2024

Medicare Plus Blue℠ PPO Part B Credit

Summary of Benefits

January 1, 2024 — December 31, 2024

To get a complete list of services we cover, call Customer Service and ask for the *Evidence of Coverage* (phone numbers are printed on the back cover of this booklet).

To join **Medicare Plus Blue PPO Part B Credit**, you must have both Medicare Part A and Medicare Part B, be a United States citizen or lawfully present in the United States and live in our geographic service area. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it. Our service area includes the state of Michigan.

www.bcbsm.com/medicare

Medicare Advantage Plans

Medicare Plus Blue PPO Part B Credit have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at **www.bcbsm.com/medicare**.

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

Premium/Cost-sharing Table for Medicare Plus Blue PPO Part B Credit

Premiums vary by county in which you permanently reside (rates are based on the use and cost of health care services in each regional segment). You must continue to pay your Medicare Part B premium. **A Medicare Part B rebate of $100 is provided.**

1) Find the county and region that you live in.

2) Look across the plan option columns to find your monthly premium rate.

Monthly premium rates per region	Part B Credit
Region 1 Allegan, Barry, Ionia, Kalamazoo, Mason, Muskegon, Newaygo, Oceana and Ottawa counties	$0
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren counties	$0
Region 3 Alcona, Alger, Alpena, Arenac, Baraga, Bay, Charlevoix, Cheboygan, Chippewa, Clare, Crawford, Gladwin, Huron, Iosco, Kalkaska, Keweenaw, Luce, Mackinac, Montmorency, Ogemaw, Ontonagon, Oscoda, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee and Tuscola counties	$0
Region 4 Antrim, Benzie, Cass, Clinton, Delta, Dickinson, Emmet, Genesee, Gogebic, Grand Traverse, Houghton, Iron, Isabella, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Marquette, Mecosta, Menominee, Midland, Missaukee, Osceola, Otsego, St. Clair and Wexford counties	$0
Region 6 Macomb, Oakland, Washtenaw and Wayne counties	$0
Optional Supplemental Dental and Vision	$20.50 (additional monthly premium)

Region 5 is not being used at this time.

Benefits	Part B Credit	What you should know
Deductible	$600 annual deductible for hospital and medical services, combined In- and Out-of-Network No deductible on Part D prescription drugs in Tiers 1 and 2. $350 deductible for Part D prescription drugs in Tiers 3, 4, and 5.	
Deductible - Optional Supplemental Dental and Vision	There is no deductible	
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	The most you could pay is $6,550 for services you receive from in-network providers. You pay $9,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	The most you pay for copays, coinsurance and other costs for medical services for the year. You will still need to pay your premiums and cost sharing for your Part D prescription drugs.

Benefits	Part B Credit	What you should know
Note: Services with a [1] may require prior authorization		
Inpatient Hospital Coverage[1]	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods. **In-network:** You pay $375, after deductible, copay per day for days 1 through 6 You pay $0, after deductible, per day for days 7 through 90 You pay $0, after deductible, per day for days 91 and beyond **Out-of-network:** You pay 50% of approved amount, after deductible, per stay	Our plan covers an unlimited number of days for an inpatient stay.
Outpatient Hospital Coverage[1]	**In-network** You pay $350 copay, after deductible, for Medicare-covered outpatient hospital services **Out-of-network** 50% of the approved amount, after deductible.	You may receive other services while in an outpatient hospital facility.

Benefits	Part B Credit	What you should know
Ambulatory Surgical Center (ASC) Services[1]	**In-network** You pay $300, after deductible, services in an ambulatory surgical center **Out-of-network** 50% of the approved amount, after deductible.	
Doctor Visits		
○ Primary	**In-network:** You pay $0 **Out-of-network:** You pay $25 copay	Our plan also covers telehealth services including those for primary care physician services and behavioral health providers.
○ Specialists	**In-network:** You pay $50 copay, after deductible **Out-of-network:** You pay $50 copay, after deductible	
Preventive Care	• In-network: You pay $0. • Out-of-network: You pay $0. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual physical exam • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • Glaucoma screening • HIV screening • Immunizations, including COVID-19, flu, hepatitis B, and pneumococcal vaccines • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and counseling • Prostate cancer screenings (PSA)	

