Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

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Medical Benefits Chart with prescription drug costs

Your medical benefits and costs as a member of the Trust VEBA Groups- Diamond with High PDP – Option 2 Medicare Plus Blue Group PPO plan

This *Medical Benefits Chart with prescription drug costs* is a part of the 2025 *Evidence of Coverage* (EOC), Chapter 4. This is an important legal document. Please keep it in a safe place.

This plan is effective January 1, 2025 - December 31, 2025.

Section 2.1 Your medical benefits and costs as a member of the plan

This *Medical Benefits Chart* lists the services Medicare Plus Blue Group PPO covers and what you pay out-of-pocket for each service. Refer to chapters 3 and 4 in your EOC for more information about coverage for medical services. Your out-of-pocket prescription drug costs can be found in the charts that follow your medical benefits. Refer to chapters 5 and 6 in your EOC for more information about prescription drug coverage.

Your formulary (drug list) is Medicare Plus Blue℠ Group PPO, Prescription Blue℠ Group PDP Enhanced Comprehensive Formulary.

Your medical benefits are listed alphabetically.  You will see this apple next to the preventive services in this *Medical Benefits Chart*. Additional Benefits (if applicable) are listed alphabetically after the core medical benefits. A listing of benefits not covered by the plan are listed in Chapter 4, Section 3 (*What benefits are not covered by the plan?*) of the EOC.

The services listed in this *Medical Benefits Chart* are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.

- Some of the services listed in this *Medical Benefits Chart* are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from Medicare Plus Blue Group PPO.
  - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*) in the *Medical Benefits Chart.*
  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at **www.medicare.gov** or ask for 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.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.

Type of maximum	In-network and Out-of-network
Annual deductible	$0
Part A and Part B combined benefit out-of-pocket maximum, except those noted separately below	$0

Type of maximum	In-network and Out-of-network
Pharmacy Out-of-Pocket Maximum for all Part D drugs/prescriptions	Not applicable
Coinsurance Maximum	Not applicable

All Part A and Part B deductibles and cost share amounts apply to the annual out-of-pocket (OOP) maximum.

Exceptions: There is no limit on cost sharing for certain services. For members who have elected the hospice benefit, any Medicare cost-sharing amounts resulting from Medicare's payment of services that are not related to the terminal condition do not contribute to annual out-of-pocket maximums.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. If you receive other services during the visit, cost sharing may apply.
Acupuncture for chronic low back pain 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 disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. <u>Provider Requirements:</u> Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:	**In-network and Out-of-network:** Acupuncture for chronic low back pain services in an office setting is covered up to 100% of the approved amount. Acupuncture for chronic low back pain services other than office visits are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
• a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services Covered ambulance services, whether for an emergency of non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. We cover ambulance services even if you are not transported to a facility, if you are stabilized at your home or another location. This service is not covered outside of the U.S. or its territories.	**In-network and Out-of-network:** Medicare-covered ambulance services are covered up to 100% of the approved amount.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. The annual wellness visit is enhanced so it can occur anytime throughout the calendar year, regardless of the date of the member's previous year's annual wellness visit.	There is no coinsurance, copayment, or deductible for the annual wellness visit. However, you will be assessed a coinsurance, copayment, or deductible if a covered service (e.g., a diagnostic test) is outside of the scope of the annual wellness visit.

Services that are covered for you	What you must pay when you get these services
Note: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered once every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. If you have a medical condition or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and your contractual cost-sharing for Medicare-covered services will apply. If you receive other services during the visit, out-of-pocket costs may apply.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months • 3-D mammograms are covered when medically necessary See Chapter 12 (Definitions of important words) in the *Evidence of Coverage* for a definition of a mammogram screening.	There is no coinsurance, copayment, or deductible for covered screening mammograms. If you have a medical condition, a follow-up (second) mammogram and/or biopsy on a separate day from the screening, the procedure is considered diagnostic and your contractual cost sharing for Medicare-covered services will apply.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Please see the Exclusions Chart in Chapter 4, Section 3.1 of the *Evidence of Coverage.*	
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. If you receive other services during the visit, out-of-pocket costs may apply.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. If you receive other services during the visit, out-of-pocket costs may apply.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high-risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. If you have a medical condition or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and your contractual cost-sharing for Medicare-covered diagnostic services will apply.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation. Your plan includes additional chiropractic services. See **Additional Benefits** for a description and cost sharing.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high-risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high-risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high-risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high-risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high-risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. See Chapter 12 (Definitions of important words) in the *Evidence of Coverage* for a definition of a colonoscopy screening.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam; however, you won't be charged additional out-of-pocket costs. An office visit copay may apply if additional conditions are discussed at the visit. If you receive other services during the visit, out-of-pocket costs may apply.

