Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

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Medical Benefits Chart with prescription drug costs

Your medical benefits and costs as a member of the City of Detroit General Retiree Health Care Trust Medicare Plus Blue Group PPO plan

This *Medical Benefits Chart with prescription drug costs* is a part of the 2026 *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, 2026 - December 31, 2026.

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

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

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

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

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

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

- Some services listed in this *Medical Benefits Chart* are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization).
- 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 get the services from:
  - If you get the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you get 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 get the covered services from an out-of-network provider who doesn't 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.* (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at **www.Medicare.gov** or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, 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	$500	
Part A and Part B in-network benefit out-of-pocket maximum, except those noted separately below	$2,500	Not Applicable
Pharmacy Out-of-Pocket Maximum for all Part D drugs/prescriptions	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	
Coinsurance Maximum	Not applicable	

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

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. If you receive other services during the visit, out-of-pocket costs may apply.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer. • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,	**In-network and Out-of-network:** For acupuncture for chronic low back pain services in an office setting, you pay a copayment of $20. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. For acupuncture for chronic low back pain services other than office visits, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Covered Service	What you pay
• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services Covered ambulance services, whether for an emergency of non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**In-network:** For Medicare-covered ambulance services, your coinsurance is 20% of the approved amount, after you meet your annual 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, your coinsurance is 20% of the approved amount, after you meet your annual deductible. Cost sharing applies for each one-way trip. These services apply to the combined annual out-of-pocket maximum.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. The annual wellness visit is enhanced so it can occur anytime throughout the calendar year, regardless of the date of the member's previous year's annual wellness visit. **Note:** Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit. However, you will be assessed a coinsurance, copayment, or deductible if a covered service (e.g., a diagnostic test) is outside of the scope of the annual wellness visit.

Covered Service	What you pay
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. If you have a medical condition or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and your contractual cost-sharing for Medicare-covered services will apply. If you receive other services during the visit, out-of-pocket costs may apply.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months • 3-D mammograms are covered when medically necessary See Chapter 12 (Definitions of important words) in the *Evidence of Coverage* for a definition of a mammogram screening.	There is no coinsurance, copayment, or deductible for covered screening mammograms. If you have a medical condition, a follow-up (second) mammogram and/or biopsy on a separate day from the screening, the procedure is considered diagnostic and your contractual cost sharing for Medicare-covered services will apply. If you receive other services during the visit, out-of-pocket costs may apply.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Please see the Exclusions Chart in Chapter 4, Section 3.1 of the *Evidence of Coverage.*	**In-network:** Your coinsurance is 20% 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.

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

Covered Service	What you pay
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high-risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high-risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high-risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. An office visit copay may apply if additional conditions are discussed at the visit. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
• Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. See Chapter 12 (Definitions of important words) in the *Evidence of Coverage* for a definition of a colonoscopy screening.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. See the **Physician/Practitioner Services, including doctor's office visits** benefit for examples of Medicare-covered dental services.	Original Medicare covers very limited medically necessary dental services. Medicare Plus Blue Group PPO will cover those same medically necessary services. The cost sharing for those services (e.g. surgery, office visits, X-rays) is referenced in other areas of this benefit chart. For more information, contact Customer Service.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit. If you receive other services during the visit, out-of-pocket costs may apply.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	
Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users), covered services include: • 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 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. **Note:** For all people who have diabetes and use insulin, covered services include — approved continuous glucose monitors and supply allowance for continuous glucose monitoring as covered by Original Medicare. Continuous glucose monitors must be obtained from any in-network pharmacy. * Diabetic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. To use an in-network supplier for diabetic supplies, including diabetic shoes and inserts, contact Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m., Monday through Friday. TTY users call 711. **For Continuous Glucose Monitors:** To use an in-network supplier for continuous glucose monitors you must go to any network pharmacy.	**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. You may pay a pharmacy coinsurance for medical supplies obtained from a pharmacy. If you receive other services during the visit, out-of-pocket costs may apply. **Note:** Diabetic shoes are subject to the deductible.