Benefits	Part B Credit	What you should know
	• Screening for lung cancer with low-dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency Care	**In- and Out-of-network:** You pay $100 copay	The copay is waived if you are admitted to the hospital within three days for the same condition. You are covered for emergency medical care worldwide.
Urgently Needed Services	**In- and Out-of-network:** You pay $55 copay at an urgent care center You pay $0 copay at a primary care physician's office	You have coverage for worldwide urgently needed services.
Diagnostic Services/Labs/ Imaging[1] ○ Diagnostic radiology services (low-tech, high-tech)	**In-network:** You pay $150-$325 copay, after deductible, depending on the service **Out-of-network:** You pay 50% of approved amount, after deductible	Using in-network providers lowers your costs.

Benefits	Part B Credit	What you should know
○ Lab services	**In-network:** You pay $0-$40 copay, after deductible, depending on the location **Out-of-network:** You pay 50% of approved amount, after deductible	Using in-network providers lowers your costs.
○ COVID-19 testing	**In-network:** You pay $0 copay, after deductible **Out-of-network:** You pay $0 copay, after deductible	
○ Diagnostic tests and procedures	**In-network:** You pay $50-$150 copay, after deductible, depending on location. **Out-of-network:** You pay 50% of approved amount, after deductible	
○ Outpatient X-rays	**In-network:** You pay $35-$150 copay, after deductible **Out-of-network:** You pay 50% of approved amount, after deductible	
○ Therapeutic radiology services	**In-network:** You pay $45 copay, after deductible **Out-of-network:** You pay 50% of approved amount, after deductible.	
Hearing Services		
○ Hearing exam to diagnose and treat hearing and balance issues	**In-network:** You pay $0 copay for Medicare-covered hearing services from a primary care provider. You pay $50 copay, after deductible, for Medicare-covered hearing services from a specialist. **Out-of-network:** You pay 50% of approved amount, after deductible.	

Benefits	Part B Credit	What you should know
○ Routine hearing exam (1 every year)	**In-network:** You pay $0 copay for Medicare-covered hearing services from a primary care provider. You pay $50 copay for Medicare-covered hearing services from a specialist. **Out-of-network:** You pay 50% of approved amount	
○ Hearing aid fitting/ evaluation (1 every three years)	**In-network:** You pay $0 **Out-of-network:** You pay 50% of approved amount	**Hearing aids:** Plan covers a $1,200 allowance maximum for both ears (up to $600 per ear) every three years for new hearing aids, including applicable dispensing fee. Over-the-Counter (OTC) hearing aids may be purchased using the OTC allowance.
Dental Services (Medicare covered)	**In-network:** You pay $0 copay for Medicare-covered dental services from a primary care provider You pay $50 copay, after deductible, for Medicare-covered dental services from a specialist. **Out-of-network:** You pay 50% of approved amount, after deductible	
Dental services (Preventive and Comprehensive)	This benefit provides a $1,000 annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services.	To find a participating dentist, visit **www.mibluedentist.com** and search for PPO dentists in the BCBSM Medicare Advantage PPO network.

Benefits	Part B Credit	What you should know
○ **Preventive** • Oral exams (up to 2 every calendar year) • Routine cleanings (up to 2 every calendar year) • Dental X-rays (1 set of up to 4 bitewing X-rays, or 1 set of up to 6 periapical films every 2 calendar years) • Fluoride treatment (1 every calendar year)	**In-network:** You pay $0 copay **Out-of-network:** You pay 50% of approved amount	To find a participating dentist, visit **www.mibluedentist.com** and search for PPO dentists in the BCBSM Medicare Advantage PPO network.
○ **Comprehensive** • Brush biopsies (2 per calendar year) • Resin and amalgam fillings (once per tooth per surface every 48 months) • Crowns for permanent teeth only (once per tooth every 84 months) • Crown repairs (3 per permanent tooth per calendar year) • Root canals (once per tooth per lifetime) • Deep cleaning (once per quadrant per 24 months) • Extractions (1 time per tooth per lifetime) • Oral Surgery (2 times per tooth per lifetime)	**In-network:** You pay $0 copay **Out-of-network:** You pay 50% coinsurance	To find a participating dentist, visit **www.mibluedentist.com** and search for PPO dentists in the BCBSM Medicare Advantage PPO network.

