St Clair County
2019 BCBS Medicare Advantage Plan Options Non Hardship Plan
Rates Effective January 1, 2019

Plans/Rates:	MAPD Current		Option 1		Option 2		Option 3		Option 4		Option 5	
Monthly Premium	$266.48		$163.09		$156.34		$147.86		$141.97		$138.04	
Annual Cost based on 590 members	$1,886,678		$1,154,677		$1,106,887		$1,046,849		$1,005,148		$977,323	
$ Savings Over Current	n/a		$732,001		$779,791		$839,830		$881,531		$909,355	
% Savings Over Current	n/a		38.80%		41.33%		44.51%		46.72%		48.20%	
Medical Benefits:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
PPO	Active		Active		Active		Active		Active		Active	
Deductible	$500		$500		$600		$750		$850		$1,000	
% Copay	5%	15%	10%	20%	10%	20%	10%	20%	10%	20%	10%	20%
OOPM	$2,000	$5,000	$2,500	$5,000	$2,500	$5,000	$2,500	$5,000	$2,500	$5,000	$2,500	$5,000
Office Visit	$20	Ded, Coins, OOPM	$25	$40	$25	$40	$25	$40	$25	$40	$25	$40
Chiropractic Office Visit	$20	Ded, Coins, OOPM	$20	$40	$20	$40	$20	$40	$20	$40	$20	$40
Specialist Services	$20	Ded, Coins, OOPM	$25	$40	$25	$40	$25	$40	$25	$40	$25	$40
Urgent Care	$20	$20	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
Emergency Room	$50	$50	$75	$75	$75	$75	$75	$75	$75	$75	$75	$75
Ambulance Services	Ded, Coins, OOPM	Ded, Coins, OOPM	$75	$75	$75	$75	$75	$75	$75	$75	$75	$75
Surgical Services	Ded, Coins, OOPM		Ded, Coins, OOPM		Ded, Coins, OOPM		Ded, Coins, OOPM		Ded, Coins, OOPM		Ded, Coins, OOPM	
Preventive Services	Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%	
Silver Sneakers	Included		Included		Included		Included		Included		Included	
Enhanced Chiropractic Services	Included		Not Included		Not Included		Not Included		Not Included		Not Included	
Prescription Drug Benefits:	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**
Tier 1: Preferred Generic up to 31 days	$10	$4	$15	$10	$15	$10	$15	$10	$15	$10	$15	$10
Tier 2: Non Preferred Generic up to 010 days Copay	$10	$4	$15	$10	$15	$10	$15	$10	$15	$10	$15	$10
Tier 3: Preferred Brand up to 31 days Copay	$40	$30	$50	$45	$50	$45	$50	$45	$50	$45	$50	$45
Tier 4: Non Preferred Brand Drugs up to 31 days Copay	$80	$70	$100	$95	$100	$95	$100	$95	$100	$95	$100	$95
Tier 5: Specialty Drugs up to 31 days Copay, 90 day supply not available	$80	$70	$100	$95	$100	$95	$100	$95	$100	$95	$100	$95
90 Day RX Copays	2x (not available for tier 5)		2x (not available for tier 5)		2x (not available for tier 5)		2x (not available for tier 5)		2x (not available for tier 5)		2x (not available for tier 5)	

Medicare Plus Blue Group PPO℠ plan for groups

Benefits at a glance: Medical and Surgical with Prescription Drugs

County of St. Clair – Option 1

Medicare Plus Blue Group PPO is available only to individuals enrolled in both Medicare Parts A and B.

This is an overview of the Medicare Plus Blue Group PPO Group Option with Prescription Drugs and does not include all covered and non-covered services or conditions of coverage. For detail about coverage, including a list of exclusions or limitations, refer to the plan *Evidence of Coverage.* **This overview informational document is for group decision makers only and should not be distributed to members. Additionally, this summary information should in no way be construed as an official dissemination of benefit information.** Members will receive official notification of benefits directly from Blue Cross Blue Shield of Michigan. For information about Blues Medicare Advantage plans for trust groups, call your Michigan Blues sales representative or certified independent agent.

