Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Medical Benefits Chart with prescription drug costs

Your medical benefits and costs as a member of the County of St. Clair – Option 1 Medicare Plus Blue Group PPO plan

This *Medical Benefits Chart with prescription drug costs* is a part of your 2020 *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, 2020 - December 31, 2020.

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 4, 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 under the following categories: **Inpatient Services**, **Outpatient Services**, **Preventive Services**, and **Additional Benefits** (if applicable). A listing of benefits not covered by the plan immediately follows the medical benefits and are also 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, and equipment) *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.
- 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 approved amount (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 2020* Handbook. View it online at **https://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.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2020, either Medicare or our plan will cover those services.

Type of maximum	In-network	Out-of-network
Combined in-network and out-of-network deductible	$750	
Part A and Part B in-network benefit out-of-pocket maximum, except those noted separately below	$2,500	Not Applicable
Part A and Part B combined in-network and out-of-network benefit out-of-pocket maximum, except those noted separately below	$5,000	

All in-network Part A and Part B deductibles and cost share amounts apply to the in-network out-of-pocket (OOP) maximum and the combined in-network and out-of-network out-of-pocket maximum. All Part A and Part B out-of-network deductibles and cost share amounts apply to the combined in-network and out-of-network 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 in-network or combined in-network and out-of-network out-of-pocket maximums.

Medical Benefits Chart

<table>
<tr><th>Services that are covered for you</th><th>What you must pay when you get these services</th></tr>
<tr><td colspan="2">Inpatient Services</td></tr>
<tr><td>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

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.

* Home health agency care services may require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.</td><td>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.

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 and Section 3.1 of this document.</td></tr>
<tr><td>Hospice care

You may receive care from any Medicare-certified hospice program. 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. Your hospice doctor can be a network provider or an out-of-network provider.

Covered services include:</td><td>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 by Original Medicare, not Medicare Plus Blue Group PPO.</td></tr>
</table>

Services that are covered for you	What you must pay when you get these services
• Drugs for symptom control and pain relief • Short-term respite care • Home care 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 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. 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: • If you obtain the covered services from a network provider, 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 services. 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: 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*. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	

Services that are covered for you	What you must pay when you get these services
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 • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse 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.	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:** For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For all other services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For facility evaluation and management services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. For all other services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to an in-network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after your condition has been stabilized.

Services that are covered for you	What you must pay when you get these services
• 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 $5000; 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. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization. **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.	

Services that are covered for you	What you must pay when you get these services
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://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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 mental health care* 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. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital. * Inpatient mental health/behavioral health services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	Our plan covers 90 days for a benefit period. A benefit period starts the day you go into an inpatient psychiatric hospital. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into an inpatient psychiatric hospital after one benefit period has ended, a new benefit period begins. You must pay the Inpatient Mental Health Care copays for each benefit period. There's no limit to the number of benefit periods. **In-network:** For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For all other services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For facility evaluation and management services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
	For all other services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
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 • 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* * Physical, speech, and occupational therapy services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	Medicare-approved clinical lab services are covered up to 100% of the approved amount. **In-network:** For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For all other services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For facility evaluation and management services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. For all other services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
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. 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 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).	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:** For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For all other services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For facility evaluation and management services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. For all other services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• A SNF where your spouse 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. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Outpatient Services	
Ambulance services • Covered ambulance services 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. • Non-emergency transportation by ambulance* is appropriate if it is 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. • Covers transport of a hospice patient to their home before enrolling in a Medicare-certified hospice program. **Note:** Please see the Exclusions Chart in Chapter 4, Section 3.1 of your *Evidence of Coverage* or Section 3.1 of this *Medical Benefits Chart*. * In-network non-emergency services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network:** For Medicare-covered ambulance services, you pay a copayment of $75. Not subject to the deductible. Cost sharing applies for each one-way trip. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For Medicare-covered ambulance services, you pay a copayment of $75. Not subject to the deductible. Cost sharing applies for each one-way trip. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
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. * Cardiac rehabilitation services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
Chiropractic services* Covered services include manual manipulation of the spine to correct subluxation. * Chiropractic services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network:** You pay a copayment of $20. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** You pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. We cover ***Medicare-covered*** dental services ***only***. 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.
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 • For all people who have diabetes and use insulin, covered services: therapeutic continuous glucose monitors and supply allowance for the therapeutic continuous glucose monitor as covered by Original Medicare * Diabetic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization. To use an in-network supplier for diabetic supplies, contact J&B Medical Supply Company at 1-888-896-6233 from 8:00 a.m. to 5:00 p.m., Monday through Friday. TTY users call 711. To use an in-network supplier for diabetic shoes and inserts, contact Northwood at 1-800-667-8496, 8:30 a.m. to 5:00 p.m., Monday through Friday. TTY users call 711.	You may pay a pharmacy coinsurance for medical supplies obtained from a pharmacy. **Note:** Diabetic shoes are subject to the deductible.
Durable medical equipment (DME) and related supplies* (For a definition of “durable medical equipment,” see Chapter 12 of the *Evidence of Coverage.)*	**In-network:** Your coinsurance is 10% of the approved amount. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.