Benefits	Part B Credit	What you should know
Dental - Optional Supplemental Benefit	The benefit provides another $1,500 annual maximum bringing your total annual maximum to $2,500 (combined in- and out-of-network) for preventive and comprehensive dental services. No Deductible. **In-network:** **25% coinsurance for:** • Onlays • Periodontics • Bridges • Dentures • Denture adjustments • Denture repairs • Denture relines • Denture rebase • Implants • Implant maintenance and repairs • Anesthesia • Consultation exams **Out-of-network:** **50% coinsurance for:** • Onlays • Periodontics • Bridges • Dentures • Denture adjustments • Denture repairs • Denture relines • Denture rebase • Implants • Implant maintenance and repairs • Anesthesia • Consultation exams	This optional supplemental benefit is available for an additional premium. For in-network benefits, you must receive dental services from a participating provider. For out-of-network services, if your provider doesn't submit your claim, you may be required to pay costs up front and submit for reimbursement. Out-of-network expenses will be reimbursed at 50% of allowed amounts up to the combined annual maximum. You may pay higher out-of-pocket amounts if you receive services from out-of-network providers The additional optional supplemental $1,500 annual maximum applies to all dental services listed in this document. This is in addition to the $1,000 annual maximum for preventive and comprehensive dental services.

Benefits	Part B Credit	What you should know
Vision Services		
○ Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	**In-network:** You pay $0 copay for Medicare-covered vision services from a primary care provider. You pay $50 copay, after deductible, for Medicare-covered vision services from a specialist. **Out-of-network:** You pay 50% of approved amount, after deductible, for Medicare-covered services	People with diabetes, screening for diabetic retinopathy is covered once per year.
○ Eyeglasses or contact lenses after cataract surgery	**In-network:** You pay $0 copay, after deductible, for eyeglasses or contact lenses after Medicare-covered cataract surgery **Out-of-network:** You pay 50% of approved amount, after deductible	
Enhanced Vision Benefits		
○ Elective Lasik and RK surgery (not provided by VSP)	**In-network:** You pay $50 copay **Out-of-network:** You pay 50% of approved amount	
○ Routine eye exam	**In-network:** You pay $0 **Out-of-network:** Reimbursed up to 50% of the allowed amount	VSP Vision Care providers represent the plan's vision network. Routine vision care must be provided by a VSP provider for services to be considered in-network. To locate a VSP Choice Network provider you can access **VSP.com** or call 1-877-365-5430, 8 a.m. to 8 p.m. local time, Monday - Saturday. Hearing impaired customers may call 1-800-428-4833 for assistance.
○ You are eligible for ONE of the following, every calendar year: • Elective contacts OR • One pair standard lenses OR • One frame OR • One complete pair of eyeglasses	**In-network:** Eyewear benefit provides a combined in- and out-of-network maximum benefit up to $100 every calendar year and may be used for either (a) elective contact lenses or, (b) one frame. One pair of standard eyeglass lenses is covered in full every calendar year.	