Member's cost-sharing responsibility and plan maximums

Members pay a deductible and coinsurance or copayment, as indicated below. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any deductible, coinsurance or copay amounts required by the plan. Certain services are always paid at the in-network level, including emergency and urgent care worldwide, and services received outside of Michigan in other U.S. states and territories. This coverage is provided pursuant to a contract entered into with the Federal government.

The benefit year for health care coverage is the 12-month period beginning on the effective date of coverage or renewal date. The deductible and annual out-of-pocket maximums are accumulated on a **benefit year** basis. Deductibles and annual out-of-pocket maximum amounts renew each year.

Member cost-sharing	**In-network**	**Out-of-network**
Hospital and medical annual deductible	$500*	
Hospital and medical cost-sharing amount • Percent coinsurance	10% of the approved amount	20% of the approved amount
Copayment – office visit	$25	$40
Hospital and medical annual out-of-pocket maximum – Based on the calendar year; all hospital and medical deductible, copayments and coinsurance apply.	$2,500	$5,000*
*Effective January 1, 2013, the out-of-network out-of-pocket maximum will be a catastrophic maximum. All member cost sharing (deductible, coinsurance and copayments for in- and out-of-network) will apply to the catastrophic maximums. The deductible is a combined deductible and is subject to in- and out-of-network services.		
Hospital and medical lifetime maximum	Unlimited	
Durable medical equipment, prosthetics and orthotics lifetime maximum	Unlimited	

Preventive services	What members pay	
	In-network	Out-of-Network
Initial preventive physical exam ("Welcome to Medicare" exam) – covered once within the first 12 months of Part B enrollment	Covered at 100%	
Personalized prevention plan services (annual wellness visit) – covered once annually	Covered at 100%.	
Abdominal aortic aneurysm screening – one-time screening for people at risk	Covered at 100%	
Annual gynecological exam – covered once annually	Covered at 100%	
Pap smear screening – covered once annually	Covered at 100%	
Mammography screening – covered once annually	Covered at 100%	
Prostate specific antigen screening with digital rectal exam – covered once annually	Covered at 100%	
Bone mass measurement – covered once annually	Covered at 100%	
Colorectal screenings – covered once annually for people age 50 and older	Covered at 100%	
Cardiovascular disease training – covered once every five years	Covered at 100%	
Immunizations – covers: • Pneumonia vaccine, as medically needed • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are risk	Covered at 100%	
HIV screening – covers one screening annually, or up to three screenings for women during a pregnancy.	Covered at 100%	
Glaucoma screening – covered once annually	Covered at 100%	
Tobacco cessation program	Covered at 100%	
Physician services		
Office visits • Primary Care • Specialist Services	$25	$40
Podiatry services • Office Visit • Services	$25 10% coinsurance after deductible	$40 20% coinsurance after deductible
Emergency medical care		
Hospital emergency room – worldwide coverage for qualified medical emergencies and first aid services (copay waived if admitted to hospital)	$75	$75
Urgent care visits – covered worldwide • Primary Care • Services	$25 per visit 10% coinsurance after deductible per visit	$25 per visit 20% coinsurance after deductible
Ambulance services – medically necessary transport; coverage applies to each one-way trip	$75	$75

Outpatient services		
MRI, MRA, PET and CAT scans and nuclear medicine	10% coinsurance after deductible	20% coinsurance after deductible
Laboratory and pathology	Covered at 100%	
X-rays, and other diagnostic tests	10% coinsurance after deductible	20% coinsurance after deductible
Chemotherapy	10% coinsurance after deductible	20% coinsurance after deductible
Radiation therapy	10% coinsurance after deductible	20% coinsurance after deductible
Surgical services		
Surgery – inpatient surgery, including related surgical services	10% coinsurance after deductible	20% coinsurance after deductible
Surgery – outpatient surgery, including related surgical services	10% coinsurance after deductible	20% coinsurance after deductible
Surgery – anesthesia services (professional services only)	10% coinsurance after deductible	20% coinsurance after deductible
Pre-surgical consultations	10% coinsurance after deductible	20% coinsurance after deductible
Inpatient hospital care	**What members pay**	
	In-network	**Out-of-Network**
Inpatient hospital care – covers unlimited days	10% coinsurance after deductible	20% coinsurance after deductible
Alternatives to hospital care		
Skilled nursing facility – covers up to 100 (Medicare limit) days per benefit period	10% coinsurance after deductible	20% coinsurance after deductible
Hospice care	Services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. Member pays cost-sharing for respite care and hospice-related outpatient prescription drugs.	
Home health care	Covered at 100%	
Human organ transplants		
Specified organ transplants – covers transplants approved by Original Medicare	10% coinsurance after deductible	20% coinsurance after deductible
Mental health care and substance abuse treatment		
Inpatient mental health care	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient mental health care – covers: • Facility and clinic services • Office visits	10% coinsurance after deductible $25	20% coinsurance after deductible $40
Inpatient substance abuse care	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient substance abuse care – covers: • Facility and clinic services • Office visits	10% coinsurance after deductible $25	20% coinsurance after deductible $40

