) • Oral exams • Bitewing X-rays • Brush biopsies	**In-Network** $50 copay **Out-of-Network** $60 copay **In- and Out-of-Network** $0 copay for an office visit that may include: • Cleanings (including periodontal cleanings) • Oral exams • Bitewing X-rays • Brush biopsies • Panoramic or full mouth X-rays • Fluoride	**In-Network** $30 copay **Out-of-Network** $40 copay **In- and Out-of-Network** $0 copay for an office visit that may include: • Cleanings (including periodontal cleanings) • Oral exams • Bitewing X-rays • Brush biopsies • Panoramic or full mouth X-rays • Fluoride
	In- and Out-of-Network Comprehensive dental: $1,200 maximum annual dental benefit	Comprehensive dental services beyond Original Medicare are not a covered benefit.	**In- and Out-of-Network** Comprehensive dental: $1,200 maximum annual dental benefit

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Dental Services (continued)	50% coinsurance for: • Fillings • Non-surgical periodontal • Full mouth debridement • Surgical periodontal • Oral surgery • Simple extractions • Root canals • Crowns and crown repairs • Dentures, bridges and repairs • Implants and implant repairs		25% coinsurance for fillings 50% coinsurance for: • Non-surgical periodontal • Full mouth debridement • Surgical periodontal • Oral surgery • Simple extractions • Root canals • Crowns and crown repairs • Dentures, bridges and repairs • Implants and implant repairs
	To find a network provider, visit **www.deltadentalsd.com/medicare-advantage** or call 1-800-881-9928 from 7 a.m. to 7 p.m., Central time, Monday through Friday. TTY users call 711. You are responsible for the cost above the plan's maximum benefit allowance. A provider who does not agree to accept the Usual and Customary Fee Schedule (our approved amount) may also charge you the difference between the approved amount and the charged amount. You can submit receipts from an out-of-network provider for reimbursement by calling the number above. Coverage restrictions apply. Ask your provider to confirm coverage prior to receiving services.		

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Vision Services **Original Medicare covers limited vision services**			
• Eyeglasses or contact lenses after cataract surgery, glaucoma screening	**In- and Out-of-Network** $0 copay	**In- and Out-of-Network** $0 copay	**In- and Out-of-Network** $0 copay
• Diabetic retinopathy screening	**In-Network** $0 copay **Out-of-Network** $25 copay	**In-Network** $0 copay **Out-of-Network** $35 copay	**In-Network** $0 copay **Out-of-Network** $10 copay
• Exam to diagnose and treat diseases and conditions of the eye	**In-Network** $50 copay **Out-of-Network** $75 copay	**In-Network** $50 copay **Out-of-Network** $60 copay	**In-Network** $30 copay **Out-of-Network** $40 copay

<table>
<tr><th>Benefits</th><th>Blue Medicare Advantage Valor PPO
$0 monthly premium
Medical coverage only</th><th>Blue Medicare Advantage Classic PPO
$55 monthly premium
Medical & Part D drug coverage</th><th>Blue Medicare Advantage Enhanced PPO
$80 monthly premium
Medical & Part D drug coverage</th></tr>
<tr><td>Vision benefits, beyond Original Medicare

• Routine eye exam every 12 months

• One pair of eyeglass lenses every 12 months, including single vision, lined bifocals, lined trifocals, standard progressive and lenticular lenses.</td><td colspan="3">In-Network through a VSP provider
$0 copay

Out-of-Network
50% coinsurance

In-Network
$0 copay

Out-of-Network
50% coinsurance</td></tr>
<tr><td>• Elective contacts every 12 months

OR

• One complete pair of frames every 12 months</td><td>In-Network
$0 copay up to $80 benefit allowance

Out-of-Network
50% coinsurance up to $80 benefit allowance</td><td>In-Network
$0 copay up to $50 benefit allowance

Out-of-Network
50% coinsurance up to $50 benefit allowance</td><td>In-Network
$0 copay up to $50 benefit allowance