Benefits	Part B Credit	What you should know
Vision Services, *continued* ○ An allowance (every calendar year) is provided for: • Elective contacts OR • One frame For a complete pair of eyeglasses, allowance is available for the frame only. Standard eyeglass lenses are covered in full every calendar year.	**Out-of-network:** Eyewear benefit provides a combined in- and out-of-network maximum benefit with 50% of allowed amounts up to $100 every calendar year and may be used for either (a) elective contact lenses or, (b) one frame. Standard eyeglass lenses are reimbursed up to 50% of the allowed amount	
Optional Supplemental Vision You are eligible for ONE of the following, every calendar year: • Elective contact lenses OR • One pair of standard eyeglass lenses OR • One frame OR • One complete pair of eyeglasses An allowance every calendar year is provided for: • Elective contact lenses OR • One frame For a complete pair of eyeglasses, the vision allowance is available for the frame only. If standard eyeglass lenses or one complete pair of eyeglasses are chosen, lenses have the options of polycarbonate lenses and anti-reflective coating.	**In-network** You have an allowance that can be used toward either elective contact lenses or one frame. The optional eyewear benefit provides a $250 combined in and out-of-network benefit maximum (in addition to the enhanced vision benefit for a total of $350) once every calendar year and may be used for either (a) elective contact lenses or (b) one frame. Standard eyeglass lenses are covered in full every calendar year as part of the Enhanced Vision benefit.	The optional supplemental benefit is available for an additional premium. Optional supplemental vision benefits are provided in conjunction with the Enhanced Vision benefits. Frequency limits apply.

Benefits	Part B Credit	What you should know
Optional Supplemental Vision *continued*		
If elective contact lenses are chosen, they are covered up to the maximum vision benefit.		
You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.	**Out-of-network** You have an allowance that can be used toward either elective contact lenses or one frame.	
Routine vision care must be from a participating VSP Choice Network provider. To locate a VSP Choice Network provider, call 1-877-365-5430 from 8 a.m. to 8 p.m. local time, Monday through Friday. TTY users call 1-800-428-4833 or visit www.vsp.com.	The optional eyewear benefit provides (in addition to the Enhanced vision benefit) a combined in- and out-of-network benefit maximum with 50% coinsurance up to $250 every calendar year and may be used for either (a) elective contact lenses or (b) frames Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts every calendar year, as part of the Enhanced Vision benefit. Exams are reimbursed at 50% coinsurance up to allowed amounts. Routine eye exams are limited to once every calendar year. For out-of-network services, you may be required to pay the cost up front and submit for reimbursement.	

Benefits	Part B Credit	What you should know
Mental Health Services	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for a benefit period.	
○ Inpatient visit[1]	**In-network:** You pay $375 copay per day, after deductible, for days 1 through 4 You pay $0 per day, after deductible, for days 5 through 90 **Out-of-network:** You pay 50% of approved amount, after deductible, per stay	Using in-network providers lowers your costs.
○ Outpatient group or individual therapy visit	**In-network:** You pay $40 copay, after deductible **Out-of-network:** You pay 50% of approved amount, after deductible	

Benefits	Part B Credit	What you should know
Mobile crisis and crisis stabilization for behavioral health For members who reside in Allegan, Barry, Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Ionia, Jackson, Kalamazoo, Macomb, Mason, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ottawa, St. Joseph, Van Buren, Washtenaw and Wayne counties only. Mobile crisis and crisis stabilization for behavioral health will improve care for people who are in crisis. Services include onsite services, mobile crisis intervention by telehealth or face to face, along with crisis stabilization.	**In-network:** You pay $40 copay for Mobile crisis and crisis stabilization for behavioral health services, after deductible **Out-of-network:** You pay 50% of the allowed amount, after deductible	For more information or to find a provider near you, visit **https://www.bcbsm.com/behavioral-mental-health/index/** or contact your Medicare Advantage plan's customer service.
Skilled Nursing Facility (SNF)[1]	**In-network:** You pay $0 per day for days 1 through 20, after deductible You pay $203 copay per day for days 21 through 100, after deductible **Out-of-network:** You pay 50% of approved amount per stay, after deductible	Our plan covers up to 100 days in a SNF. No prior hospital stay is required for a skilled nursing facility stay.
Physical Therapy	**In-network:** You pay $40 copay **Out-of-network:** You pay 50% of approved amount	Physical Therapy is available in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities.