Services that are covered for you	What you must pay when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. See the **Physician/Practitioner Services, including doctor's office visits** benefit for examples of Medicare-covered dental services.	Original Medicare covers very limited medically necessary dental services. Medicare Plus Blue Group PPO will cover those same medically necessary services. The cost sharing for those services (e.g. surgery, office visits, X-rays) is referenced in other areas of this benefit chart. For more information, contact Customer Service.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit. If you receive other services during the visit, out-of-pocket costs may apply.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity or a history of high blood sugar (glucose) Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. If you receive other services during the visit, out-of-pocket costs may apply.
Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users), covered services include:	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount for diabetes self-management training, diabetic services and supplies.

Services that are covered for you	What you must pay when you get these services
• Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. **Note:** For all people who have diabetes and use insulin, covered services include — approved continuous glucose monitors and supply allowance for continuous glucose monitoring as covered by Original Medicare. Continuous glucose monitors must be obtained from any in-network pharmacy. * Diabetic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. To use an in-network supplier for diabetic supplies, including diabetic shoes and inserts, contact Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m., Monday through Friday. TTY users call 711. **For Continuous Glucose Monitors:** To use an in-network supplier for continuous glucose monitors you must go to any network pharmacy. At the back of your *Evidence of Coverage* document, we include an addendum which tells you the brands and manufacturers of continuous diabetic blood glucose monitors and traditional blood glucose monitors and test strips that we will cover.	You may pay a pharmacy coinsurance for medical supplies obtained from a pharmacy. If you receive other services during the visit, out-of-pocket costs may apply.
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of the *Evidence of Coverage.)*	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. Generally, we cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.bcbsm.com/providersmedicare. **Note:** You must have a prescription from your provider to obtain Durable Medical Equipment (DME) items and services. To use an in-network provider in Michigan, contact Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m. Monday through Friday. TTY users call 711. **For Continuous Glucose Monitors:** To use an in-network supplier for continuous glucose monitors you must go to any network pharmacy. To find a network pharmacy, you can look in your Provider/Pharmacy Directory, visit our website (www.bcbsm.com/pharmaciesmedicare). * Durable medical equipment and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition.	*Outside the U.S.:* You may be responsible for the difference between the approved amount and the provider's charge. **In-network and Out-of-network:** Medicare-covered emergency room visits are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Medicare Plus Blue Group PPO includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories. Your plan includes the foreign travel health care benefit. See **Additional Benefits** for a description and cost sharing.	
Glaucoma screening Glaucoma screening once per year for people who fall into at least one of the following high-risk categories: • People with a family history of glaucoma • People with diabetes • African Americans who are age 50 and older • Hispanic Americans who are age 65 and older	There is no coinsurance, copayment, or deductible for Medicare-covered glaucoma screening for people at high-risk. If you receive other services during the visit, out-of-pocket costs may apply.
Health and wellness education programs Medicare Plus Blue PPO offers health education programs that include: **24-Hour Nurse Advice Line:** • Speak to a registered nurse health coach 24 hours a day, 7 days a week for assistance with health-related questions. You can reach the nurse line by calling 1-855-624-5214. TTY users call 711. **Tobacco Cessation Coaching:**	There is no coinsurance, copayment, or deductible for health and wellness education programs. If you receive other services during the visit, out-of-pocket costs may apply.

Services that are covered for you	What you must pay when you get these services
• Our Tobacco Cessation Coaching program is a yearly program offered as a self-guided experience with 24/7 access via web or mobile, or live coaching with enrollment online or over phone and available via telephonic or platform chat. Members should call 1-833-380-8436. TTY users should call 711. Customer Service support is available Monday through Friday, 8 a.m. to 9 p.m. , Eastern Time. Health coaches are available: Monday through Thursday, 8 a.m. to 11 p.m.; Friday, 8 a.m. to 7 p.m. and Saturday, 9 a.m. to 3 p.m.; all Eastern Time. • SilverSneakers® fitness program (available only if your plan includes this program as an additional benefit – see Additional Benefits). • Other programs designed to enrich the health and lifestyles of members such as Blue Cross Virtual Well-Being, available on our website at bcbsm.com/medicare.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified providers. Diagnostic hearing exam – 1 per year. Your plan includes both the routine hearing exam and hearing aids benefits. See **Additional Benefits** for a description and cost sharing.	**In-network and Out-of-network:** Diagnostic hearing office visits are covered up to 100% of the approved amount. Diagnostic testing services are covered up to 100% of the approved amount.
Hepatitis C screening For people who are at high-risk for Hepatitis C infection, including persons with a current or history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992, we cover: • One screening exam • Additional screenings every 12 months for persons who have continued illicit injection drug use since the prior negative screening test	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive Hepatitis C screening. If you receive other services during the visit, out-of-pocket costs may apply.