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. 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 or a Certificate of Medical Necessity from your doctor to obtain Durable Medical Equipment (DME) or Prosthetic and Orthotic (P&O) items and services. To use an in-network provider in Michigan, contact Northwood at 1-800-667-8496. 8:30 a.m. to 5:00 p.m. Monday through Friday. TTY users call 711. * Durable medical equipment and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**Out-of-network:** Your coinsurance is 10% of the approved amount. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.
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. 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, 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.	**In-network:** For Medicare-covered emergency room visits, you pay a copayment of $75 (waived if admitted within three days). Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For Medicare-covered emergency room visits, you pay a copayment of $75 (waived if admitted within three days). Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **Worldwide Coverage** 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. _Outside the U.S.:_ You may be responsible for the difference between the approved amount and the provider's charge.	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to an in-network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after your condition has been stabilized. For information on Observation Care, see Outpatient Hospital Services.
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 provider. Diagnostic hearing exam – 1 per year.	Routine hearing exams and hearing aids are not covered by this plan. **In-network:** For diagnostic hearing office visits, you pay a copayment of $25. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. For diagnostic testing services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For diagnostic hearing office visits, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. For diagnostic testing services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

<table>
<tr><th>Services that are covered for you</th><th>What you must pay
when you get these services</th></tr>
<tr><td>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
• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan
• Clotting factors you give yourself by injection if you have hemophilia
• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
• 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
• Antigens
• Certain oral anti-cancer drugs and anti-nausea drugs
• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa).
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases
• Covered Part B drugs that may be subject to step therapy include: anti-cancer agents and cancer-supportive therapy agents, anti-gout agents, anti-inflammatory agent, antirheumatic agents, antispasticity agents, bisphosphonates, blood products, gastrointestinal agents, immunosuppressive agents, knee injections, ophthalmic agents, respiratory agents</td><td>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:
For all other services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.

Out-of-network:
For all other services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.</td></tr>
</table>

Services that are covered for you	What you must pay when you get these services
The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://www.bcbsm.com/content/dam/public/Providers/Documents/ma-ppo-bcna-medical-drugs-prior-authorization.pdf * Medicare Part B drugs may require prior authorization and/or step therapy; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization. Chapter 5 of your *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 your *Evidence of Coverage* below.	
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	**In-network:** For opioid treatment program services, you pay a copayment of $25. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For opioid treatment program services, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.
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	**In-network:** Services are covered up to 100% of the approved amount for Medicare-approved diagnostic lab services rendered at a preferred Joint Venture Hospital Lab (JVHL) or Quest Diagnostics Lab.