Benefits	Part B Credit	What you should know
Ambulance • Ground or Air • Ambulance without transportation	**In-network:** You pay $290 copay, after deductible, for each one-way emergent trip for Medicare-covered services You pay $90 copay, after deductible, for ambulance services not requiring transportation **Out-of-network:** You pay $290 copay, after deductible, for each one-way emergent trip for Medicare-covered services You pay $90 copay, after deductible, for ambulance services not requiring transportation or 50% of approved amount, after deductible, for non-emergency transportation	Copay is for each one-way trip. We cover ambulance services even if you are not transported to a facility, if you are stabilized at your home or another location. This service is not covered outside of the U.S. or its territories.
Transportation All members are eligible for 1 round trip per calendar year to an Enhanced Wellness Visit within the state of Michigan, no referral needed. To arrange transportation, call 1-888-617-0468 from 6 a.m. to 6 p.m. Eastern time, Monday through Saturday. TTY users call 711. Please call 48 hours in advance to schedule transportation.	$0 copay for transportation to an Enhanced Wellness Visit for 1 round trip per calendar year within the state of Michigan; no referral needed.	No referral needed.
For qualified members who reside in Wayne, Oakland, Macomb and Washtenaw counties only, non-emergency, medical transportation is covered for up to 28 days after a hospital discharge. Qualified members who have been selected for Blue Cross Coordinated Care℠, our care management program for members with special health needs, may be eligible	$0 copay for qualified members who live in Wayne, Oakland, Macomb and Washtenaw counties, non-emergency medical transportation is covered for up to 28 days after a hospital discharge.	Your Care Manager must arrange your transportation with the plan-approved transportation provider.

Benefits	Part B Credit	What you should know
Transportation *continued* for non-emergency medical transportation (NEMT) provided by a plan-approved transportation provider to medical appointments, physical therapy, a pharmacy, or other plan-approved locations.		
Medicare Part B Drugs[1] ○ Medicare Part B Insulin Drugs (one-month's supply) ○ Part B drugs such as chemotherapy drugs and other Part B drugs	**In- and Out-of-network:** Not more than a $35 copay **In-network:** You pay 0% – 20% of approved amount **Out-of-network:** You pay 50% of approved amount	Step therapy may be required.
Rehabilitation Services ○ Occupational therapy visit ○ Speech and language therapy visit	**In-network:** You pay $40 copay, after deductible **Out-of-network:** You pay 50% of approved amount, after deductible **In-network:** You pay $40 copay **Out-of-network:** You pay 50% of approved amount	Rehabilitation services are available in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-network:** You pay $20 copay for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services. **Out-of-network:** You pay 50% of the approved amount for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services.	

Benefits	Part B Credit	What you should know
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:** You pay $15 copay for Medicare-covered pulmonary rehabilitation services. **Out-of-network:** You pay 50% of the approved amount for Medicare-covered pulmonary rehabilitation services.	
Foot Care (podiatry services) [1] Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	**In-network:** You pay $50 copay, after deductible **Out-of-network:** You pay 50% of approved amount, after deductible	Your doctor may charge an outpatient surgical copay for toenail clipping.
Medical Equipment/ Supplies[1] ○ Durable Medical Equipment (e.g., wheelchairs, oxygen)	**In-network:** You pay 20% of approved amount, after deductible **Out-of-network:** You pay 50% of approved amount, after deductible	For in-network cost sharing for DME, 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.
○ Prosthetics (e.g., braces, artificial limbs)	**In-network:** You pay 20% of approved amount **Out-of-network:** You pay 50% of approved amount	For in-network cost sharing for diabetic supplies, contact J&B Medical Supply Company at 1-888-896-6233 from 8 a.m. to 6 p.m., Monday through Friday. TTY users call 711.
○ Diabetes supplies (e.g., monitoring, including approved continuous glucose monitors and supplies as covered by Original Medicare, therapeutic shoes or inserts)	**In-network:** You pay $0 **Out-of-network:** You pay $0	Select continuous glucose monitors and other diabetic supplies (except diabetic shoes) may be obtained from any in-network pharmacy.