Services that are covered for you	What you must pay when you get these services
For all others born between 1945 and 1965, we cover one screening exam.	
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. If you receive other services during the visit, out-of-pocket costs may apply.
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies * Home health agency care services may require prior authorization. Your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount. Medical supplies ordered by physicians, such as durable medical equipment are not covered under home health agency care. See Durable Medical Equipment for more information. Please Note: Custodial care is not the same as home health agency care. For information, see Custodial Care in the exclusion list in Chapter 4, Section 3.1 of your *Evidence of Coverage*.
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administrations of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to:	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
• Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier * Home infusion therapy may require prior authorization. Your plan provider will arrange for this authorization, if needed.	
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Medicare Plus Blue Group PPO.

Services that are covered for you	What you must pay when you get these services
For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network service. For services that are covered by Medicare Plus Blue Group PPO but are not covered by Medicare Part A or B: Medicare Plus Blue Group PPO will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost-sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (*What if you're in Medicare-certified hospice?*) in the *Evidence of Coverage*.	

Services that are covered for you	What you must pay when you get these services
Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines, such as ShingRix under our Part D prescription drug benefit. Refer to Chapter 6, Section 7 for additional information.	There is no coinsurance, copayment, or deductible for pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. Flu, pneumonia, COVID-19 and other vaccines are also available at retail network pharmacies. If you receive other services during the visit, out-of-pocket costs may apply.
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies	You have an unlimited number of medically necessary inpatient hospital days. Medicare approved clinical lab services and preventive services are covered at 100% of the approved amount. **In-network and Out-of-network:** Facility evaluation and management services are covered up to 100% of the approved amount. All other services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
• Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Medicare Plus Blue Group PPO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Coverage is up to $5,000; travel and lodging is covered for only one year after the initial transplant (includes up to five additional days prior to the initial transplant). Outside of the service area is defined as 100 miles or more, one-way to the facility, from your home address. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services * Inpatient hospital care services rendered by plan providers may require prior authorization; your plan provider will arrange for this authorization, if needed.	

Services that are covered for you	What you must pay when you get these services
Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital* Covered services include mental health care services that require a hospital stay. There is a lifetime limit of 190 days for inpatient services in a psychiatric hospital. You have unlimited days of coverage for mental health services provided in a psychiatric unit of a general hospital (the 190-day limit does not apply). * Inpatient mental health/behavioral health services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Facility evaluation and management services are covered up to 100% of the approved amount. All other services are covered up to 100% of the approved amount.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services	Medicare-approved clinical lab services are covered up to 100% of the approved amount. **In-network and Out-of-network:** Facility evaluation and management services are covered up to 100% of the approved amount. All other services are covered up to 100% of the approved amount. Additional cost share may apply for professional services. We will cover medical services; however, we no longer cover SNF

Services that are covered for you	What you must pay when you get these services
• Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	facility charges unless there is an approved authorization on file. Member may exercise appeal rights if SNF is not approved.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services. If you receive other services during the visit, out-of-pocket costs may apply.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit. If you receive other services during the visit, out-of-pocket costs may apply.

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision	Services are covered up to 100% of the approved amount for drugs used in covered durable medical equipment, certain oral anti-cancer and anti-nausea drugs, and certain immunosuppressive drugs following a Medicare-covered transplant. Retail and mail-order drugs are covered by your BCBSM Part D prescription drug plan and are subject to copayments. **In-network and Out-of-network:** All other services are covered up to 100% of the approved amount. Drugs may be subject to step therapy. Insulin cost sharing is subject to a coinsurance cap of $35 for 1-month's supply of insulin.

Services that are covered for you	What you must pay when you get these services
• Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.bcbsm.com/content/dam/public/Providers/Documents/ma-ppo-bcna-medical-drugs-prior-authorization.pdf.	

Services that are covered for you	What you must pay when you get these services
We also cover some vaccines under our Part B and Part D prescription drug benefit. * Medicare Part B prescription drugs may require prior authorization and/or step therapy; your plan provider will arrange for this authorization, if needed. Chapter 5 of the *Evidence of Coverage* explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in the excerpts from Chapter 6 of the *Evidence of Coverage* below.	
Mobile crisis and crisis stabilization for behavioral health Mobile Mental Health Crisis Solutions will improve care for people that are in crisis. Ideally to prevent higher levels of care. Services include onsite services, mobile crisis intervention by telehealth or face to face, along with Crisis stabilization. Services include crisis stabilization centers, where clinicians provide assessment, diagnosis, treatment planning, initiation of treatment, lab exams and other interventions similar to medical/surgical observation services. Mobile intervention is provided by a crisis intervention team led by social workers who can obtain consultations from psychologists, or consulting psychiatrist. Mobile crisis services onsite in the field can include assessment, diagnosis, short term crisis psychotherapy intervention either face to face or via telehealth, medication consultation, and triage to the appropriate level of care. For more information or to find a provider near you, visit www.bcbsm.com/mentalhealth or contact your Medicare Advantage plan's customer service.	**In-network and Out-of-network:** Mobile crisis and crisis stabilization for behavioral health is covered up to 100% of the approved amount.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. If you receive other services during the visit, out-of-pocket costs may apply.

