2016

UAW Retirees of the Dana Corporation Health and Welfare Trust

Summary of Benefits

January 1, 2016 – December 31, 2016

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

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage.*

bcbsm.com/medicare

Please read this Important Information about Medicare Plus Blue Group PPO

I understand that:

- **Medicare Plus Blue Group PPO** is a Medicare Advantage plan that requires that I be entitled to Medicare Part A and enrolled in Part B and continue to pay my Part B premium.
- I can only be in one Medicare Advantage PPO or HMO plan at a time. My enrollment in this plan will automatically end my enrollment in any other Medicare Advantage PPO or HMO plan or Medicare Part D stand-alone prescription drug plan.
- I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
- Once I am a member of **Medicare Plus Blue Group PPO**, I have the right to appeal plan decisions about payment or services if I disagree.
- Once I am enrolled, I will read the *Evidence of Coverage* document from **Medicare Plus Blue Group PPO** that will provide detailed guidelines I must follow in order to receive coverage under Medicare Advantage.
- By joining the **Medicare Plus Blue Group PPO**, I acknowledge that this Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

For more information about this plan:

Visit us at **www.bcbsm.com/medicare** or call **Medicare Plus Blue Group PPO** Customer Service at 1-866-684-8216. We're available Monday through Friday, from 8:30 a.m. to 5:00 p.m. Eastern time. From October 1 through February 14, hours are from 8 a.m. to 8 p.m., seven days a week. (TTY users should call 711.)

For more information about Medicare, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, seven days a week. Or, visit **www.medicare.gov** on the web.

To request this document in an alternate format, please call the Customer Service number above.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-684-8216. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-684-8216. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-684-8216。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-684-8216。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-684-8216. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-684-8216. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-684-8216. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-684-8216. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-684-8216. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-684-8216. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا بمساعدتك. هذه خدمة مجانية على 1-866-684-8216. سيقوم شخص ما يتحدث العربية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-684-8216. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-684-8216. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-684-8216. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-684-8216. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-684-8216पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-684-8216 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

SECTION I – Introduction of Summary of Benefits

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government.

- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Medicare Plus Blue Group PPO**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medicare Plus Blue Group PPO** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on **www.medicare.gov**.

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

Sections in this booklet

- Things to Know About **Medicare Plus Blue Group PPO**

- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

- Covered Medical and Hospital Benefits

This document is available in other formats such as Braille and large print. For additional information, call us at 1-866-684-8216. This document may be available in a non-English language.

Things to know about Medicare Plus Blue Group PPO

Hours of Operation

Monday through Friday, 8:30 a.m. to 5:00 p.m. Eastern time. From October 1 through February 14, hours are from 8 a.m. to 8 p.m., seven days a week.

Medicare Plus Blue Group PPO Phone Numbers and Website

- Call, toll-free, 1-866-684-8216. TTY users should call 711.
- Our website: **www.bcbsm.com/medicare**

Who can join?

To join **Medicare Plus Blue Group PPO**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area is available to employer and union group members who live in our plan service area, which includes all 50 states and all U.S. territories.

Which doctors and hospitals can I use?

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

Outside Michigan, your costs are the same as in-network services when you use providers that accept Medicare. Using providers that do not accept Medicare may cost you more. Call Customer Service for more information. We are available Monday through Friday, 8:30 a.m. to 5:00 p.m. Eastern time. From October 1 through February 14, hours are from 8 a.m. to 8 p.m., seven days a week.

To locate a provider in our network, use the Find a Doctor tool on our website at:
www.bcbsm.com/providersmedicare.

Or, call us and we will send you a copy of the provider directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.

- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

SECTION II – Summary of Benefits

If you have any questions about this plan's benefits or costs, please call **Medicare Plus Blue Group PPO** Customer Service at 1-866-684-8216, Monday through Friday from 8:30 a.m. to 5:00 p.m. Eastern time. From October 1 through February 14, hours are from 8 a.m. to 8 p.m., seven days a week. (TTY users call 711.)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
1 How much is the monthly premium?	In addition to the Medicare Part B premium, you may also be required to pay a premium contribution as defined by your employer or union group.
How much is the deductible?	Services are subject to a combined in-network and out-of-network annual deductible of $300.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $1,500 for services you receive from in-network providers. $4,500 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note: You will still need to pay your monthly premiums (if applicable).
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Benefits	Medicare Plus Blue Group PPO In-network	Out-of-network
COVERED MEDICAL AND HOSPITAL BENEFITS – INPATIENT CARE		
Note: Services with a [1] may require prior authorization.		
2 **Home Health Care** (Includes medically necessary intermittent skilled nursing care, home health aide services, home infusion, rehabilitation services, etc.)	Services are covered up to 100% of the approved amount.	Services are covered up to 100% of the approved amount.
3 **Hospice** (You must receive care from a Medicare-certified hospice.)	When you enroll in a Medicare-certified hospice program, your hospice services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	When you enroll in a Medicare-certified hospice program, your hospice services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
4 **Inpatient Hospital Care**[1] (Includes Substance Abuse and Rehabilitation Services)	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 facility evaluation and management services, your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