Other services		
Cardiac rehabilitation	10% coinsurance after deductible	20% coinsurance after deductible
Allergy testing	10% coinsurance after deductible	20% coinsurance after deductible
Allergy therapy (injection)	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient physical, speech and occupational therapy	10% coinsurance after deductible	20% coinsurance after deductible, up to Medicare's annual dollar maximum
Chiropractic care – covers spinal manipulation	$20	$40
Outpatient diabetes management program	Covered at 100%	Covered at 100%
Diabetic supplies	Covered at 100%	
Kidney dialysis – covers: • Dialysis equipment and supplies • Dialysis services	Equipment and supplies covered at 100% 10% coinsurance after deductible	Equipment and supplies covered at 100% Other services: 20% coinsurance after deductible
Kidney disease education	Covered at 100%	Covered at 100%
Medical nutritional therapy –for people with diabetes or (non-dialysis) kidney disease, or following transplant	Covered at 100%	
Foreign health care – other than emergency/urgent care	Same cost-share as if services are provided in the U.S.	
Inpatient dental services	10% coinsurance after deductible	20% coinsurance after deductible
Other services, continued	**What members pay**	
	In-network	**Out-of-Network**
Medically necessary eyeglasses and lenses following cataract surgery	Covered at 100% up to the approved amount	
Hearing services – covers: • Diagnostic hearing services	10% coinsurance after deductible	20% coinsurance after deductible
Durable medical equipment and medical supplies*	10% coinsurance after deductible	20% coinsurance, after deductible
Prosthetics, orthotics and related supplies*	10% coinsurance after deductible	20% coinsurance, after deductible
Select education health and wellness programs	Covered at 100%	
Part B prescription drugs – covers limited array of drugs under medical plan.	10% coinsurance after deductible	20% coinsurance after deductible

SilverSneakers® • Fitness center membership at any participating location across the country • Customized SilverSneakers® classes, seminars and other social events • A trained Senior Advisor℠ at the fitness center to show you around and help you get started • Conditioning classes, exercise equipment, pool, sauna and other available amenities • Online support that can help you lose weight, quit smoking or reduce your stress • SilverSneakers in-home fitness program for members • without convenient access to a SilverSneakers facility	Covered at 100%	The SilverSneakers® Fitness Program is not a gym membership, but a specialized program designed specifically for seniors. This is not a covered benefit for gym memberships or fitness programs that are not part of the SilverSneakers Fitness Program.

Part D prescription drugs
Part D drugs are not covered at non-network pharmacies except in certain situations. Refer to the plan's Evidence of Coverage *for more information.*

Formulary Type	Comprehensive Enhanced	
Annual deductible for prescription drugs	$0	
32-90 day supply mail-order copay multiplier	2x preferred / 2x standard	
Clinical edits (Step Therapy, Prior Authorization, Quantity Limits)	Yes	
Up to a 31-day supply	**Preferred retail and mail order pharmacies**	**Standard retail and mail order pharmacies**
Tier 1 – Generic drugs	$10	$15
Tier 2 – Standard Generic drugs	$10	$15
Tier 3 – Preferred Brand drugs	$45	$50
Tier 4 – Standard Brand drugs	$95	$100
Tier 5 – Specialty drugs (not available at mail order)	$95	$100
Up to a 90-day supply	**Preferred retail or mail-order network pharmacies**	**Standard retail or mail-order network pharmacies**
Tier 1 – Generic drugs	$20	$30
Tier 2 – Standard Generic drugs	$20	$30
Tier 3 – Preferred Brand drugs	$90	$100
Tier 4 – Standard Brand drugs	$190	$200
Tier 5 (Specialty drugs) are not available in a supply greater than 31 days		

Additional prescription drug services	
Oral & injectable contraceptives	Covered
Smoking cessation drugs	Covered
Weight loss drugs	Covered
Impotency drugs	Not covered
Infertility drugs	Not covered

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information about Blues Medicare Advantage plans for employer groups, call your Michigan Blues sales representative or certified independent agent.