Services that are covered for you	What you must pay when you get these services
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA) - approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**In-network and Out-of-network:** Opioid treatment services are covered up to 100% of the approved amount.
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests including sleep studies • High-tech radiology services (e.g., CT scans, echocardiography, MRAs, MRIs, PET scans, or nuclear medicine)	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount for Medicare-approved diagnostic lab services rendered at a preferred lab. Services are covered up to 100% of the approved amount for COVID-19 testing. All other services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Note: For Medicare-covered diagnostic radiological services 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. * Outpatient diagnostic tests and therapeutic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.
Outpatient hospital services* We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. You may receive other services while in observation or an outpatient hospital facility. The cost for those services can be found in this document. * Outpatient hospital services may require prior authorization; your plan provider will arrange for this authorization, if needed.	Medicare-covered emergency room visits are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-network and Out-of-network:** Mental health services in an office are covered up to 100% of the approved amount. Mental health services rendered at a mental health facility are covered up to 100% of the approved amount. Telehealth behavioral health services are covered up to 100% of the approved amount.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	Original Medicare therapy limits/thresholds apply to rehabilitation services provided. **In-network and Out-of-network:** Services are covered up to 100% of the approved amount.
Outpatient substance use disorder services Outpatient substance use disorder services include counseling, detoxification, medical testing and diagnostic evaluation.	**In-network and Out-of-network:** Substance abuse treatment services in an office are covered up to 100% of the approved amount. Substance abuse treatment services rendered at a facility are covered up to 100% of the approved amount. Telehealth behavioral health services are covered up to 100% of the approved amount.
Outpatient surgery*, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount. Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more.

Services that are covered for you	What you must pay when you get these services
* Outpatient surgery services, including services provided at hospital outpatient facilities and ambulatory surgical centers may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Partial hospitalization services and Intensive outpatient services* *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. * Partial hospitalization services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • One routine physical exam per year	**In-network and Out-of-network:** Facility evaluation and management services are covered up to 100% of the approved amount. After the first 12 months of Part B coverage, an annual routine physical exam is covered up to 100% of the approved amount. Office visits are covered up to 100% of the approved amount. Telehealth medical visits are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
• Total body skin examination performed by a trained health care professional, usually a dermatologist, to search for any unusual or suspicious lesions or conditions on the skin's surface, including hands and arms, legs and feet, torso, scalp, inside of the mouth and external genital area. Covered once in a lifetime. • Basic hearing and balance exams performed by your primary care provider or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: primary care physician services and individual sessions for mental health specialty services • As part of your Medicare Advantage plan, we offer safe and secure Virtual Care • Virtual Care gives you urgent care and behavioral health care through your phone, tablet, or computer from anywhere in the United States. Virtual urgent care visits from U.S. board-certified doctors are available 24/7, without an appointment. Virtual behavioral health visits are available by appointment from licensed behavioral health providers such as therapists, counselors, and U.S. board-certified psychiatrists. Virtual Care is available through Teladoc Health®, an independent company and our plan-approved vendor. This service is separate from any virtual care your personal doctor might offer. • You can also use Teladoc Health® to access telehealth services. Visit bcbsm.com/virtualcare for more information or call 1-800-835-2362, available 24 hours a day, 7 days a week, 365 days a year for general questions, scheduling and general customer service. TTY users call 1-855-636-1578. • Urgent general medical appointments available 24 hours a day, 7 days a week, 365 days a year (e.g., sore throat, fever, etc.) • Mental health actual appointment availability is 7 days a week; 7 a.m. to 9 p.m. local time (by appointment).	Surgical services performed in an office are covered up to 100% of the approved amount. All other services are covered up to 100% of the approved amount. **Note:** Provider offices or outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more. If a surgical or diagnostic procedure is performed during an office visit, these procedures are considered diagnostic and you will be responsible for the Medicare-covered surgical service out-of-pocket costs in addition to your office visit copay.