Out-of-Network
50% coinsurance up to $50 benefit allowance</td></tr>
</table>

Benefits	Blue Medicare Advantage Valor PPO **$0 monthly premium** Medical coverage only	Blue Medicare Advantage Classic PPO **$55 monthly premium** Medical & Part D drug coverage	Blue Medicare Advantage Enhanced PPO **$80 monthly premium** Medical & Part D drug coverage
Vision benefits, beyond Original Medicare (continued)	You are responsible for any charges above the plan's benefit allowance. You get lower in-network copays when you receive your non-Medicare-covered vision care from a VSP Choice Network provider. You have access to VSP vision discounts and a broad vision network, including Costco, Walmart, Sam's Club and Visionworks. To locate a VSP Choice Network provider, visit **www.vsp.com/choiceretail** or call 1-855-492-9028 (TTY: 711) from 8 a.m. to 8 p.m., 7 days a week. To submit receipts for reimbursement from a non-VSP provider that participates with Medicare visit **VSP.com/claims/submit-oon-claim**.		

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Mental Health Services	*Authorization rules may apply to inpatient stays; your plan provider will arrange for this prior authorization, if needed.* Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If your psychiatric hospital stay is longer than 90 days, our plan provides for up to 100 additional days of coverage, subject to the Medicare lifetime limit of 190 days. This limitation does not apply to inpatient psychiatric services furnished in a psychiatric unit of a general hospital. A benefit period starts the day you go into an inpatient psychiatric hospital. It ends when you go for 60 days in a row without inpatient psychiatric hospital care. No prior hospital stay is required. Copays restart as new benefit period begins.		
• Inpatient mental health	**In-Network** $380 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay per day for days 91 through 190, until lifetime limitation is exhausted **Out-of-Network** 40% coinsurance per stay, until lifetime limitation is exhausted	**In- and Out-of-Network** $390 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay per day for days 91 through 190, until lifetime limitation is exhausted **Out-of-Network** 40% coinsurance per stay, until lifetime limitation is exhausted	**In-Network** $460 copay per stay, until lifetime limitation is exhausted **Out-of-Network** $600 copay per stay, until lifetime limitation is exhausted

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Mental Health Services (continued)			
• Outpatient mental health	**In-Network** $50 copay for outpatient group or individual therapy visit or psychiatric service **Out-of-Network** $75 copay for outpatient group or individual therapy visit or psychiatric service	**In-Network** $50 copay for outpatient group or individual therapy visit or psychiatric service **Out-of-Network** $60 copay for outpatient group or individual therapy visit or psychiatric service	**In-Network** $30 copay for outpatient group or individual therapy visit or psychiatric service **Out-of-Network** $40 copay for outpatient group or individual therapy visit or psychiatric service
• Telehealth visit	**In-Network** $0 copay for telehealth services delivered through Wellmark Advantage Health Plan Virtual Visits. To access telehealth services visit **DoctorOnDemand.com/WellmarkMA** or call 1-800-997-6196. TTY users call 711.		
Skilled Nursing Facility (SNF) Our plan covers up to 100 days in a SNF.	*Authorization rules may apply; your plan provider will arrange for this authorization, if needed.*		
	In-Network $0 copay per day for days 1 through 20 $204 copay per day for days 21 through 100 **Out-of-Network** $0 copay per day for days 1 through 20 $230 copay per day for days 21 through 100	**In-Network** $0 copay per day for days 1 through 20 $218 copay per day for days 21 through 100 **Out-of-Network** $0 copay per day for days 1 through 20 $230 copay per day for days 21 through 100	**In-Network** $0 copay per day for days 1 through 20 $200 copay per day for days 21 through 100 **Out-of-Network** $0 copay per day for days 1 through 20 $230 copay per day for days 21 through 100

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Physical Therapy	**In-Network** $40 copay **Out-of-Network** $75 copay	**In-Network** $50 copay **Out-of-Network** $60 copay	**In-Network** $20 copay **Out-of-Network** $40 copay
Ambulance	*Authorization rules may apply to non-emergency air ambulance.*		
	In- and Out-of-Network $400 copay for each Medicare-covered, one-way ground or air ambulance trip	**In- and Out-of-Network** $450 copay for each Medicare-covered, one-way ground ambulance trip 20% coinsurance for each Medicare-covered, one-way air ambulance trip	**In- and Out-of-Network** $325 copay for each Medicare-covered, one-way ground or air ambulance trip
	Outside the U.S. and its territories: You have coverage for worldwide emergency transportation. See Worldwide Emergency Coverage later in this chart.		
Transportation	Non-emergency transportation is not covered.		