Medicare Plus Blue Group PPO is available to all eligible Medicare beneficiaries entitled to Medicare Part A and enrolled in Part B and who live in the United States or its territories. Routine services performed by non-network providers in Michigan will cost more.

Premiums, deductibles, copayments and coinsurance amounts vary by plan. Members must continue to pay their Part B premium. The Medicare Advantage prescription drug benefit is only available to members of a Medicare Advantage prescription drug plan. This document is available in other formats. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2020. Please contact a Michigan Blues sales representative or certified independent agent for details.

For people without employer group coverage: To be eligible to enroll in the Medicare Plus Blue PPO individual plan, an individual must have a permanent residence in Michigan and live here at least six months of each year. Individual Medicare beneficiaries may only enroll in Medicare Advantage plans during certain times of the year or through the Online Enrollment Center located at www.medicare.gov.

Medicare Plus Blue Group PPO℠ plan for groups

Benefits at a glance: Medical and Surgical with Prescription Drugs

County of St. Clair – Option 5

Medicare Plus Blue Group PPO is available only to individuals enrolled in both Medicare Parts A and B.

This is an overview of the Medicare Plus Blue Group PPO Group Option with Prescription Drugs and does not include all covered and non-covered services or conditions of coverage. For detail about coverage, including a list of exclusions or limitations, refer to the plan *Evidence of Coverage.* **This overview informational document is for group decision makers only and should not be distributed to members. Additionally, this summary information should in no way be construed as an official dissemination of benefit information.** Members will receive official notification of benefits directly from Blue Cross Blue Shield of Michigan. For information about Blues Medicare Advantage plans for trust groups, call your Michigan Blues sales representative or certified independent agent.

Member's cost-sharing responsibility and plan maximums

Members pay a deductible and coinsurance or copayment, as indicated below. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any deductible, coinsurance or copay amounts required by the plan. Certain services are always paid at the in-network level, including emergency and urgent care worldwide, and services received outside of Michigan in other U.S. states and territories. This coverage is provided pursuant to a contract entered into with the Federal government.

The benefit year for health care coverage is the 12-month period beginning on the effective date of coverage or renewal date. The deductible and annual out-of-pocket maximums are accumulated on a **benefit year** basis. Deductibles and annual out-of-pocket maximum amounts renew each year.

Member cost-sharing	**In-network**	**Out-of-network**
Hospital and medical annual deductible	$1,000*	
Hospital and medical cost-sharing amount • Percent coinsurance	10% of the approved amount	20% of the approved amount
Copayment – office visit	$25	$40
Hospital and medical annual out-of-pocket maximum – Based on the calendar year; all hospital and medical deductible, copayments and coinsurance apply.	$2,500	$5,000*
*Effective January 1, 2013, the out-of-network out-of-pocket maximum will be a catastrophic maximum. All member cost sharing (deductible, coinsurance and copayments for in- and out-of-network) will apply to the catastrophic maximums. The deductible is a combined deductible and is subject to in- and out-of-network services.		
Hospital and medical lifetime maximum	Unlimited	
Durable medical equipment, prosthetics and orthotics lifetime maximum	Unlimited	