Covered Service	What you pay
At the back of your *Evidence of Coverage* document, we include an addendum which tells you the brands and manufacturers of continuous diabetic blood glucose monitors and traditional blood glucose monitors and test strips that we will cover.	
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3, Section 7 of the *Evidence of Coverage.)* Covered items include, but aren't 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. In this *Evidence of Coverage* document, we include Medicare Plus Blue Group PPO's list of DME brands and manufacturers with limited coverage. The most recent list of suppliers is available on our website at www.bcbsm.com/providersmedicare. Generally, Medicare Plus Blue Group PPO covers any DME covered by Original Medicare from the brands and manufacturers on this list. We won't cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. If you're new to Medicare Plus Blue Group PPO and using a brand of DME not on our list, we'll continue to cover this band for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) If you (or your provider) don't agree with our plan's coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical decision. (For more information, go to Chapter 9.)	**In-network:** Your coinsurance is 20% 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.

Covered Service	What you pay
Note: You must have a prescription from your provider to obtain Durable Medical Equipment (DME) items and services. To use an in-network provider in Michigan, contact Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m. Monday through Friday. TTY users call 711. **For Continuous Glucose Monitors:** To use an in-network supplier for continuous glucose monitors you must go to any network pharmacy. To find a network pharmacy, you can look in your Provider/Pharmacy Directory, visit our website (www.bcbsm.com/pharmaciesmedicare). * Durable medical equipment and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost-sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. 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. **In-network:** For Medicare-covered emergency room visits, you pay a copayment of $65 (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 $65 (waived if admitted within three days). Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Covered Service	What you pay
	If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital 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'll pay the out-of-network cost-sharing amount for the part of your stay after you're stabilized.
Glaucoma screening Glaucoma screening once per year for people who fall into at least one of the following high-risk categories: • People with a family history of glaucoma • People with diabetes • African Americans who are age 50 and older • Hispanic Americans who are age 65 and older	There is no coinsurance, copayment, or deductible for Medicare-covered glaucoma screening for people at high-risk. If you receive other services during the visit, out-of-pocket costs may apply.
Health and Wellness education programs Medicare Plus Blue PPO offers health and wellness education programs that include: • **24-Hour Nurse Advice Line:** Speak to a registered nurse 24 hours a day, 7 days a week for assistance with health-related questions. You can reach the nurse line by calling 1-855-624-5214. TTY users call 711. • **Tobacco Cessation Coaching:** Our Tobacco Cessation Coaching program is a yearly program offered as a self-guided experience with 24/7 access via web or mobile, or live coaching with enrollment online or over phone and available via telephonic or platform chat. Online access is https://join.personifyhealth.com/bluecrossmedicarerewards. Phone support and hours of operation are 1-888-573-3113, Monday through Thursday: 8 a.m. through 11 p.m. Eastern time; Friday: 8 a.m. through 7 p.m. Eastern time; Saturday: 9 a.m. through 3 p.m. Eastern time. TTY users call 711.	There is no coinsurance, copayment, or deductible for health and wellness education programs. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
• **SilverSneakers® fitness program**: (available only if your plan includes this program as an additional benefit – see Additional Benefits).	
Hearing services Medicare-covered hearing services include diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment. These are covered as outpatient care when you get them from a physician, audiologist, or other qualified providers. Diagnostic hearing exam – 1 per year. Your plan includes both the routine hearing exam and hearing aids benefits. See **Additional Benefits** for a description and cost sharing.	**In-network:** 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 20% 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 $50. 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.
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. If you receive other services during the visit, out-of-pocket costs may apply.
Home health agency care* Before you get 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.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Covered Service	What you pay
Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies * Home health agency care may require prior authorization. Your plan provider will arrange for this authorization, if needed.	Medical supplies ordered by physicians, such as durable medical equipment are not covered under home health agency care. See Durable Medical Equipment for more information. Please Note: Custodial care is not the same as home health agency care. For information, see Custodial Care in the exclusion list in Chapter 4, Section 3.1 of your *Evidence of Coverage*.
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administrations of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier * Home infusion therapy may require prior authorization. Your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount.

Covered Service	What you pay
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for geting service, you pay only our plan cost-sharing amount for in-network services.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Medicare Plus Blue Group PPO.

Covered Service	What you pay
• If you get the covered services from an out-of-network provider, you pay the cost-sharing under Original Medicare. **For services covered by Medicare Plus Blue Group PPO but not covered by Medicare Part A or B:** Medicare Plus Blue Group PPO will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition you pay cost-sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please go to Chapter 5, Section 9.4 (*If you're in Medicare-certified hospice*) in the *Evidence of Coverage*. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 in the *Evidence of Coverage* for more information.	There is no coinsurance, copayment, or deductible for pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. Flu, pneumonia, COVID-19 and other vaccines are also available at retail network pharmacies. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't 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 use disorder services	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 20% 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 20% 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 get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you'd pay at a network hospital.