Benefits	Part B Credit	What you should know
Health fitness program 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.	**In-network:** You pay $0 for the health fitness program. GetSetUp is a third-party provider and is not owned or operated by Tivity Health, Inc. ("Tivity") or its affiliates. Users must have internet service to access GetSetUp service. Internet service charges are responsibility of user. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2023 Tivity Health, Inc. All rights reserved.	Benefits include: • Use of exercise equipment, classes, and other amenities at thousands of participating locations • SilverSneakers LIVE online classes and workshops taught by instructors trained in senior fitness • SilverSneakers On-Demand online library with hundreds of workout videos • SilverSneakers GO mobile app with on-demand videos and live classes • SilverSneakers Community gives you options to get active outside of traditional gyms (like recreation centers, malls, and parks) • Online fitness tips and healthy eating information • Social connections through events such as shared meals, holiday celebrations, and class socials • GetSetUp virtual enrichment program with classes on topics ranging from healthy eating to aging in place
Bathroom Safety Members may use the annual plan benefit maximum towards supplemental bathroom safety items such as: • Shower/bathtub grab bar • Tub stool or transfer bench • Commode rails • Elevated toilet seats	You pay $0 copay Covered in full up to $100 annual plan benefit maximum.	Installation and in-home assessment are not covered. If a noncovered item and/or service is elected, the member is responsible for the entire charge associated with that item and/or service.

Benefits	Part B Credit	What you should know
Chiropractic Care		
○ Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position)	**In-network:** You pay $15 copay, after deductible **Out-of-network:** You pay 50% of approved amount, after deductible	One routine office visit per year. You have coverage for 1 set of X-rays (up to 3 views) per year performed by a chiropractor.
○ Routine Care 1 visit per year	**In-network:** You pay $50 copay **Out-of-network:** You pay 50% of approved amount	
○ Chiropractic X-rays	**In-network:** You pay $35 copay **Out-of-network:** You pay 50% of approved amount	
Home Health Care[1]	**In-network:** You pay $0, after deductible **Out-of-network:** You pay 50% of approved amount, after deductible	Home health care does not include custodial care.
Home Infusion Therapy[1] • Intravenous or subcutaneous administration of drugs or biologicals to an individual at home	**In- and Out-of-network:** 0% coinsurance for Medicare-covered home infusion therapy services.	
Hospice	You pay $0 for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details (phone numbers are on the back of this booklet).	

Benefits	Part B Credit	What you should know
Meal benefit Qualified members who have been selected to be a part of Blue Cross Coordinated Care℠, a care management program for members with special health needs and have been discharged from a hospital may be eligible for a two-week (14-day) meal benefit. Members are eligible for this benefit during the 30-day period after they return home from the hospital.	$0 copay for qualified members	Twenty-eight (28) meals will be delivered to your home in a refrigerated cooler pack in two shipments (14 meals per shipment). Meals can be tailored to meet certain dietary needs. An assessment with your Blue Cross nurse care manager is required to determine eligibility for the meal benefit. Members can receive up to 28 meals following each hospital discharge. There is no annual limit to the number of occurrences.
Outpatient Substance Abuse Group and individual therapy visit	**In-network:** You pay $50 copay, after deductible **Out-of-network:** You pay 50% of approved amount	Includes detoxification, medical testing and diagnostic evaluation.
Renal dialysis	**In-network:** You pay 20% coinsurance, after deductible **Out-of-network:** You pay 50% of approved amount, after deductible	Certain drugs for dialysis are covered under your Medicare Part B drug benefit.