Services that are covered for you	What you must pay when you get these services

• Providers will contact members directly; Appointments are not conducted through the 800 number above.
• Some telehealth services including consultation, diagnosis and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  ○ You have an in-person visit within 6 months prior to your first telehealth visit
  ○ You have an in-person visit every 12 months while receiving these telehealth services
  ○ Exceptions can be made to above for certain circumstances
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  ○ You're a new patient **and**
  ○ The check-in isn't related to an office visit in the past 7 days **and**
  ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:	

Services that are covered for you	What you must pay when you get these services
○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) *Teladoc Health® is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.* Your plan includes an annual physical exam with no coinsurance, copayment, or deductible. See **Additional Benefits** for a description of coverage.	
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs *Note: For services other than specialist office visits, refer to the following sections of this benefit chart for member cost-sharing:* • Physician/Practitioner services, including doctor's office visits • Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-network and Out-of-network:** Podiatry services in an office are covered up to 100% of the approved amount. Some medically necessary foot care services other than office visits are covered up to 100% of the approved amount. **Note:** Your doctor may charge an outpatient surgical copay for toenail clipping. See "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" for more information.

Services that are covered for you	What you must pay when you get these services
• Outpatient diagnostic tests and therapeutic services and supplies * Podiatry services may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Prostate cancer screening exams For men, age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test or a digital rectal exam. If you receive other services during the visit, out-of-pocket costs may apply.
Prosthetic and orthotic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery - see **Vision Care** later in this section for more detail. **Note:** You must have a prescription from your provider to obtain Prosthetic and Orthotic (P&O) items and services. *To use an in-network provider, contact Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m., Monday through Friday. TTY users call 711.* * Prosthetic and Orthotic devices and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.
Screening and counseling to reduce alcohol misuse We cover 1 alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. If you receive other services during the visit, out-of-pocket costs may apply.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT. If you receive other services during the visit, out-of-pocket costs may apply.

Services that are covered for you	What you must pay when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. If you receive other services during the visit, out-of-pocket costs may apply.
Services to treat kidney disease* Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the *Evidence of Coverage* or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies	Kidney disease education services are covered up to 100% of the approved amount. **In-network and Out-of-network:** Dialysis services are covered up to 100% of the approved amount. Professional charges are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, *Medicare Part B prescription drugs*.	
Skilled nursing facility (SNF) care* (For a definition of skilled nursing facility care, see Chapter 12 of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called SNFs.) No prior hospital stay is required. **Note:** Private duty nursing is not covered. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner Services	Plan covers up to 100 days for each benefit period. A benefit period begins the day you are admitted to a hospital or SNF as an inpatient and ends after you have not been an inpatient of a hospital (or received skilled care in a SNF) for 60 consecutive days. Once the benefit period ends, a new benefit period begins when you have an inpatient admission to a hospital or SNF. New benefit periods do not begin due to a change in diagnosis, condition, or calendar year. **In-network and Out-of-network:** Facility evaluation and management services are covered up to 100% of the approved amount. All other services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital * Skilled nursing facility care may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover 2 counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to 4 face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover 2 counseling quit attempts within a 12-month period; however, you will pay the applicable inpatient or outpatient cost sharing. Each counseling attempt includes up to 4 face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefit. If you receive other services during the visit, out-of-pocket costs may apply.
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. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
• Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts with. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. Medicare Plus Blue Group PPO includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories. Your plan includes the foreign travel health care benefit. See **Additional Benefits** for a description and cost sharing.	*Outside the U.S.:* You may be responsible for the difference between the approved amount and the provider's charge. **In-network and Out-of-network:** Services are covered up to 100% of the approved amount. Telehealth medical visits are covered up to 100% of the approved amount.
Vision care Covered services include:	Routine eye exams and eyeglasses are not covered by this plan.

Services that are covered for you	What you must pay when you get these services
• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high-risk of glaucoma, we will cover 1 glaucoma screening each year. People at high-risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have 2 separate cataract operations, you cannot reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. **Note:** Medically necessary contacts (not elective contacts) require provider approval and must meet criteria of "medically necessary."	Services are covered up to 100% of the approved amount for corrective lenses following cataract surgery. If you receive other services during the visit, out-of-pocket costs may apply. **In-network and Out-of-network:** Medical vision services in an office are covered up to 100% of the approved amount. Diagnosis and treatment of diseases and conditions of the eye are covered up to 100% of the approved amount.
Welcome to Medicare preventive visit The plan covers the one-time **Welcome to Medicare** preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the **Welcome to Medicare** preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your **Welcome to Medicare** preventive visit.	There is no coinsurance, copayment, or deductible for the **Welcome to Medicare** preventive visit.(This is different from the Annual wellness visit). However, you will be assessed a coinsurance, copayment or deductible if you receive a covered service (e.g. diagnostic test) that is outside the scope of the **Welcome to Medicare** preventive visit. If you receive other services during the visit, out-of-pocket costs may apply.