Covered Service	What you pay
• 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'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Medicare Plus Blue Group PPO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. Coverage is up to $5,000; travel and lodging is covered for only one year after the initial transplant (includes up to five additional days prior to the initial transplant). Outside of the service area is defined as 100 miles or more, one-way to the facility, from your home address. • Blood - including storage and administration. Coverage of whole blood and packed red cells and all other components begin 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. **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're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	

Covered Service	What you pay
Inpatient services in a psychiatric hospital* Covered services include mental health care services that require a hospital stay. There is a lifetime limit of 190 days for inpatient services in a psychiatric hospital. You have unlimited days of coverage for mental health services provided in a psychiatric unit of a general hospital (the 190-day limit doesn't apply). * Inpatient mental health/behavioral health services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-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 in-network 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 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.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't 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	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 20% 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 20% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.

Covered Service	What you pay
• 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	**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. Additional cost share may apply for professional services. We will cover medical services; however, we no longer cover SNF facility charges unless there is an approved authorization on file. Member may exercise appeal rights if SNF is not approved.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get 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 get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit. If you receive other services during the visit, out-of-pocket costs may apply.
Medicare Part B drugs* **These drugs are covered under Part B of Original Medicare. Members of our plan get 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 get get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them	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 20% 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. Drugs may be subject to step therapy. Insulin cost sharing is subject to a coinsurance cap of $35 for 1-month's supply of insulin.

Covered Service	What you pay
• Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding)	

Covered Service	What you pay
This link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://www.bcbsm.com/amslibs/content/dam/microsites/medicare/documents/2025/pharmacy/ma-ppo-bcna-medical-drugs-prior-authorization.pdf. We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit. * Medicare Part B prescription drugs may require prior authorization and/or step therapy; your plan provider will arrange for this authorization, if needed. *We may require you to try a Part D drug before we allow a Part B drug.* Chapter 5 of the *Evidence of Coverage* explains the Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in the excerpts from Chapter 6 of the *Evidence of Coverage* below.	
Non-Medicare covered mobile mental health services Mobile Mental Health Crisis Solutions will improve care for people that are in crisis. Ideally to prevent higher levels of care. Services include onsite services, mobile crisis intervention by telehealth or face to face, along with Crisis stabilization. Services include crisis stabilization centers, where clinicians provide assessment, diagnosis, treatment planning, initiation of treatment, lab exams and other interventions similar to medical/surgical observation services. Mobile intervention is provided by a crisis intervention team led by social workers who can obtain consultations from psychologists, or consulting psychiatrist. Mobile crisis services onsite in the field can include assessment, diagnosis, short term crisis psychotherapy intervention either face to face or via telehealth, medication consultation, and triage to the appropriate level of care. For more information or to find a provider near you, visit www.bcbsm.com/mentalhealth or contact your Medicare Advantage plan's customer service.	**In-network:** Mobile crisis and crisis stabilization for behavioral health, 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:** Mobile crisis and crisis stabilization for behavioral health, you pay a copayment of $50. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Covered Service	What you pay
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. If you receive other services during the visit, out-of-pocket costs may apply.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA) - approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**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 $50. 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 aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests	**In-network:** Services are covered up to 100% of the approved amount for Medicare-approved diagnostic lab services rendered at a preferred lab. Services are covered up to 100% of the approved amount for COVID-19 testing. For all other services, your coinsurance is 20% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.

Covered Service	What you pay
• Blood - including storage and administration. Coverage of whole blood and packed red cells and all other components begin with the first pint used. • Other outpatient diagnostic tests including sleep studies • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem **Note:** For Medicare-covered diagnostic radiological services and Medicare-covered X-ray services performed in an outpatient setting, refer to Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers. * Outpatient diagnostic tests and therapeutic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	**Out-of-network:** Services are covered up to 100% of the approved amount for Medicare-approved diagnostic lab services. Services are covered up to 100% of the approved amount for COVID-19 testing. 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.
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 Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person 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're 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 aren't sure if you're an outpatient, ask the hospital staff.	**In-network:** Your coinsurance is 20% 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.

Covered Service	What you pay
Get more information in the Medicare fact sheet called *Medicare Hospital Benefits.* This fact sheet is available at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
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 aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff. * Outpatient hospital services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network:** Your coinsurance is 20% 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 $65 (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:** 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 $65 (waived if admitted within three days). Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. Provider office or outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more. You may receive other services while in observation or an outpatient hospital facility. The cost for those services can be found in this document.