Benefits	Part B Credit	What you should know
Over-the-Counter (OTC) Allowance: Advantage Dollars Over-the-Counter (OTC) items are drugs and health related products that do not need a prescription. This benefit covers certain approved non-prescription over-the-counter drugs and health-related items. Covered items include but are not limited to antacids, cough drops, denture adhesive, eye drops, pain medications, toothpaste and first aid items. There are four ways to use your benefit: 1) **In-store**. You will receive an Advantage Dollars card in the mail. You can use this card to purchase many common items at local retailers. You can find a complete list of plan-approved retailers online at **www.bcbsm.com/medicareotc**. 2) **Online**. Go to **www.bcbsm.com/medicareotc** and follow the prompts to place the order using the online catalog. Items will be mailed to you. 3) **Mail**. You may request a printed catalog and order form by calling 1-855-856-7878 (TTY: 711), 8 a.m. – 11 p.m. Eastern time, Monday – Friday. Complete and return the order form. Items will be mailed to you.	You receive $50 per quarter An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will carry forward into the next quarter but not into the next calendar year. The final day to spend allowance dollars is December 31, 2024. Any unspent allowance will not carry over to 2025. Note: All purchases must be made through plan-approved retailers.	Members will receive one card for purchasing approved non-prescription, over-the-counter drugs, and health-related items, at participating retail locations. In addition to the over-the-counter benefit, qualified members will be able to use their allowance to purchase healthy foods. See *Special supplemental benefits for the chronically ill, Food Allowance,* for more information.

Benefits	Part B Credit	What you should know
4) **Telephone**. Select items using the printed or online catalog and call 1-855-856-7878 (TTY: 711), 8 a.m. – 11 p.m. Eastern time, Monday – Friday, to place an order. Items will be mailed to you.		
Special supplemental benefits for the chronically ill **Food and Produce Allowance** Members with certain health conditions can use their quarterly over-the-counter Advantage Dollars allowance to buy approved foods. This benefit will be available only to plan-identified members who have been diagnosed with: Arthritis; autoimmune disorders (polyarteritis nodosa, polymyositis rheumatica, polymyositis, systemic lupus erythematosus); cancer (excluding pre-cancer conditions or in-situ status);]), cardiac arrhythmias; chronic alcohol and/or other drug dependence; chronic cardiovascular disorders (coronary artery disease [CAD], peripheral vascular, chronic venous thromboembolic disorder); chronic and disabling mental health conditions; chronic heart failure; chronic lung disorders (chronic obstructive pulmonary disease [COPD, dementia; diabetes; pre-diabetes; end-stage liver disease, end-stage renal disease (ESRD) requiring dialysis; HIV/AIDS;	You receive $50 per quarter An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will carry forward into the next quarter but not into the next calendar year. The final day to spend allowance dollars is December 31, 2024. Any unspent allowance will not carry over to 2025. Note: All purchases must be made through plan-approved retailers.	The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify. See **Over-the-Counter (OTC) Allowance: Advantage Dollars** benefit for more information on the over-the-counter items benefit.

Benefits	Part B Credit	What you should know
hypertension; neurologic disorders; severe hematologic disorders (aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease [excluding having the sickle-cell trait], chronic venous thromboembolic disorder); and/or stroke.		
Support for caregivers of enrollees Eligible members who have a non-professional caregiver (e.g., a family member or other person who cares for them) may be eligible for access to an online Caregiver Support tool. The tool provides training, coaching and support to family members or other persons who care for members with dementia and other high-risk conditions. Caregivers will have access to online coaching, education, and support where they can learn: • How to manage stress and social isolation • How to access available resources such as transportation and home health assistance • Home safety improvements • How to prevent falls • About advanced care planning Qualifying members will be referred to this program by their care manager.	$0 copay for support for caregivers of enrollees. An eligibility assessment with a care manager is required to determine eligibility.	Qualifying members will be referred to this program by their Care Manager. For a caregiver to qualify for this benefit, the member must meet the following requirements: 1. Have been selected to be a part of a Blue Cross Coordinated Care℠, a care management program for members with special health needs. 2. Be cared for at home by a family member or other person who would benefit from the support, training and coaching this program provides.