Preventive services	What members pay	
	In-network	Out-of-Network
Initial preventive physical exam ("Welcome to Medicare" exam) – covered once within the first 12 months of Part B enrollment	Covered at 100%	
Personalized prevention plan services (annual wellness visit) – covered once annually	Covered at 100%.	
Abdominal aortic aneurysm screening – one-time screening for people at risk	Covered at 100%	
Annual gynecological exam – covered once annually	Covered at 100%	
Pap smear screening – covered once annually	Covered at 100%	
Mammography screening – covered once annually	Covered at 100%	
Prostate specific antigen screening with digital rectal exam – covered once annually	Covered at 100%	
Bone mass measurement – covered once annually	Covered at 100%	
Colorectal screenings – covered once annually for people age 50 and older	Covered at 100%	
Cardiovascular disease training – covered once every five years	Covered at 100%	
Immunizations – covers: • Pneumonia vaccine, as medically needed • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are risk	Covered at 100%	
HIV screening – covers one screening annually, or up to three screenings for women during a pregnancy.	Covered at 100%	
Glaucoma screening – covered once annually	Covered at 100%	
Tobacco cessation program	Covered at 100%	
Physician services		
Office visits • Primary Care • Specialist Services	$25	$40
Podiatry services • Office Visit • Services	$25 10% coinsurance after deductible	$40 20% coinsurance after deductible
Emergency medical care		
Hospital emergency room – worldwide coverage for qualified medical emergencies and first aid services (copay waived if admitted to hospital)	$75	$75
Urgent care visits – covered worldwide • Primary Care • Services	$25 per visit 10% coinsurance after deductible per visit	$25 per visit 20% coinsurance after deductible
Ambulance services – medically necessary transport; coverage applies to each one-way trip	$75	$75

Outpatient services		
MRI, MRA, PET and CAT scans and nuclear medicine	10% coinsurance after deductible	20% coinsurance after deductible
Laboratory and pathology	Covered at 100%	
X-rays, and other diagnostic tests	10% coinsurance after deductible	20% coinsurance after deductible
Chemotherapy	10% coinsurance after deductible	20% coinsurance after deductible
Radiation therapy	10% coinsurance after deductible	20% coinsurance after deductible
Surgical services		
Surgery – inpatient surgery, including related surgical services	10% coinsurance after deductible	20% coinsurance after deductible
Surgery – outpatient surgery, including related surgical services	10% coinsurance after deductible	20% coinsurance after deductible
Surgery – anesthesia services (professional services only)	10% coinsurance after deductible	20% coinsurance after deductible
Pre-surgical consultations	10% coinsurance after deductible	20% coinsurance after deductible
Inpatient hospital care	**What members pay**	
	In-network	**Out-of-Network**
Inpatient hospital care – covers unlimited days	10% coinsurance after deductible	20% coinsurance after deductible
Alternatives to hospital care		
Skilled nursing facility – covers up to 100 (Medicare limit) days per benefit period	10% coinsurance after deductible	20% coinsurance after deductible
Hospice care	Services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. Member pays cost-sharing for respite care and hospice-related outpatient prescription drugs.	
Home health care	Covered at 100%	
Human organ transplants		
Specified organ transplants – covers transplants approved by Original Medicare	10% coinsurance after deductible	20% coinsurance after deductible
Mental health care and substance abuse treatment		
Inpatient mental health care	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient mental health care – covers: • Facility and clinic services • Office visits	10% coinsurance after deductible $25	20% coinsurance after deductible $40
Inpatient substance abuse care	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient substance abuse care – covers: • Facility and clinic services • Office visits	10% coinsurance after deductible $25	20% coinsurance after deductible $40

Other services		
Cardiac rehabilitation	10% coinsurance after deductible	20% coinsurance after deductible
Allergy testing	10% coinsurance after deductible	20% coinsurance after deductible
Allergy therapy (injection)	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient physical, speech and occupational therapy	10% coinsurance after deductible	20% coinsurance after deductible, up to Medicare's annual dollar maximum
Chiropractic care – covers spinal manipulation	$20	$40
Outpatient diabetes management program	Covered at 100%	Covered at 100%
Diabetic supplies	Covered at 100%	
Kidney dialysis – covers: • Dialysis equipment and supplies • Dialysis services	Equipment and supplies covered at 100% 10% coinsurance after deductible	Equipment and supplies covered at 100% Other services: 20% coinsurance after deductible
Kidney disease education	Covered at 100%	Covered at 100%
Medical nutritional therapy –for people with diabetes or (non-dialysis) kidney disease, or following transplant	Covered at 100%	
Foreign health care – other than emergency/urgent care	Same cost-share as if services are provided in the U.S.	
Inpatient dental services	10% coinsurance after deductible	20% coinsurance after deductible
Other services, continued	**What members pay**	
	In-network	**Out-of-Network**
Medically necessary eyeglasses and lenses following cataract surgery	Covered at 100% up to the approved amount	
Hearing services – covers: • Diagnostic hearing services	10% coinsurance after deductible	20% coinsurance after deductible
Durable medical equipment and medical supplies*	10% coinsurance after deductible	20% coinsurance, after deductible
Prosthetics, orthotics and related supplies*	10% coinsurance after deductible	20% coinsurance, after deductible
Select education health and wellness programs	Covered at 100%	
Part B prescription drugs – covers limited array of drugs under medical plan.	10% coinsurance after deductible	20% coinsurance after deductible