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Medicare Part B Drugs • Part B insulin drugs • Chemotherapy drugs • Other Part B drugs	*Authorization rules may apply; your plan provider will arrange for this authorization, if needed.* **In- and Out-of-Network** $35 copay maximum for a one-month supply of insulin **In-Network** 20% coinsurance for Medicare-covered chemotherapy drugs and all other Part B drugs **Out-of-Network** 30% coinsurance for Medicare-covered chemotherapy drugs and all other Part B drugs		
Medicare Part B Immunizations	**In- and Out-of-Network** 0% coinsurance for pneumonia, influenza, Hepatitis B and COVID-19 vaccines **In-Network** 0% coinsurance for other Medicare-covered Part B vaccines **Out-of-Network** 30% coinsurance for other Medicare-covered Part B vaccines		

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Rehabilitation Services			
• Cardiac rehabilitation services	**In-Network** $35 copay **Out-of-Network** $45 copay	**In-Network** $40 copay **Out-of-Network** $50 copay	**In-Network** $40 copay **Out-of-Network** $45 copay
• Intensive cardiac rehabilitation services	**In-Network** $50 copay **Out-of-Network** $60 copay	**In-Network** $50 copay **Out-of-Network** $60 copay	**In-Network** $40 copay **Out-of-Network** $45 copay
• Pulmonary rehabilitation	**In-Network** $20 copay **Out-of-Network** $40 copay	**In-Network** $35 copay **Out-of-Network** $45 copay	**In-Network** $25 copay **Out-of-Network** $30 copay
• Occupational therapy visit	**In-Network** $45 copay **Out-of-Network** $75 copay	**In-Network** $50 copay **Out-of-Network** $60 copay	**In-Network** $20 copay **Out-of-Network** $40 copay
• Speech language therapy	**In-Network** $40 copay **Out-of-Network** $75 copay	**In-Network** $50 copay **Out-of-Network** $60 copay	**In-Network** $20 copay **Out-of-Network** $40 copay

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Foot Care (podiatry services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	**In-Network** $50 copay **Out-of-Network** $75 copay	**In-Network** $50 copay **Out-of-Network** $60 copay	**In-Network** $30 copay **Out-of-Network** $40 copay
Medical Equipment/Supplies	*Authorization rules may apply; your plan provider will arrange for this authorization, if needed.* *Non-preferred diabetic supplies require prior authorization.*		
• Durable medical equipment (for example, wheelchairs, oxygen)	**In-Network** 20% coinsurance for Medicare-covered durable medical equipment **Out-of-Network** 30% coinsurance for Medicare-covered durable medical equipment	**In-Network** 20% coinsurance for Medicare-covered durable medical equipment **Out-of-Network** 35% coinsurance for Medicare-covered durable medical equipment	**In-Network** 20% coinsurance for Medicare-covered durable medical equipment **Out-of-Network** 30% coinsurance for Medicare-covered durable medical equipment
• Home infusion therapy	**In-Network** 20% coinsurance for Medicare-covered home infusion therapy **Out-of-Network** 30% coinsurance for Medicare-covered home infusion therapy	**In-Network** 20% coinsurance for Medicare-covered home infusion therapy **Out-of-Network** 35% coinsurance for Medicare-covered home infusion therapy	**In-Network** 20% coinsurance for Medicare-covered home infusion therapy **Out-of-Network** 30% coinsurance for Medicare-covered home infusion therapy