Benefits	Part B Credit	What you should know
Virtual Care Visits This Virtual Care benefit applies to certain telehealth services. This service is separate from any virtual care your personal doctor might offer. **Medical:** Members can get virtual urgent care visits from U.S. board-certified doctors 24 hours a day, 7 days a week for minor illnesses and symptoms through Teladoc Health™. Examples of symptoms that can be addressed in a virtual primary care physician visit include: • Respiratory and sinus infections • Colds, flu and seasonal allergies • Eye irritation or redness • Strains and sprains **Mental Health:** Members can schedule virtual individual mental health visits. These virtual visits are available by appointment from licensed behavioral health providers such as therapists, counselors, and U.S. board-certified psychiatrists.	$0 copay for each telehealth primary care physician medical visit through plan-approved vendor. $0 copay for each telehealth mental health visit through plan-approved vendor.	Virtual Care through Teladoc Health, our plan-approved vendor, gives you virtual urgent care and behavioral health care through your phone, tablet, or computer from anywhere in the United States. • 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 are available 24 hours a day, 7 days a week, 365 days a year • 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.
Worldwide emergency coverage ○ Worldwide emergency coverage ○ Worldwide urgent coverage ○ Worldwide emergency transportation	**In- and Out-of-Network** You pay $100 for worldwide emergency coverage. **In- and Out-of-Network** You pay $55 for worldwide urgent coverage. **In- and Out-of-Network** You pay $290 for worldwide emergency transportation.	If you need care when you're outside of the United States, we cover emergency and urgently needed services and emergency transportation, only. There is a combined $50,000 lifetime limit that applies to both urgent and emergent medical care and emergency transportation outside of the United States and its territories.

Outpatient Prescription Drugs - Part B Credit

Phase 1: The Deductible Stage

No deductible on Part D prescription drugs in Tiers 1 and 2. $350 deductible for Part D prescription drugs in Tiers 3, 4, and 5.

Phase 2: The Initial Coverage Stage

You pay the amounts listed in the tables below, and on the next page, until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Your share of the cost when you get a *one-month* (31-day) supply of a covered Part D prescription drug:

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$5	$0
Tier 2: Generic	$20	$10
Tier 3: Preferred Brand	$47	$45
Tier 4: Non-Preferred Drug	50%	50%
Tier 5: Specialty Tier	27%	27%

You won't pay more than $35 for a one-month supply of each insulin product regardless of the cost sharing tier.

Your share of the cost when you get a *long-term* (32- to 90-day) supply of a covered Part D prescription drug:

Essential, *continued*	**Standard retail and standard mail-order cost sharing (in-network)**	**Preferred retail cost sharing (in-network)**	**Preferred mail-order cost sharing (in-network)**
Tier 1: Preferred Generic	$15	$0	$0
Tier 2: Generic	$60	$0	$0
Tier 3: Preferred Brand	$141	$135	$90
Tier 4: Non-Preferred Drug	50%	50%	50%
Tier 5: Specialty Tier	Not offered	Not offered	Not offered

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online at **www.bcbsm.com/medicare**.

Phase 3 & 4: The Coverage Gap & The Catastrophic Stages

You have coverage for generic and brand-name drugs during the Coverage Gap stage. During this stage, you will pay 25% for generic and brand-name drugs. You pay no more than $35 for a 31-day supply for each covered insulin product regardless of the cost-sharing tier. You also have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0 for the cost of the drug. Most members do not reach the Coverage Gap stage or the Catastrophic Coverage stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* online at **www.bcbsm.com/medicare**.

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.

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

You can see the most complete and current information about which drugs are covered on our website (**www.bcbsm.com/formularymedicare**).

For more information

A complete list of services is found in the *Evidence of Coverage*. For a copy of the *Evidence of Coverage*, go to **www.bcbsm.com/medicare-evidence-of-coverage**, or contact Customer Service at 1-877-241-2583 from October 1 to March 31, 7 days a week from 8 a.m. to 9 p.m. Eastern time and from April 1 to September 30, Monday through Friday from 8 a.m. to 9 p.m. Eastern time, for more information. TTY users call 711.

You can order a copy of the "Medicare & You" handbook at **www.medicare.gov**, or you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

For more information, please call us at the phone number below or visit us at **www.bcbsm.com/medicare**.

If you are not a member of this plan, call toll-free 1-888-563-3307. TTY users should call 711.

If you are a member of this plan, call toll-free 1-877-241-2583. TTY users should call 711.

From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 9 p.m. Eastern time.

From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. Eastern time.

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

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

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

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