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Part D prescription drugs
Part D drugs are not covered at non-network pharmacies except in certain situations. Refer to the plan's Evidence of Coverage *for more information.*

Formulary Type	Comprehensive Enhanced	
Annual deductible for prescription drugs	$0	
32-90 day supply mail-order copay multiplier	2x preferred / 2x standard	
Clinical edits (Step Therapy, Prior Authorization, Quantity Limits)	Yes	
Up to a 31-day supply	**Preferred retail and mail order pharmacies**	**Standard retail and mail order pharmacies**
Tier 1 – Generic drugs	$10	$15
Tier 2 – Standard Generic drugs	$10	$15
Tier 3 – Preferred Brand drugs	$45	$50
Tier 4 – Standard Brand drugs	$95	$100
Tier 5 – Specialty drugs (not available at mail order)	$95	$100
Up to a 90-day supply	**Preferred retail or mail-order network pharmacies**	**Standard retail or mail-order network pharmacies**
Tier 1 – Generic drugs	$20	$30
Tier 2 – Standard Generic drugs	$20	$30
Tier 3 – Preferred Brand drugs	$90	$100
Tier 4 – Standard Brand drugs	$190	$200
Tier 5 (Specialty drugs) are not available in a supply greater than 31 days		

Additional prescription drug services	
Oral & injectable contraceptives	Covered
Smoking cessation drugs	Covered
Weight loss drugs	Covered
Impotency drugs	Not covered
Infertility drugs	Not covered

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information about Blues Medicare Advantage plans for employer groups, call your Michigan Blues sales representative or certified independent agent.

Medicare Plus Blue Group PPO is available to all eligible Medicare beneficiaries entitled to Medicare Part A and enrolled in Part B and who live in the United States or its territories. Routine services performed by non-network providers in Michigan will cost more.

Premiums, deductibles, copayments and coinsurance amounts vary by plan. Members must continue to pay their Part B premium. The Medicare Advantage prescription drug benefit is only available to members of a Medicare Advantage prescription drug plan. This document is available in other formats. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2020. Please contact a Michigan Blues sales representative or certified independent agent for details.

For people without employer group coverage: To be eligible to enroll in the Medicare Plus Blue PPO individual plan, an individual must have a permanent residence in Michigan and live here at least six months of each year. Individual Medicare beneficiaries may only enroll in Medicare Advantage plans during certain times of the year or through the Online Enrollment Center located at www.medicare.gov.

Medicare Plus Blue℠ PPO
Medical Benefits with Prescription Drugs

2018

County of St Clair – Option 1

Benefits-at-a-Glance

January 1, 2018 – December 31, 2018

The information provided is a **Summary of Benefits**. It is a summary of what we cover and what you pay. A complete list of services is found in your *Evidence of Coverage* and the *Medical Benefits Chart.* If you have any questions about this plan's benefits or costs, please call Medicare Plus Blue Group PPO Customer Service (phone numbers are on the back cover of this booklet). You can always view your most current *Evidence of Coverage* and riders by signing into Member Secured Services at **www.bcbsm.com/medicare** or by requesting them from Customer Service.

To join Medicare Plus Blue Group PPO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area of all 50 states and U.S. territories.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. Payment amounts are based on the Blue Cross Blue Shield approved amount, less any applicable deductible and/or copay amounts required by the plan. The formulary, provider network, and/or pharmacy network may change at any time. You will receive notice when necessary.