Covered Service	What you pay
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-network:** 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. 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 in-network annual out-of-pocket maximum. For telehealth behavioral health 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 mental health services in an office, you pay a copayment of $50. 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. For telehealth behavioral health services, you pay a copayment of $50. Not subject to the 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.	Original Medicare therapy limits/thresholds apply to rehabilitation services provided.

Covered Service	What you pay
Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-network:** Your coinsurance is 20% 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.
Outpatient substance use disorder services Outpatient substance use disorder services include counseling, detoxification, medical testing and diagnostic evaluation.	**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 20% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For telehealth behavioral health 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 substance abuse treatment services in an office, you pay a copayment of $50. 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.

Covered Service	What you pay
	For telehealth behavioral health services, you pay a copayment of $50. Not subject to the 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 **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're 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. * 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.	**In-network:** Your coinsurance is 20% 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. Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more.
Partial hospitalization services and Intensive outpatient services* *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	**In-network:** Your coinsurance is 20% 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.

Covered Service	What you pay
* Partial hospitalization services may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • One routine physical exam per year • Basic hearing and balance exams performed by your primary care provider or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: primary care physician services and individual sessions for mental health specialty services • You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	**In-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 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. For telehealth medical 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 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 in-network 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 in-network annual out-of-pocket maximum.

Covered Service	What you pay

• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  ○ You have an in-person visit within 6 months prior to your first telehealth visit
  ○ You have an in-person visit every 12 months while getting these telehealth services
  ○ Exceptions can be made to above for certain circumstances
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Telehealth services provided by qualified occupational therapists (OTs), physical therapists (PTs), speech-language pathologists (SLPs), and audiologists
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  ○ You're not a new patient **and**
  ○ The check-in isn't related to an office visit in the past 7 days **and**
  ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
  ○ You're not a new patient **and**
  ○ The evaluation isn't related to an office visit in the past 7 days **and**
  ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record
• Second opinion prior to surgery
	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 $50 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 $50. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.
	For telehealth medical visits, you pay a copayment of $50. 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.
	Note: Provider offices or outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more.

Covered Service	What you pay
As part of your Medicare Advantage plan, we offer safe and secure Virtual Care. Virtual Care gives you urgent care and behavioral health care through your phone, tablet, or computer from anywhere in the United States. Virtual urgent care visits from U.S. board-certified doctors are available 24/7, without an appointment. Virtual behavioral health visits are available by appointment from licensed behavioral health providers such as therapists, counselors, and U.S. board-certified psychiatrists. Virtual Care is available through Teladoc Health™, an independent company and our plan-approved vendor. (This service is separate from any virtual care your personal doctor might offer. • You can also use Teladoc Health™ to access telehealth services. Visit bcbsm.com/virtualcare for more information or call 1-800-835-2362, available 24 hours a day, 7 days a week, 365 days a year. TTY users call 1-855-636-1578. • Urgent general medical appointments available 24 hours a day, 7 days a week, 365 days a year (e.g., sore throat, fever, etc.) • Mental health appointment availability is 7 days a week; 7 a.m. to 9 p.m. local time • Providers will contact members directly. Appointments are not conducted through the 800 number above. • 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) • 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.	If a surgical or diagnostic procedure is performed during an office visit, these procedures are considered diagnostic and you will be responsible for the Medicare-covered surgical service out-of-pocket costs in addition to your office visit copay.

Covered Service	What you pay
Teladoc Health™ is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.	
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs *Note: For services other than specialist office visits, refer to the following sections of this benefit chart for member cost-sharing:* • Physician/Practitioner services, including doctor's office visits • Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers • Outpatient diagnostic tests and therapeutic services and supplies * Podiatry services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**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 20% 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 $50. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. 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. **Note:** Your doctor may charge an outpatient surgical copay for toenail clipping. See "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" for more information.

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable **drug**, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	There is no coinsurance, copayment, or deductible for the PrEP benefit. If you receive other services during the visit, out-of-pocket costs may apply.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test or a digital rectal exam. If you receive other services during the visit, out-of-pocket costs may apply.
Prosthetic and orthotic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery - go to **Vision Care** later in this table for more detail.	**In-network:** Your coinsurance is 20% 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.