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Medical Equipment/Supplies (continued)	*Authorization rules may apply; your plan provider will arrange for this authorization, if needed.* *Non-preferred diabetic supplies require prior authorization.*		
	In-Network	**In-Network**	**In-Network**
• Prosthetics (for example, braces, artificial limbs)	20% coinsurance for Medicare-covered prosthetics	20% coinsurance for Medicare-covered prosthetics	20% coinsurance for Medicare-covered prosthetics
• Diabetic supplies • Preferred brands of diabetic supplies are Accu-Chek and True Metrix	0% coinsurance for Medicare-covered preferred diabetic supplies	0% coinsurance for Medicare-covered preferred diabetic supplies	0% coinsurance for Medicare-covered preferred diabetic supplies
• Diabetic shoes and inserts	0% coinsurance for Medicare-covered diabetic shoes and inserts	20% coinsurance for Medicare-covered diabetic shoes and inserts	0% coinsurance for Medicare-covered diabetic shoes and inserts
• Diabetic monitoring supplies	$0 copayment for select Medicare-covered continuous glucose monitors from a DME provider or in-network pharmacy	$0 copayment for select Medicare-covered continuous glucose monitors from a DME provider or in-network pharmacy	$0 copayment for select Medicare-covered continuous glucose monitors from a DME provider or in-network pharmacy
	Out-of-Network	**Out-of-Network**	**Out-of-Network**
	20% coinsurance for Medicare-covered prosthetics	35% coinsurance for Medicare-covered prosthetics	30% coinsurance for Medicare-covered prosthetics
	20% coinsurance for Medicare-covered preferred diabetic supplies	20% coinsurance for Medicare-covered preferred diabetic supplies	20% coinsurance for Medicare-covered preferred diabetic supplies
	20% coinsurance for Medicare-covered diabetic shoes and inserts	20% coinsurance for Medicare-covered diabetic shoes and inserts	20% coinsurance for Medicare-covered diabetic shoes and inserts

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Medical Equipment/Supplies (continued)	30% coinsurance for select Medicare-covered continuous glucose monitors from a DME provider 20% coinsurance for select Medicare-covered continuous glucose monitors from an out-of-network pharmacy	35% coinsurance for select Medicare-covered continuous glucose monitors from a DME provider 20% coinsurance for select Medicare-covered continuous glucose monitors from an out-of-network pharmacy	30% coinsurance for select Medicare-covered continuous glucose monitors from a DME provider 20% coinsurance for select Medicare-covered continuous glucose monitors from an out-of-network pharmacy
Health Fitness Programs (SilverSneakers®)	You pay $0 for the health fitness program. SilverSneakers is a registered trademark of Tivity Health, Inc. © Tivity Health, Inc. All rights reserved.	Not covered	Not covered
Chiropractic Care • Manual manipulation of the spine to correct subluxation	**In-Network** $15 copay for each Medicare-covered visit **Out-of-Network** $40 copay for each Medicare-covered visit	**In-Network** $15 copay for each Medicare-covered visit **Out-of-Network** $55 copay for each Medicare-covered visit	**In-Network** $15 copay for each Medicare-covered visit **Out-of-Network** $25 copay for each Medicare-covered visit
Home Health Care Includes medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services. Custodial care is not a benefit.	*Authorization rules may apply; your plan provider will arrange for this authorization, if needed.* **In-Network** $0 copay **Out-of-Network** $40 copay	**In-Network** $0 copay **Out-of-Network** $50 copay	**In- and Out-of-Network** $0 copay

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Nurse Advice Line	**In- and Out-of-Network** $0 copay		
	Speak to a nurse anytime day or night by calling our 24-hour Nurse Line at 1-833-968-1747. TTY users call 711.		
Telehealth Use your smartphone, computer or tablet anywhere in the United States to meet with doctors and behavioral health care providers when it's convenient for you. Prescriptions can be sent to your local pharmacy.	$0 copay for Wellmark Advantage Health Plan Virtual Visits provided by Doctor on Demand, an independent company and our plan-approved vendor, including urgent care, mental health and psychiatric services. This service is separate from any telehealth care your personal doctor might offer. Get urgent general medical services from U.S. board-certified doctors without an appointment for: • Sore throat, coughs, fevers • Ear and sinus infections • Pink eye • Bronchitis • Allergies • Headache We also offer online behavioral health support from licensed behavioral health providers. Wellmark Advantage Health Plan Virtual Visits to access telehealth services by visiting **DoctorOnDemand.com/WellmarkMA** or calling 1-800-997-6196. TTY users call 711.		
Outpatient Substance Use Disorder Individual or group therapy visit	**In-Network** $50 copay **Out-of-Network** $75 copay	**In-Network** $50 copay **Out-of-Network** $60 copay	**In-Network** $30 copay **Out-of-Network** $40 copay