Services that are covered for you	What you must pay when you get these services
Additional Benefits	
Adult briefs and incontinence liners We cover adult diapers and incontinence liners to provide effective bladder control protection.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Annual physical exam
Covered services include:
One yearly routine physical exam (an annual preventive medical exam that is more comprehensive than an annual wellness visit)
• An examination performed by a primary care physician or other provider that collects health information. Services include:
  ○ An age and gender appropriate physical exam, including vital signs and measurements.
  ○ Guidance, counseling and risk factor reduction interventions.
  ○ Administration or ordering of immunizations, lab tests or diagnostic procedures.
  ○ Covered only in the following locations: provider's office, outpatient hospital or a member's home.
	In-network and Out-of-network:
	Services are covered up to 100% of the approved amount.
	However, you will be assessed a coinsurance, copayment or deductible if a covered service (e.g., a diagnostic test) is outside of the scope of the annual physical exam.
	Note: If a biopsy or removal of a lesion or growth is performed during an office visit, these procedures are considered diagnostic. You will be responsible for the Medicare-covered surgical service out-of-pocket costs in addition to your office visit copayment.

Chiropractic services Covered services include: • Evaluation and management services • Spine X-rays and chiropractic radiology services • Chiropractic physical therapy visits	**In-network and Out-of-network:** Spine X-rays, other chiropractic radiological, chiropractic physical therapy services, and evaluation and management services are covered up to 100% of the approved amount.
Determination of refractive state Determination of refractive state is necessary for obtaining glasses and is covered under these circumstances: • A provider must identify your refractive state to determine an injury, illness or disease • An ophthalmologist or an optometrist must determine the refractive state for corrective lenses	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
• Your refractive state is determined as part of a surgical procedure.	
Foreign travel health care – not restricted to emergency/urgent care Your plan provides coverage outside the United States for medical care that is not urgent or an emergency.	Your cost-share amount is the same as if services are rendered in the United States.
Gradient compression stockings* We cover gradient compression stockings that squeeze the leg to reduce and prevent swelling as well as improve blood flow. * Gradient compression stockings may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.
Hearing aids Hearing aids are covered when furnished by a physician, audiologist, or other qualified provider and based on the most recent hearing exam and hearing aid evaluation. A medical evaluation is required to find the cause of the hearing loss and determine if it can be improved with a hearing aid prior to hearing aids being dispensed. Additional hearing aid batteries, repairs, adjustments, or reconfigurations are not covered. You are responsible for the difference between the plan's benefits and the cost of the hearing aid(s).	**In-network and Out-of-network:** Standard (analog or basic digital) hearing aids are covered up to $500 every 36 months. You are responsible for the difference between the plan's benefit and the cost of the hearing aid(s).
Hearing services – routine exam A medical evaluation to find the cause of the hearing loss and determine if it can be improved with a hearing aid is covered as an office visit when furnished by a physician, audiologist, or other qualified provider. The following tests are covered under the hearing aids benefit: • A hearing aid evaluation test to determine what type of hearing aid should be prescribed • A test to evaluate the performance of a hearing aid (conformity-exam)	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
The following test is covered as an office visit under the hearing services benefit when furnished by a physician, audiologist or other qualified provider: • An annual routine exam to measure hearing ability	