Services that are covered for you	What you must pay when you get these services
• 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., CAT scans, echocardiography, MRAs, MRIs, PET scans or nuclear medicine) rendered by plan providers require prior authorization. **Note:** For Medicare-covered diagnostic radiological services and Medicare-covered X-ray services, 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. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	For all other services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Services are covered up to 100% of the approved amount for Medicare-approved diagnostic lab services. For all other services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

<table>
<tr><th>Services that are covered for you</th><th>What you must pay
when you get these services</th></tr>
<tr><td>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://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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</td><td>In-network:
Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.

Out-of-network:
Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.</td></tr>
<tr><td>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.

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</td><td>In-network:
Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.

For Medicare-covered emergency room visits, you pay a copayment of $75 (waived if admitted within three days). Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.</td></tr>
</table>

Services that are covered for you	What you must pay when you get these services
• 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://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. For Medicare-covered emergency room visits, you pay a copayment of $75 (waived if admitted within three days). Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to an in-network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after your condition has been stabilized.
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, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-network:** For mental health services in an office, you pay a copayment of $25. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
* Outpatient mental/behavioral health services rendered by plan providers may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	For mental health services rendered at a mental health facility, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For mental health services in an office, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. For mental health services rendered at a mental health facility, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
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). * Outpatient rehabilitation services rendered by plan providers may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	Original Medicare therapy limits apply to rehabilitation services provided. See Chapter 12, definition of Therapy Limits/Thresholds. **In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services* Coverage under Medicare Part B is available for treatment services provided in the outpatient department of a hospital. A coverage example is a patient who has been discharged from an inpatient stay for the treatment of substance abuse or who requires additional treatment but does not require services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. * Outpatient mental/substance abuse services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network:** For substance abuse treatment services in an office, you pay a copayment of $25. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. For substance abuse treatment services rendered at a facility, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For substance abuse treatment services in an office, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. For substance abuse treatment services rendered at a facility, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
Outpatient surgery*, including services provided at hospital outpatient facilities and ambulatory surgical centers Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more. **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:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

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. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Partial hospitalization 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 or therapist's office and is an alternative to inpatient hospitalization. * Partial hospitalization services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
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 • 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.	**In-network:** For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. After the first 12 months of Part B coverage, you pay a copayment of $25 for an annual routine physical exam. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. For office visits, you pay a copayment of $25. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• Certain telehealth services including consultation, diagnosis and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Additional telehealth services including primary care physician services and individual sessions for mental health specialty services. You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth. You can also use Blue Cross Online Visits to access telehealth services. Visit bcbsmonlinevisits.com for more information. • Telehealth services for monthly ESRD-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 for diagnosis, evaluation or treatment of symptoms of an acute stroke • Brief virtual (for example, via telephone or video chat) 5-10 minute check-ins with your doctor—if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment • Second opinion prior to surgery • Remote evaluation of pre-recorded video and/or images you send to your doctor, including your doctor's interpretation and follow-up within 24 hours—if you are an established patient and the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment • Consultation your doctor has with other physicians via telephone, Internet, or electronic health record assessment—if you are an established patient	For surgical services performed in an office, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For all other services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For facility evaluation and management services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. After the first 12 months of Part B coverage, you pay a copayment of $40 for an annual routine physical exam. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. For office visits, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. For surgical services performed in an office, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. For all other services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• 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) • One routine physical exam per year. • 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. **Note:** Provider offices or outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more. 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 cost-share in addition to your office visit copayment.	
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 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 • Outpatient diagnostic tests and therapeutic services and supplies	**In-network:** For podiatry services in an office, you pay a copayment of $25. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. For some medically necessary foot care services other than office visits, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For podiatry services in an office, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
* Podiatry services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	For some medically necessary foot care services other than office visits, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
Prosthetic 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: 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 devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery. See “Vision Care” later in this section for more details. **Note:** You must have a prescription or a Certificate of Medical Necessity from your doctor 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 devices and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network:** Your coinsurance is 10% of the approved amount. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 10% of the approved amount. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.
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:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
* Pulmonary rehabilitation services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
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 six 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*) • 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 • 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 listed benefit, “Medicare Part B prescription drugs.”	Kidney disease education services are covered up to 100% of the approved amount. **In-network:** For dialysis services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For professional charges, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For dialysis services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. For professional charges, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
* Dialysis services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. 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 • 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.	**In-network:** Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** Your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.	**In-network:** You pay a copayment of $25. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** You pay a copayment of $25. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Worldwide Coverage** 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. *Outside the U.S.:* You may be responsible for the difference between the approved amount and the provider's charge.	
Vision care Covered services include: • 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 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 two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	Routine eye exams and eyeglasses are not covered by this plan. Services are covered up to 100% of the approved amount for corrective lenses following cataract surgery. **In-network:** For medical vision services in an office, you pay a copayment of $25. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum. For diagnosis and treatment of diseases and conditions of the eye, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. **Out-of-network:** For medical vision services in an office, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
	For diagnosis and treatment of diseases and conditions of the eye, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
Preventive	
Note: 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 are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a contractual cost share may apply for the care received for the existing medical condition.	
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 beneficiaries eligible for this preventive screening.
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. **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" preventive visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
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.