Benefits	Blue Medicare Advantage Valor PPO **$0 monthly premium** Medical coverage only	Blue Medicare Advantage Classic PPO **$55 monthly premium** Medical & Part D drug coverage	Blue Medicare Advantage Enhanced PPO **$80 monthly premium** Medical & Part D drug coverage
Renal Dialysis	**In- and Out-of-Network** 20% coinsurance		
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.	**In-Network** $25 copay **Out-of-Network** $30 copay	**In-Network** $25 copay **Out-of-Network** $35 copay	**In-Network** $25 copay **Out-of-Network** $30 copay

Benefits	Blue Medicare Advantage Valor PPO **$0 monthly premium** Medical coverage only	Blue Medicare Advantage Classic PPO **$55 monthly premium** Medical & Part D drug coverage	Blue Medicare Advantage Enhanced PPO **$80 monthly premium** Medical & Part D drug coverage
Over-the-Counter Items (from authorized vendor only) We offer certain drugs and health related products that do not need a prescription. More than 300 OTC items are available under this benefit. Covered items include but are not limited to antacids, cough drops, denture adhesive, eye drops, ibuprofen, toothpaste and first aid items.	You get up to $30 every quarter to spend on certain approved non-prescription over-the-counter drugs and health-related items. This benefit is built into the plan with no additional cost. Benefits are available each quarter (January, April, July, October). OTC amounts do not roll over to the next quarter or to the next calendar year. There is a limit on the total dollar amount we contribute each quarter. However, you can order more than that amount, and you will be asked to pay the difference. All orders must be placed through the plan's approved vendor. Benefit can be used toward OTC hearing aids. Items can't be obtained from any other vendor or retailer. Direct member reimbursement is not available.	Not covered	Not covered

Benefits	Blue Medicare Advantage Valor PPO **$0 monthly premium** Medical coverage only	Blue Medicare Advantage Classic PPO **$55 monthly premium** Medical & Part D drug coverage	Blue Medicare Advantage Enhanced PPO **$80 monthly premium** Medical & Part D drug coverage
Over-the-Counter Items (from authorized vendor only) (continued)	There are three ways to use your benefit: 1. **Online.** Go to **wellmarkma.nationsbenefits.com** and follow the prompts to place the order using the online catalog. 2. **Phone.** Select items using the online NationsOTC catalog and place an order by calling 1-877-271-1467, 8 a.m. to 8 p.m., 7 days a week. TTY users call 711. Items will be mailed to you. 3. **Using the app.** Download the Benefits Pro™ app and enjoy access to shopping, benefit information, transaction history and more.		

Benefits	Blue Medicare Advantage Valor PPO **$0 monthly premium** Medical coverage only	Blue Medicare Advantage Classic PPO **$55 monthly premium** Medical & Part D drug coverage	Blue Medicare Advantage Enhanced PPO **$80 monthly premium** Medical & Part D drug coverage
Personal Emergency Response Services (PERS) Blue Medicare Advantage Valor PPO and Blue Medicare Advantage Enhanced PPO cover Personal Emergency Response Services (PERS) to give you added security and protection with a medical alert system that offers two-way connectivity to a live agent and around-the-clock monitoring. For more information, visit **wellmarkma.nationsbenefits.com/PERS** or call 1-877-271-1467, 8 a.m. to 8 p.m., 7 days a week. TTY users call 711.	This benefit is built into the plan with no additional cost	Not covered	This benefit is built into the plan with no additional cost
Worldwide Emergency Coverage • Worldwide emergency medical coverage • Worldwide emergency transportation (ambulance) • Worldwide urgent coverage	$125 copay	$130 copay $450 copay $130 copay	$120 copay $325 copay $120 copay
	If you need care when you're outside the U.S., you have coverage for emergency medical care, emergency transportation and urgently needed services only. You are responsible for the difference between the approved amount and the provider's charge. Emergency medical care, emergency transportation and urgent care are subject to a combined $50,000 lifetime maximum benefit outside the U.S. and its territories.		