Covered Service	What you pay
Note: You must have a prescription from your provider to obtain Prosthetic and Orthotic (P&O) items and services. *To use an in-network provider, contact Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m., Monday through Friday. TTY users call 711.* * Prosthetic and Orthotic devices and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	
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 20% 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.
Screening and counseling to reduce alcohol misuse We cover 1 alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive Hepatitis C screening. If you receive other services during the visit, out-of-pocket costs may apply.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are:** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
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 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, like a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. If you receive other services during the visit, out-of-pocket costs may apply.
Services to treat kidney disease* Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the *Evidence of Coverage* or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're 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)	Kidney disease education services are covered up to 100% of the approved amount. **In-network:** For dialysis services, your coinsurance is 20% 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 20% 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.

Covered Service	What you pay
Certain drugs for dialysis are covered under your Medicare Part B. For information about coverage for Part B Drugs, go to, **Medicare Part B drugs** in this table.	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.
Skilled nursing facility (SNF) care* (For a definition of skilled nursing facility care, go to Chapter 12 of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called SNFs.) No prior hospital stay is required. **Note:** Private duty nursing is not covered. Covered services include but aren't 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 our 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, and all other components being 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 get SNF care from network facilities. 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.	Plan covers up to 100 days for each benefit period. A benefit period begins the day you are admitted to a SNF and ends after you have not been received skilled care in a SNF for 60 consecutive days. Once the benefit period ends, a new benefit period begins when you have an admission to a 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 20% 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 20% 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.

Covered Service	What you pay
• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital * Skilled nursing facility care may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefit. If you receive other services during the visit, out-of-pocket costs may apply.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • 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	**In-network:** Your coinsurance is 20% 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.

Covered Service	What you pay
• Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Medicare Plus Blue Group PPO includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories.	*Outside the U.S.:* You may be responsible for the difference between the approved amount and the provider's charge. **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. For telehealth medical visits, 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. For telehealth medical visits, you pay a copayment of $50. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.
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	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. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
• For people who are at high-risk for glaucoma, we cover one glaucoma screening each year. People at high-risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. **Note:** Medically necessary contacts (not elective contacts) require provider approval and must meet criteria of "medically necessary."	**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 20% 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 $50. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. 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.
Welcome to Medicare preventive visit Our 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 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 want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the **Welcome to Medicare** preventive visit. (This is different from the Annual wellness visit). However, you will be assessed a coinsurance, copayment or deductible if you receive a covered service (e.g. diagnostic test) that is outside the scope of the **Welcome to Medicare** preventive visit. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
Additional Benefits	
Hearing aids Hearing aids are covered when furnished by a physician, audiologist, or other qualified provider and based on the most recent hearing exam and hearing aid evaluation. A medical evaluation is required to find the cause of the hearing loss and determine if it can be improved with a hearing aid prior to hearing aids being dispensed. Additional hearing aid batteries, repairs, adjustments, or reconfigurations are not covered. You are responsible for the difference between the plan's benefits and the cost of the hearing aid(s).	**In-network and Out-of-network:** **Note:** Members are encouraged to use in-network providers to minimize out-of-pocket costs. Standard (analog or basic digital) hearing aids are covered up to $2,000 every 36 months. You are responsible for the difference between the plan's benefit and the cost of the hearing aid(s).
Hearing services – routine exam A medical evaluation to find the cause of the hearing loss and determine if it can be improved with a hearing aid is covered as an office visit when furnished by a physician, audiologist, or other qualified provider. The following tests are covered under the hearing aids benefit: • A hearing aid evaluation test to determine what type of hearing aid should be prescribed • A test to evaluate the performance of a hearing aid (conformity-exam) The following test is covered as an office visit under the hearing services benefit when furnished by a physician, audiologist or other qualified provider: • An annual routine exam to measure hearing ability	**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 $50. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.
SilverSneakers® Members are covered for a fitness benefit through SilverSneakers®. SilverSneakers is a comprehensive program that can improve overall well-being and social connections. Designed for all levels and abilities, SilverSneakers provides convenient access to a nationwide fitness network, a variety of programming options and activities beyond the gym that incorporate physical well-being and social interaction. Benefits include:	**In-network and Out-of-network:** Services are covered at 100%. Fitness services must be provided at SilverSneakers® participating locations. You can find a location or request information at www.silversneakers.com or 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call 711.