Home infusion therapy*
Home infusion therapy is the continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy.
Coverage for additional home infusion therapy service components are provided based on the member's condition.
The additional Medicare Plus Blue home infusion therapy benefit provides coverage for the in-home administration of infusion therapy services when the Original Medicare coverage criteria are not met. Coverage is available when the infusion therapy is:
• Prescribed by a physician to:
  ○ Manage a chronic condition
  ○ Treat a condition that requires acute care if it can be managed safely at home
• Certified by the physician as medically necessary for the treatment of the condition
• Appropriate for use in the patient's home
• Medical IV therapy, injectable therapy or total parenteral nutrition therapy
Components of care available regardless of whether the patient is confined to the home:
• Nursing visits
• Durable medical equipment, medical supplies and solutions
• Catheter care
• Injectable therapy
• Drugs
	In-network and Out-of-network:
	Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Hospice respite care - cost share for respite and drugs You must get care from a Medicare-certified hospice program. You pay 5% of the Medicare-approved amount for inpatient respite care. You pay a copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management. Note: Once Medicare pays for the hospice respite care and prescription drugs related to hospice care, receipts should be submitted for the member cost share to our plan for reimbursement. We will cover the 5% coinsurance for hospice respite care and the coinsurance/copayment for prescription drugs related to hospice care. • Drugs unrelated to your terminal condition may be covered by your Prescription Drug coverage. Please see Chapter 5 in the *Evidence of Coverage* for more information. Coverage for the coinsurance/copayments for these drugs is not covered under the hospice care benefit and we will not reimburse you for the copay/coinsurance.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Human organ transplants – additional coverage
You have additional coverage for certain human organ transplants not covered by Original Medicare. These transplant procedures are included:
• Bone marrow and hematopoietic stem cell transplants when required for the following conditions:
• Allogeneic (from a donor) transplants for:
  ○ Osteopetrosis
  ○ Renal cell cancer
  ○ Primary amyloidosis
• Autologous (from the patient) transplants for:
  ○ Renal cell cancer
  ○ Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
  ○ Neuroblastoma (stage III or IV)
	In-network and Out-of-network:
	Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
○ Primitive neuroectodermal tumors ○ Ewing's sarcoma ○ Medulloblastoma ○ Wilms' tumor ○ Primary amyloidosis ○ Rhabdomyosarcoma • A second bone marrow transplant for multiple myeloma after a failed first bone marrow transplant. When directly related to a covered transplant, we cover immunosuppressive drugs and other transplant–related prescription drugs, during and after the benefit period. For non–covered transplants, your prescription drug plan is responsible for immunosuppressive drugs and other transplant–related prescription drugs. There is no lifetime maximum for non-Medicare covered organs.	
Private duty nursing We provide nursing to individuals who need skilled care and require individualized continuous 24-hour nursing care that's more intense than what is available under other benefits when ordered by a physician (M.D. or D.O.) who is involved with your ongoing care. • At least two trained caregivers (a family member, a friend, etc.) must be trained and competent to give care when the nurse is not in attendance. • The family or caregivers must provide at least 8 hours of skilled care/day. • Generally, more than 16 hours per day of Private Duty Nursing will not be approved • However, up to 16 hours per day may be approved for up to 30 days while you are being transitioned from an inpatient setting to home	**In-network and Out-of-network:** Your coinsurance is 50% of the approved amount. Not subject to an annual deductible. These services do not apply toward your annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Private duty nursing does **not** cover services provided by, or within the scope of practice of, medical assistants, nurse's aides, home health aides, or other non-nurse level caregivers. This benefit is not intended to supplement the care-giving responsibility of the family, guardian or other responsible parties.	
SilverSneakers® Members are covered for a fitness benefit through SilverSneakers®. 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 a nationwide fitness network, a variety of programming options and activities beyond the gym that incorporate physical well-being and social interaction. Benefits include: • Use of exercise equipment, classes, and other amenities at thousands of participating locations • SilverSneakers LIVE online classes and workshops taught by instructors trained in senior fitness • Burnalong® access with a supportive virtual community and thousands of classes for all interests and abilities • SilverSneakers On-Demand online library with hundreds of workout videos • SilverSneakers GO mobile app with on-demand videos and live classes • SilverSneakers Community gives you options to get active outside of traditional gyms (like recreation centers, malls, and parks) • Online fitness tips and healthy eating information • Social connections through events such as shared meals, holiday celebrations, and class socials • GetSetUP virtual enrichment program with classes on topics ranging from healthy eating to aging in place	**In-network and Out-of-network:** Services are covered at 100%. Fitness services must be provided at SilverSneakers® participating locations. You can find a location or request information at www.silversneakers.com or 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call 711.

Services that are covered for you	What you must pay when you get these services
Go to http://www.silversneakers.com to learn more or call 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call 711. GetSetUp is a third-party provider and is not owned or operated by Tivity Health, Inc. (“Tivity”) or its affiliates. Users must have internet services to access GetSetUp service. Internet service charges are the responsibility of the user. Burnalong is a registered trademark of Burnalong, Inc. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved.	
Travel and lodging for covered transplants and clinical trials • The benefit period begins five days prior to the initial transplant and extends through the patient’s transplant episode of care. The transplant surgery must be performed at a Medicare-approved transplant facility at least 100 miles from home. • Travel and lodging benefits are also payable during covered clinical trials, and begin with the first service date of the clinical trials and end 180 days after that date. • Coverage includes expenses for the patient and one other person eligible to accompany the patient and two persons if the patient is a child under age 18 or if the transplant involves a living donor. • Benefits are payable up to a combined maximum of $150 per day for the covered duration. The maximum amount payable for travel and lodging services related to the initial solid organ transplant is $10,000. The maximum amount payable for services related to an approved clinical trial or bone marrow transplant is $5,000.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.
Wigs, wig stand, adhesive Wigs must be prescribed by a physician and hair loss must be due to chemotherapy.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Section 2.2 Medicare Plus Blue Group PPO covers services nationwide

This plan's service area includes the entire United States and its territories. You have coverage for health care services regardless of the provider's network affiliation. This plan also covers emergency and urgent care services worldwide (see Chapter 3, Section 3 in the *Evidence of Coverage*).

Note: You are responsible for your deductible and/or copayment, if applicable.

Note: Please read Chapter 6. *What you pay for your Part D prescription drugs* in its entirety in the *Evidence of Coverage* document. The contents below are only selected sections from that chapter.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for Medicare Plus Blue Group PPO members?