Comprehensive Enhanced Formulary
59830600-602 10/17

Medicare Plus Blue is a PPO plan with a Medicare contract.
Enrollment in Medicare Plus Blue depends on contract renewal.

Benefit	In-network:	Out-of-network:
Premium	In addition to the Medicare Part B premium, you may also be required to pay a premium contribution as defined by your employer or union group.	
Combined Deductible	$500	
Out-of-Pocket Maximum	$2,000 In-network medical and hospital care services below apply to this annual amount.	Not Applicable
Combined Out-of-Pocket Maximum	$5,000 All medical and hospital care services below apply to this annual amount.	
Inpatient Care	**Note:** Services with a [1] may require prior authorization.	
Home health care[1]	Covered – 100%	Covered – 100%
Hospice care	Services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. Member may have to pay part of the costs for respite care and hospice-related outpatient prescription drugs.	
Inpatient facility evaluation and management[1]	5% of approved amount, after deductible	15% of approved amount, after deductible
Inpatient hospital care[1]	5% of approved amount, after deductible	15% of approved amount, after deductible
Inpatient mental health care[1]	5% of approved amount, after deductible	15% of approved amount, after deductible
Skilled nursing facility[1] – covers up to 100 days per benefit period	5% of approved amount, after deductible	15% of approved amount, after deductible

Benefit	In-network:	Out-of-network:
Office Visits	*Including Diagnostic Hearing, Outpatient Substance Abuse, Podiatry, and Vision	
Office visits*	$20	15% of approved amount, after deductible
Outpatient mental health services in an office[1]	$20	15% of approved amount, after deductible
Outpatient Care		
Ambulance services[1] – medically necessary transport; coverage applies to each one-way trip	5% of approved amount, after deductible	15% of approved amount, after deductible
Cardiac and pulmonary rehabilitation services[1]	5% of approved amount, after deductible	15% of approved amount, after deductible
Chiropractic care[1] – covered services include manual manipulation of the spine to correct subluxation	$20	15% of approved amount, after deductible
Dental services	Original Medicare covers very limited medically necessary dental services. Your Medicare Plus Blue Group PPO plan will cover those same medically necessary services. For cost sharing information for those services (e.g. surgery, office visits, X-rays), contact Customer Service.	
Diabetes programs and supplies[1] (includes coverage for glucose monitors, test strips, lancets, screening tests and self-management training)	Services are covered up to 100% of the approved amount for diabetes screenings, diabetes-related durable medical equipment or supplies, and self-management training. Diabetic shoes covered up to 100% of approved amount, after deductible	Services are covered up to 100% of the approved amount for diabetes screenings, diabetes-related durable medical equipment or supplies, and self-management training. Diabetic shoes covered up to 100% of approved amount, after deductible

Benefit	In-network:	Out-of-network:
Diagnostic tests, lab services, and radiology services[1] (costs for these services may vary based on place of service)	5% of approved amount, after deductible	15% of approved amount, after deductible
Durable medical equipment[1]	5% of approved amount, after deductible	15% of approved amount, after deductible
Emergency care – worldwide coverage for qualified medical emergencies and first aid services (copay waived if admitted to hospital within 3 days)	$50 (waived if admitted within three days)	$50 (waived if admitted within three days)
Hearing services • Diagnostic testing	5% of approved amount, after deductible	15% of approved amount, after deductible
Kidney disease and conditions • Dialysis services[1] • Professional charges	5% of approved amount, after deductible 5% of approved amount, after deductible	15% of approved amount, after deductible 15% of approved amount, after deductible
Outpatient mental health services[1] • Facility and clinic services	5% of approved amount, after deductible	15% of approved amount, after deductible
Outpatient physical, speech and occupational therapy[1]	5% of approved amount, after deductible	15% of approved amount, after deductible
Outpatient services[1]	5% of approved amount, after deductible	15% of approved amount, after deductible
Outpatient substance abuse care[1] • Facility and clinic services	5% of approved amount, after deductible	15% of approved amount, after deductible