Benefits	Medicare Plus Blue Group PPO In-network	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 in-network annual out-of-pocket maximum. Medicare-approved clinical lab services and preventive services are covered at 100% of the approved amount. You have unlimited days of inpatient care coverage.	For all other services, your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. Medicare-approved clinical lab services and preventive services are covered at 100% of the approved amount. You have unlimited days of inpatient care coverage. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition has been stabilized, you must move to an in-network hospital in order to pay the in-network cost-sharing amount for the part of your stay after stabilization. If you stay at the out-of-network hospital, your stay will be covered, but you will pay the out-of-network cost-sharing amount for the part of your stay after your condition has been stabilized.

Benefits	Medicare Plus Blue Group PPO In-network	Out-of-network
5 **Inpatient Mental Health Care**[1]	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. You have unlimited days of inpatient care coverage.	For facility evaluation and management services, your coinsurance is 40% 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 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. You have unlimited days of inpatient care coverage.
6 **Skilled Nursing Facility**[1] (You must receive care in a Medicare-certified skilled nursing facility.)	Plan covers up to 100 days for each benefit period. 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.	Plan covers up to 100 days for each benefit period. For facility evaluation and management services, your coinsurance is 40% 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 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

Benefits	In-network	Out-of-network
Medicare Plus Blue Group PPO		
COVERED MEDICAL AND HOSPITAL BENEFITS – OUTPATIENT CARE		
7 **Ambulance Services** (Medically necessary ambulance services)	You pay a copayment of $25 for Medicare-covered ambulance services. Not subject to the deductible. Cost sharing applies for each one-way trip. These services apply to the in-network out-of-pocket maximum.	You pay a copayment of $40 for Medicare-covered ambulance services. Not subject to the deductible. Cost sharing applies for each one-way trip. These services apply to the combined out-of-pocket maximum.
8 **Cardiac and Pulmonary Rehabilitation 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.	Your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
9 **Chiropractic Services** (For manual manipulation of the spine to correct subluxation (when 1 or more of the bones of your spine move out of position) if you receive services from a chiropractor or other qualified provider.)	You pay a copayment of $20. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.	You pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Benefits	Medicare Plus Blue Group PPO In-network	Out-of-network
10 **Dental Services**	Original Medicare covers very limited medically necessary dental services. Your Medicare Plus Blue Group PPO plan will cover those same medically necessary services. For cost sharing information for those services (e.g. surgery, office visits, X-rays), contact Customer Service.	Original Medicare covers very limited medically necessary dental services. Your Medicare Plus Blue Group PPO plan will cover those same medically necessary services. For cost sharing information for those services (e.g. surgery, office visits, X-rays), contact Customer Service.
11 **Diabetes Programs and Supplies** (Includes coverage for glucose monitors, test strips, lancets, screening tests and self-management training.)	Services are covered up to 100% of the approved amount for diabetes screenings, diabetes-related durable medical equipment or supplies, and self-management training. Diabetic shoes are covered up to 100% of the approved amount, after you meet your annual deductible.	Services are covered up to 100% of the approved amount for diabetes screenings, diabetes-related durable medical equipment or supplies, and self-management training. Diabetic shoes are covered up to 100% of the approved amount, after you meet your annual deductible.
12 **Diagnostic Tests, X-rays, Lab Services and Radiology Services** (Costs for these services may vary based on place of service)	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.	Your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

	Medicare Plus Blue Group PPO		
	Benefits	**In-network**	**Out-of-network**
13	**Doctor Office Visits**	You pay a copayment of $20. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.	You pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.
14	**Durable Medical Equipment** (Includes wheelchairs, oxygen, etc.)	Services are covered up to 100% of the approved amount.	Your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
15	**Emergency Care** (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay a copayment of $50 for Medicare-covered emergency room visits (waived if admitted within three days). Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.	You pay a copayment of $50 for Medicare-covered emergency room visits (waived if admitted within three days). Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Benefits	Medicare Plus Blue Group PPO In-network	Out-of-network
		If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition has been stabilized, you must move to an in-network hospital in order to pay the in-network cost-sharing amount for the part of your stay after stabilization. If you stay at the out-of-network hospital, your stay will be covered, but you will pay the out-of-network cost-sharing amount for the part of your stay after your condition has stabilized.
16 **Hearing Services**	You pay a copayment of $20 for diagnostic hearing office visits. 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.	You pay a copayment of $40 for diagnostic hearing office visits. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. For diagnostic testing services, your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