Services that are covered for you	What you must pay when you get these services
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 See Chapter 12 (Glossary) 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.
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 are eating healthy.	There is no coinsurance, copayment, or deductible for the cardiovascular disease risk reduction preventive benefit.
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.
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.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.

Services that are covered for you	What you must pay when you get these services
One of the following every 12 months. • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy Outpatient surgery copays apply to diagnostic colonoscopies (a colonoscopy performed to diagnose a medical problem), which are not considered colorectal cancer screenings. If a physician performs a screening colonoscopy and a polyp or abnormality is found, the procedure is now considered a diagnostic procedure per Medicare guidelines. See Chapter 12 (Glossary) in the *Evidence of Coverage* for a definition of a colonoscopy screening.	If you have a medical condition, such as gastrointestinal symptoms, or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and your contractual cost sharing for Medicare-covered surgical services will apply. When a physician performs a screening colonoscopy and nothing is found, the deductible and procedure copay are waived; however, an office visit copay may apply if additional conditions are discussed at the visit.
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.
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. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

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

Health and Wellness education programs
Supplemental programs designed to enrich the health and lifestyles of members.
The plan covers the following supplemental education and wellness programs:
• Telemonitoring Services
  o Members who are diagnosed with heart failure may be targeted for the remote monitoring intervention.
  o Members in the program will be sent a symptom appropriate monitor and provided with the support needed to operate it.
• Tobacco Cessation Coaching is a 12-week telephone-based program administered by WebMD® Health Services that provides counseling and support for members suffering from all forms of tobacco addiction and empowers them to successfully quit using tobacco products. Program includes intervention via telephone-based coaching provided by specially trained health coaches. There is not a limit to the number of calls the member can make within the 12-week program.
• Tivity Health™ SilverSneakers® fitness program (available only if your plan includes this program as an additional benefit – see Additional Benefits)
	There is no coinsurance, copayment, or deductible for health and wellness education programs.

Services that are covered for you	What you must pay when you get these services
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 For all others born between 1945 and 1965, we cover one screening exam.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive Hepatitis C screening.
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 beneficiaries eligible for Medicare-covered preventive HIV screening.

Immunizations
Covered Medicare Part B services include:
• Pneumonia vaccine
  o An initial pneumococcal vaccine to Medicare beneficiaries who have never received the vaccine under Medicare Part B; **and**
  o A different, second pneumococcal vaccine 1 year after the first vaccine was administered
• Flu shots, each flu season in the fall and winter, with additional flu shots if medically necessary
• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
• Other vaccines if you are at risk and they meet Medicare Part B coverage rules
We also cover some vaccines under our Part D prescription drug benefit.
	There is no coinsurance, copayment, or deductible for pneumonia, influenza and Hepatitis B vaccines.
	Flu and pneumonia shots are also available at retail network pharmacies.