Benefit	In-network:	Out-of-network:
Outpatient surgery, including related surgical services[1]	5% of approved amount, after deductible	15% of approved amount, after deductible
Podiatry: • Medically necessary foot care services other than office visits[1]	5% of approved amount, after deductible	15% of approved amount, after deductible
Prosthetic and orthotic appliances[1]	5% of approved amount, after deductible	15% of approved amount, after deductible
Urgent care visits – covered worldwide	$20	$20
Vision services • Diagnosis and treatment of diseases and conditions of the eye	5% of approved amount, after deductible	15% of approved amount, after deductible
Additional Services		
Chiropractic spinal X-rays, other chiropractic radiological, chiropractic physical therapy services, and evaluation and management services[1] (must be provided by chiropractors or other qualified providers)	$20	15% of approved amount, after deductible
TivityHealth™ SilverSneakers®	Covered up to 100% The SilverSneakers Fitness Program is a specialized program designed for seniors. SilverSneakers provides access to exercise equipment, classes and fun social activities at thousands of locations nationwide.	

Preventive Services and Wellness/Education Programs	

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease screening and behavioral therapy
- Cervical and vaginal cancer screening
- Colorectal cancer screening
  o Screening fecal occult blood test
  o Screening flexible sigmoidoscopy
  o Screening colonoscopy
  o Screening barium enema
  o Multi-target stool DNA test
- Depression screenings
- Diabetes screening
- Diabetes self-management training
- Flu shots (vaccine)
- Glaucoma screening
- Hepatitis B shots (vaccine)
- Hepatitis C screening
- HIV screening
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and counseling
- Pneumococcal screening
- Prostate cancer screening (prostate specific antigen (PSA) test only)
- Screening for lung cancer with low dose computed tomography (LDCT)
- Sexually transmitted infections screening and counseling
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Welcome to Medicare prevention visits (initial preventive physical exam)
- Yearly “Wellness” visit
Any additional preventive services approved by Medicare during the contract year will be covered.
	In-network and Out-of-network:
	
	Covered – 100%

Prescription Drugs		
Formulary Type	Comprehensive Enhanced Formulary	
Stage 1: Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	
Stage 2: Initial Coverage Stage	You pay the following until your out-of-pocket costs reach $5,000. See Chapter 4 Section 5.6 of the *Evidence of Coverage* for information about how Medicare counts your out-of-pocket costs.	
Up to a 31-day supply	**Preferred retail and preferred mail-order pharmacies**	**Standard retail and standard mail-order pharmacies**
Tier 1 – Preferred Generic	$4	$10
Tier 2 – Generic	$4	$10
Tier 3 – Preferred Brand	$30	$40
Tier 4 – Non-Preferred Drug	$70	$80
Tier 5 – Specialty	$70	$80
Up to a 90-day supply	**Preferred retail and preferred mail-order pharmacies**	**Standard retail and standard mail-order pharmacies**
Tier 1 – Preferred Generic	$8	$20
Tier 2 – Generic	$8	$20
Tier 3 – Preferred Brand	$60	$80
Tier 4 – Non-Preferred Drug	$140	$160
Tier 5 (Specialty) are not available in a supply greater than 31 days		
Stage 3 & 4: Coverage Gap and Catastrophic Coverage Stages	Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* online at **www.bcbsm.com/medicare**.	
Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.		

Medicare Plus Blue Group PPO has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network in Michigan, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

Out-of-network/non-contracted providers are under no obligation to treat Medicare Plus Blue Group PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Outside Michigan, your costs are the same as in-network services when you use providers that accept Medicare. Using providers that do not accept Medicare may cost you more. To locate a provider in our network, use the Find a Doctor tool on our website at: **www.bcbsm.com/providersmedicare**.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website (**www.bcbsm.com/pharmaciesmedicare**).

Or, call us and we will send you a copy of the *Provider/Pharmacy Directory* or *Provider/Pharmacy Locator* for members outside Michigan (phone numbers are on the back cover of this booklet).

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **www.bcbsm.com/formularymedicare.**

For more information, please call us at 1-866-684-8216, Monday through Friday from 8:30 a.m. to 5:00 p.m. Eastern time. From October 1 through February 14, hours are from 8:00 a.m. to 9:00 p.m., Eastern time, seven days a week. TTY users should call 711. Or you can visit us at **www.bcbsm.com/medicare**.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Medicare PLUS Blue℠ PPO

Blue Cross
Blue Shield
of Michigan

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