Benefits	Medicare Plus Blue Group PPO In-network	Out-of-network
17 **Kidney Disease and Conditions**	Your coinsurance is 20% of the approved amount for dialysis services, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. Your coinsurance is 20% of the approved amount for professional charges, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. Home dialysis equipment and supplies are covered up to 100% of the approved amount. Kidney disease education services are covered up to 100% of the approved amount.	Your coinsurance is 40% of the approved amount for dialysis services, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. Your coinsurance is 40% of the approved amount for professional charges, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. Home dialysis equipment and supplies are covered up to 100% of the approved amount. Kidney disease education services are covered up to 100% of the approved amount.
18 **Outpatient Mental Health Care**[1]	For mental health services in an office, you pay a copayment of $20. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.	For mental health services in an office, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Benefits	Medicare Plus Blue Group PPO In-network	Out-of-network
	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 mental health services rendered at a mental health facility, your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
19 **Outpatient Rehabilitation Services**[1] (Occupational therapy, physical therapy, speech, and language therapy)	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.	Your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
20 **Outpatient 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.	Your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

Benefits	In-network	Out-of-network
	Medicare Plus Blue Group PPO	
21 **Outpatient Substance Abuse Care**[1]	For substance abuse treatment services in an office, you pay a copayment of $20. 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 substance abuse treatment services in an office, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. For substance abuse treatment services rendered at a facility, your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
22 **Outpatient Surgery Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers**	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.	Your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
23 **Podiatry Services**	For podiatry services in an office, you pay a copayment of $20. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.	For podiatry services in an office, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Benefits	Medicare Plus Blue Group PPO In-network	Out-of-network
	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.	For some medically necessary foot care services other than office visits, your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
24 **Prosthetic and Orthotic Devices** (Braces, artificial limbs, etc.)	Services are covered up to 100% of the approved amount.	Your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.
25 **Urgently Needed Care** (This is NOT emergency care.)	You pay a copayment of $20. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.	You pay a copayment of $20. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.

Medicare Plus Blue Group PPO		
Benefits	**In-network**	**Out-of-network**
26 **Vision Services**	For medical vision services in an office, you pay a copayment of $20. 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. Services are covered up to 100% of the approved amount for corrective lenses following cataract surgery. Routine eye exams and eyeglasses are not covered by this plan.	For medical vision services in an office, you pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum. For diagnosis and treatment of diseases and conditions of the eye, your coinsurance is 40% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. Services are covered up to 100% of the approved amount for corrective lenses following cataract surgery. Routine eye exams and eyeglasses are not covered by this plan.

COVERED MEDICAL AND HOSPITAL BENEFITS – PREVENTIVE SERVICES		

27	**Preventive Services and Wellness/Education Programs**	**In-network and Out-of-network:**
		Preventive services are covered at 100% of the approved amount. Some limitations apply.
		- Abdominal Aortic Aneurysm Screening
		- Alcohol Misuse Screening and Counseling
		- Bone Mass Measurement
		- Breast Cancer Screening (Mammogram)
		- Cardiovascular Disease Screening and Behavioral Therapy
		- Cervical and Vaginal Cancer Screening
		- Colorectal Cancer Screening
		  o Screening Fecal Occult Blood Test
		  o Screening Flexible Sigmoidoscopy
		  o Screening Colonoscopy
		  o Screening Barium Enema
		- Depression Screenings
		- Diabetes Screening
		- Diabetes Self-Management Training
		- Flu Shots (Vaccine)
		- Glaucoma Screening
		- Hepatitis B Shots (Vaccine)
		- Hepatitis C Screening
		- HIV Screening
		- Lung Cancer Screening and Counseling
		- Medical Nutrition Therapy Services
		- Obesity Screening and Counseling
		- Pneumococcal Screening
		- Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only)
		- Sexually transmitted infections screening and counseling
		- Tobacco Use Cessation counseling for people with no sign of tobacco-related disease
		- Welcome to Medicare Prevention Visits (initial preventive physical exam)
		- Yearly “Wellness” Visit
		Any additional preventive services approved by Medicare during the contract year will be covered.

Benefits	Medicare Plus Blue Group PPO In-network	Out-of-network
OTHER SERVICES		
Hearing Aids	Standard hearing aids are covered up to $2,500 every 36 months.	Standard hearing aids are covered up to $2,500 every 36 months.
Hearing Services – Routine Exam	You pay a copayment of $20. Not subject to the deductible. These services apply to the in-network annual out-of-pocket maximum.	You pay a copayment of $40. Not subject to the deductible. These services apply to the combined annual out-of-pocket maximum.
SilverSneakers®	Services are covered up to 100% of the approved amount.	The SilverSneakers Fitness Program is not a gym membership, but a specialized program designed specifically for seniors. This is not a covered benefit for gym memberships or other fitness programs that are not part of the SilverSneakers Fitness Program.

Notes

Customer Service for

Medicare Plus Blue Group PPO

1-866-684-8216

TTY users should call 711

Monday through Friday, 8:30 a.m. - 5:00 p.m. Eastern time

From October 1 through February 14, hours are
from 8 a.m. to 8 p.m., seven days a week.

www.bcbsm.com/medicare