A complete list of services is found in the *Evidence of Coverage*. For a copy of the *Evidence of Coverage*, go to **Wellmark.com/Medicare/Advantage/Resources**, or contact Customer Service at 1-855-716-2544 from 8 a.m. to 8 p.m., local time, seven days a week from Oct. 1 through March 31; 8 a.m. to 8 p.m., local time, Monday through Friday from April 1 through Sept. 30, for more information. TTY users call 711.

Blue Medicare Advantage Valor PPO

Outpatient Prescription Drugs
This plan does not cover Part D prescription drugs.

Blue Medicare Advantage Classic PPO

Stage 1: Deductible	No deductible for Tiers 1, and 2. $300 total deductible per year for Tiers 3, 4, and 5. Deductible does not apply to insulins.		
Stage 2: Initial Coverage	**Standard retail 30-day supply**	**Mail-order 30-day supply**	**Long-term care 31-day supply**
Tier 1: Preferred Generic	$0	$0	$0
Tier 2: Generic	$5	$5	$5
Tier 3: Preferred Brand	20%	20%	20%
Tier 4: Non-Preferred	25%	25%	25%
Tier 5: Specialty	29%	29%	29%
Stage 2: Initial Coverage	**Standard retail 100-day supply**	**Mail-order 100-day supply**	**Long-term care 100-day supply**
Tier 1: Preferred Generic	$0	$0	Not offered
Tier 2: Generic	$15	$12.50	Not offered
Tier 3: Preferred Brand	20%	20%	Not offered
Tier 4: Non-Preferred	25%	25%	Not offered
Tier 5: Specialty	Not offered	Not offered	Not offered
Stage 3: Catastrophic Coverage	Once your year-to-date out-of-pocket costs (your payments) total $2,100, you move to Stage 3: Catastrophic Coverage. During this stage, you pay $0.		

You won't pay more than $35 for a one-month or $105 for a 100-day supply of each insulin product regardless of the cost-sharing tier.

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 or access our *Evidence of Coverage* online at **www.Wellmark.com/Medicare/Advantage/Resources**.

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website **(www.Wellmark.com/Finder-Medicare)**.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's pharmacy directory at our website **(www.Wellmark.com/Finder-Medicare)**.

Blue Medicare Advantage Enhanced PPO

Stage 1: Deductible	No deductible for Tiers 1, and 2. $300 total deductible per year for Tiers 3, 4, and 5. Deductible does not apply to insulins.		
Stage 2: Initial Coverage	**Standard retail 30-day supply**	**Mail-order 30-day supply**	**Long-term care 31-day supply**
Tier 1: Preferred Generic	$0	$0	$0
Tier 2: Generic	$5	$5	$5
Tier 3: Preferred Brand	20%	20%	20%
Tier 4: Non-Preferred	25%	25%	25%
Tier 5: Specialty	29%	29%	29%
Stage 2: Initial Coverage	**Standard retail 100-day supply**	**Mail-order 100-day supply**	**Long-term care 100-day supply**
Tier 1: Preferred Generic	$0	$0	Not offered
Tier 2: Generic	$15	$12.50	Not offered
Tier 3: Preferred Brand	20%	20%	Not offered
Tier 4: Non-Preferred	25%	25%	Not offered
Tier 5: Specialty	Not offered	Not offered	Not offered
Stage 3: Catastrophic Coverage	Once your year-to-date out-of-pocket costs (your payments) total $2,100, you move to Stage 3: Catastrophic Coverage. During this stage, you pay $0.		

You won't pay more than $35 for a one-month or $105 for a 100-day supply of each insulin product regardless of the cost-sharing tier.

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 or access our *Evidence of Coverage* online at **www.Wellmark.com/Medicare/Advantage/Resources**.

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website **(www.Wellmark.com/Finder-Medicare)**.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's pharmacy directory at our website **(www.Wellmark.com/Finder-Medicare)**.

For more information or to enroll online, visit us at **www.WellmarkAdvantageHealthPlan.com**

If you are not a member of this plan, call toll-free **1-800-213-3771**.

If you are a member of this plan, call toll-free **1-855-716-2544**.

TTY users should call 711.

Oct. 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. local time.

April 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. local time.

This document is available in other formats such as audio CD and large print. This document may be available in a non-English language.

You can order a copy of the "Medicare & You" handbook at **www.medicare.gov**, or you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Wellmark® Advantage Health Plan

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