Covered Service	What you pay
• Use of exercise equipment, classes, and other amenities at thousands of participating locations • SilverSneakers LIVE online classes and workshops taught by instructors trained in senior fitness • SilverSneakers On-Demand online library with hundreds of workout videos • SilverSneakers GO mobile app with on-demand videos and live classes • SilverSneakers Community gives you options to get active outside of traditional gyms (like recreation centers, malls, and parks) • Online fitness tips and healthy eating information • Social connections through events such as shared meals, holiday celebrations, and class socials Go to http://www.silversneakers.com to learn more or call 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call 711. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved.	

Section 2.1 Medicare Plus Blue Group PPO covers services nationwide

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

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

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

SECTION 2 Drug payment stages for Medicare Plus Blue Group PPO members

There are 3 **drug payment stages** for your drug coverage under Medicare Plus Blue Group PPO. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. If your plan has a deductible, your deductible amount for prescription drugs can be found in the chart below. Keep in mind you are always responsible for our plan's monthly premium regardless of the drug payment stage. Details of each stage are explained in this chapter.

The stages are:

Stage 1: Yearly Deductible Stage (if applicable)

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

Stage 1 Yearly Deductible Stage	Stage 2 Initial Coverage Stage	Stage 3 Catastrophic Coverage Stage
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach $2,100. (Details are in Section 5 below.) You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible (if applicable).	During this stage, **the plan pays the full cost** of your drugs for the rest of the calendar year (through December 31, 2026). (Details are in Section 6 below.)

SECTION 3 Your Part D Explanation of Benefits (EOB) explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs**: this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).

- **Total Drug Costs**: this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

- **Information for that month**. This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1**. This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions**. This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

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

- **Show your membership card every time you get a prescription filled**. This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need**. There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
    - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
    - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
    - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you**. Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you**. When you get a *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Customer Service at 1-866-684-8216 (TTY users call 711). Be sure to keep these reports.

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

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

SECTION 5 The Initial Coverage Stage

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

During the Initial Coverage Stage, our plan pays its share of the cost of your covered 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.

Our plan has five cost-sharing tiers

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

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

To find out which cost-sharing tier your drug is in, look it up in our 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 preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- A network pharmacy that offers standard cost sharing.
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.4 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

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

Section 5.2 Your costs for a *one-month* supply of a covered drug

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

The amount of the copayment or coinsurance depends on the cost-sharing tier.

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

Your costs for a *one-month* supply (or less) of a covered Part D drug:

Tier	Standard retail and standard mail-order cost sharing (in-network) (up to a 31-day supply)	Preferred retail and preferred mail-order cost sharing (in-network) (up to a 31-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 31-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$20	$10	$20	$20
Cost-Sharing Tier 2 (Generic)	$20	$10	$20	$20
Cost-Sharing Tier 3 (Preferred Brand)	$60	$45	$60	$60
Cost-Sharing Tier 4 (Non-Preferred Drug)	50% Minimum: $60 Maximum: $120	50% Minimum: $60 Maximum: $120	50% Minimum: $60 Maximum: $120	50% Minimum: $60 Maximum: $120
Cost-Sharing Tier 5 (Specialty Tier)	50% Minimum: $300 Maximum: $600	50% Minimum: $300 Maximum: $600	50% Minimum: $300 Maximum: $600	50% Minimum: $300 Maximum: $600

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

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

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

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

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply, if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

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

Section 5.4 Your costs for a *long-term* (up to 90-day) supply of a covered Part D drug

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

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

Your costs for a *long-term* supply of a covered Part D drug :

Tier	Standard retail cost sharing (in-network) (32- to 90-day supply)	Preferred retail cost sharing (in-network) (32- to 90-day supply)	Standard mail-order cost sharing (in-network) (32- to 90-day supply)	Preferred mail-order cost sharing (in-network) (32- to 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$40	$20	$40	$20
Cost-Sharing Tier 2 (Generic)	$40	$20	$40	$20
Cost-Sharing Tier 3 (Preferred Brand)	$120	$90	$120	$90
Cost-Sharing Tier 4 (Non-Preferred Drug)	50% Minimum: $120 Maximum: $240	50% Minimum: $120 Maximum: $240	50% Minimum: $120 Maximum: $240	50% Minimum: $120 Maximum: $240
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in Tier 5.			

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

You won't pay more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible (if applicable).

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,100. You then move to the Catastrophic Coverage Stage. For Enhanced Formularies, we offer additional coverage on some prescription drugs that are n't normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs won't count toward your total out-of pocket costs.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties, have spent on your behalf for your drugs during the year. Not all members will reach the $2,100 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Chapter 6 Section 1.3 in the *Evidence of Coverage* for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

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

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

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