Services that are covered for you	What you must pay when you get these services
Other Medicare-covered vaccines (such as shingles vaccine or tetanus booster) may be covered by your Medicare Part D prescription drug coverage. What you pay for vaccinations covered by Part D will depend on where you receive the vaccine. If your vaccine is administered during an office visit, you may have an additional charge. (See Chapter 6, Section 8 of the *Evidence of Coverage* for more information.)	
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 the 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.
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.
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.

Services that are covered for you	What you must pay when you get these services
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 digital rectal exam.
Screening and counseling to reduce alcohol misuse We cover one 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.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. Eligible enrollees are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written 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 a written 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.

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 to prevent STIs preventive benefit.
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 two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four 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 two 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 four face-to-face visits. Tobacco Cessation Coaching is a 12-week telephone-based program administered by WebMD® Health Services that provides counseling and support for members suffering from all forms of tobacco addiction and empowers them to successfully quit using tobacco products. Program includes intervention via telephone-based coaching provided by specially trained health coaches. There is not a limit to the number of calls the member can make within the 12-week program.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefit.

Services that are covered for you	What you must pay when you get these services
“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), 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.
Additional Benefits	
Tivity Health™ SilverSneakers® The SilverSneakers benefit doesn’t include gym or health club memberships other than for those facilities that participate in the SilverSneakers fitness program. Benefits include: • Fitness program membership at any participating location across the country • Customized SilverSneakers classes and seminars • A trained Senior Advisor℠ at the fitness center to show you around and help get you started • Conditioning classes, exercise equipment, pool, sauna and other available amenities • SilverSneakers Steps℠ in-home fitness program for members without convenient access to a SilverSneakers facility	**In-network and Out-of-network:** Services are covered at 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.

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.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are “excluded” from Medicare coverage and, therefore, are not covered by this plan. If a service is “excluded,” it means that this plan doesn’t cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won’t pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in the *Evidence of Coverage*.)

All exclusions or limitations on services are described in the *Medical Benefits Chart* or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture	✓	
Care provided in conjunction with an ambulance call when no transport is provided. Ambulance service is a transport benefit, and it is only payable when you’re transported to a hospital. If an ambulance is called and you receive care, but decide not to be transported to a hospital, we do not cover those services. (See *Ambulance Services* section of the *Medical Benefits Chart*.)		✓

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		✓ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Covered prescription drugs beyond 90-day supply limit including early refill requests	✓	
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care.		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Phase III cardiac rehabilitation programs are considered maintenance programs, do not require physician supervision and monitoring, and are not considered medically necessary.	✓	
Prescriptions written by prescribers who are subject to the plan's Prescription Prescriber Block policy For more information, see Prescriber Block policy definition in Chapter 12.	✓	
Private duty nurses		✓ Unless your employer group has selected the additional Private Duty Nursing benefit **Check under the Additional Benefits section above to see if you have additional Private Duty Nursing services.**
Private room in a hospital.		✓ Covered only when medically necessary.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Radial keratotomy (RK) and LASIK surgery.		✓ Unless your employer group has selected the additional LASIK and RK surgery benefit. **Check under the Additional Benefits section above to see if you have additional LASIK and RK surgery services.**
Reversal of sterilization procedures, non-prescription contraceptive supplies, including Intrauterine Devices (IUDs), and/or any contraceptive method not payable under your Part D benefit.	✓	
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered. **Check under the Additional Benefits section above to see if you have additional services under this benefit.**
Routine dental care, such as cleanings, fillings or dentures.		✓ Covered under certain plans.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine eye examinations, eyeglasses and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Routine hearing exams, hearing aids, or exams to fit hearing aids.		✓ Unless your employer or union group has selected additional hearing benefits. **Check under the Additional Benefits section above to see if you have additional hearing services (routine hearing exams and/or hearing aids)**
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Services from providers who appear on the CMS Preclusion List. *For more information, see CMS Preclusion List definition in Chapter 12.*	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Temporomandibular Joint Syndrome (TMJ)	✓	
Vacation supplies of Medicare Part D drugs	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