There are three drug payment stages for your prescription drug coverage under Medicare Plus Blue Group PPO. How much you pay depends on what stage you are in when you get a prescription filled or refilled. If your plan has a deductible, your deductible amount for prescription drugs can be found in the chart below. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage. Details of each stage are in Sections 4 through 6 of this chapter.

The stages are:

Stage 1: Yearly Deductible Stage (if applicable)

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

Stage 1 Yearly Deductible Stage	Stage 2 Initial Coverage Stage	Stage 3 Catastrophic Coverage Stage
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach $2,000. (Details are in Section 5 below.)	During this stage, **the plan pays the full cost** of your drugs for the rest of the calendar year (through December 31, 2025). (Details are in Section 6 below.) You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible (if applicable).

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the *Part D EOB*)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- We keep track of your **Total Drug Costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1**. This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the year began.

- **Drug price information**. This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions**. This will include information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled**. This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need**. There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Here are examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
  - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others have made for you**. Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you**. When you receive a *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Service. Be sure to keep these reports.

SECTION 4 There is no deductible for Medicare Plus Blue Group PPO

There is no deductible for Medicare Plus Blue Group PPO. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has five cost-sharing tiers

Every drug on the plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1 - Preferred Generic: These are generic drugs in the lowest cost-sharing tier.
- Tier 2 - Generic: These are still generic drugs but not the lowest cost-sharing tier.
- Tier 3 - Preferred Brand: This tier contains mostly brand-name drugs and also includes some high-cost generics. You pay no more than $35 per month supply of each covered insulin product on this tier.
- Tier 4 - Non-Preferred Drug: These are brand-name and generic drugs not in a preferred tier. You pay no more than $35 per month supply of each covered insulin product on this tier.
- Tier 5 - Specialty Tier: This contains high-cost generic and brand-name drugs (the highest tier). You pay no more than $35 per month supply of each covered insulin product on this tier.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers standard cost sharing.
- A network retail pharmacy that offers preferred cost sharing.Costs may be less at pharmacies that offer preferred cost sharing.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in the *Evidence of Coverage* and the plan's *Provider/Pharmacy Directory* or *Provider/Pharmacy Locator* (for members outside of Michigan*)* https://www.bcbsm.com/providersmedicare*.*

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Standard retail and standard mail-order cost sharing (in-network) (up to a 31-day supply)	Preferred retail and preferred mail-order cost sharing (in-network) (up to a 31-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 31-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$10	$2	$10	$10
Cost-Sharing Tier 2 (Generic)	$10	$2	$10	$10
Cost-Sharing Tier 3 (Preferred Brand)	$50	$40	$50	$50
Cost-Sharing Tier 4 (Non-Preferred Drug)	$100	$75	$100	$100
Cost-Sharing Tier 5 (Specialty Tier)	30%	30%	30%	30%

Note: Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please see your *List of Covered Drugs* (Formulary) to determine if your drugs are subject to any limitations.

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible (if applicable).

Please see Section 7 of the *Evidence of Coverage* for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to

prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (32- to 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is a 32- to 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

Sometimes the cost of the drug is lower than your copayment. In these cases you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug :

Tier	Standard retail cost sharing (in-network) (32- to 90-day supply)	Preferred retail cost sharing (in-network) (32- to 90-day supply)	Standard mail-order cost sharing (in-network) (32- to 90-day supply)	Preferred mail-order cost sharing (in-network) (32- to 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$20	$4	$20	$4
Cost-Sharing Tier 2 (Generic)	$20	$4	$20	$4
Cost-Sharing Tier 3 (Preferred Brand)	$100	$80	$100	$80
Cost-Sharing Tier 4 (Non-Preferred Drug)	$200	$150	$200	$150

Tier	Standard retail cost sharing (in-network) (32- to 90-day supply)	Preferred retail cost sharing (in-network) (32- to 90-day supply)	Standard mail-order cost sharing (in-network) (32- to 90-day supply)	Preferred mail-order cost sharing (in-network) (32- to 90-day supply)
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in Tier 5.			

Note: Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please see your *List of Covered Drugs* (Formulary) to determine if your drugs are subject to any limitations.

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing even if you haven't paid your deductible (if applicable).

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage. For Enhanced Formularies, we offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count toward your total out-of pocket costs.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf for your drugs during the year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Chapter 6 Section 1.3 in the *Evidence of Coverage* on how Medicare calculates your out-of-pocket costs.

SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.
- You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

This information is not a complete description of benefits. Call Medicare Plus Blue Group PPO at 1-866-684-8216, Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time for more information. From October 1 through March 31, hours are from 8 a.m. to 9 p.m., Eastern time, seven days a week. (TTY users should call 711.)

Out-of-network/non-contracted providers are under no obligation to treat Medicare Plus Blue Group PPO members, except in emergency situations. Please call our customer service number or see the *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.