Note: Please read Chapter 6. *What you pay for your Part D prescription drugs* in its entirety in the *Evidence of Coverage* booklet. 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?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under Medicare Plus Blue Group PPO. How much you pay for a drug depends on which of these stages you are in at the time 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.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
Because there is no deductible for the plan, this payment stage does not apply to you. (Details are in Section 4 below.)	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 $6,350. (Details are in Section 5 below.)	Because there is no coverage gap for the plan, this payment stage does not apply to you.	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2020). (Details are in Section 7 below.)

SECTION 4 There is no deductible for 2020

Section 4.1 You do not pay a deductible for your Part D drugs

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 or six cost-sharing tiers, based on your formulary
Every drug on the plan's Drug List is in one of five or six 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.

- Tier 4 - Non-Preferred Drug: These are brand-name and generic drugs not in a preferred tier.
- Tier 5 - Specialty Drugs: This contains high-cost generic and brand-name drugs (the highest tier).
- Tier 6 - Select Care Drugs: This is a $0 copay tier at preferred in-network pharmacies.

  NOTE: Tier 6 applies only to groups with the *Medicare Plus Blue℠ Group PPO Essential, Vitality, Signature & Assure, Prescription Blue℠ Group PDP Plus Comprehensive Formulary*. See page 1 of this *Medical Benefits Chart* to determine if your group uses this formulary.

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
- A pharmacy that is not in the plan's network
- 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.

Generally, we will cover your prescriptions *only* if they are filled at one of our network pharmacies. Some of our network pharmacies also offer preferred cost sharing. You may go to either network pharmacies that offer preferred cost sharing or other network pharmacies that offer standard cost sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost sharing.

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.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the cost share amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the cost share amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5, in the *Evidence of Coverage* for information about when we will cover a prescription filled at an out-of-network pharmacy.

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

Tier	Preferred retail and preferred mail-order cost sharing (in-network) (up to a 31-day supply)	Standard retail and standard 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	$15	$15	$15
Cost-Sharing Tier 2 (Generic)	$10	$15	$15	$15
Cost-Sharing Tier 3 (Preferred Brand)	$45	$50	$50	$50
Cost-Sharing Tier 4 (Non-Preferred Drug)	$95	$100	$100	$100
Cost-Sharing Tier 5 (Specialty Tier)	$95	$100	$100	$100

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.

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

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4 in the *Evidence of Coverage*.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the cost share amount, *whichever is lower*.

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

Tier	Preferred retail and preferred mail-order cost sharing (up to a 90-day supply)	Standard retail and standard mail-order cost sharing (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$20	$30
Cost-Sharing Tier 2 (Generic)	$20	$30
Cost-Sharing Tier 3 (Preferred Brand)	$90	$100
Cost-Sharing Tier 4 (Non-Preferred Drug)	$190	$200
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available 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.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $6,350

You stay in the Initial Coverage Stage until your out-of-pocket costs reach $6,350. Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. (See Section 5.6 of the *Evidence of Coverage* for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $6,350, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

The *Part D Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $6,350 limit in a year.

We will let you know if you reach this $6,350 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

SECTION 6 There is no coverage gap for Medicare Plus Blue Group PPO

Section 6.3 You do not have a coverage gap for your Part D drugs

There is no coverage gap for Medicare Plus Blue Group PPO. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $6,350 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 stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment.
- Once you qualify for catastrophic coverage, you'll pay $3.60 (for generic), $8.95 (for all other) or 5%, whichever is greater, but never more than your Medicare Plus Blue Group PPO copayment or coinsurance.

Medicare Plus Blue^{SM} is a PPO plan with a Medicare contract. Enrollment in Medicare Plus Blue depends on contract renewal.

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 5:00 p.m. Eastern time for more information. From October 1 through March 31, hours are from 8:00 a.m. to 9:00 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 your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.