2025

Medicare Plus Blue[SM] PPO

Essential, Vitality, Signature and Assure

Summary of Benefits

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 Essential, Vitality, Signature or Assure, 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

Premium/Cost-sharing Table for Medicare Plus Blue PPO

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. **For the Essential plan only, a Medicare Part B premium reduction is provided (Region 1 = $3, Region 2 = $3, Region 3 = $3.50, Region 4 = $3 and Region 6 = $2).**

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

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

	Medicare Plus Blue premium rates per month			
Regions with counties	**Essential**	**Vitality**	**Signature**	**Assure**
Region 1 Allegan, Barry, Ionia, Kalamazoo, Mason, Muskegon, Newaygo, Oceana and Ottawa counties	$0	$29	$91	$187
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren counties	$0	$64	$113	$248
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	$75	$141	$281
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	$67	$112	$213
Region 6 Macomb, Oakland, Washtenaw and Wayne counties	$0	$72	$129	$284
Optional Supplemental Dental and Vision	$21.80 (additional monthly premium)			

Region 5 is not being used at this time.

Benefits	Essential	Vitality	Signature	Assure
Deductible	This plan does not have a deductible for hospital and medical services. This plan does not have a deductible for Part D prescription drugs			
Deductible - Optional Supplemental Dental and Vision	There is no deductible			
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$6,250 for services from any provider	$5,000 for services from in-network providers $6,700 for services from any provider	$4,700 for services from in-network providers $6,500 for services from any providers	$3,425 for services from in-network providers $5,150 for services from any provider
Note: Services with a [1] may require prior authorization				
Inpatient Hospital Coverage[1] Our plan covers an unlimited number of days for an inpatient stay.	**In-network:** $420 days 1-7 $0 days 8 and beyond **Out-of-network:** 50% of approved amount	**In-network:** $250 days 1-7 $0 days 8 and beyond **Out-of-network:** 40% of approved amount	**In-network:** $175 days 1-7 $0 days 8 and beyond **Out-of-network:** 40% of approved amount	**In-network:** $100 days 1-7 $0 days 8 and beyond **Out-of-network:** 30% of approved amount
Outpatient Hospital Coverage[1]	**In-network:** $150 copay for non-surgical services. $350 copay for surgical services **Out-of-network:** 50% of approved amount	**In-network:** $150 copay for non-surgical services. $220 copay for surgical services **Out-of-network:** 40% of approved amount	**In-network:** $125 copay non-surgical services. $205 copay for surgical services **Out-of-network:** 40% of approved amount	**In-network:** $75 copay for non-surgical services. $150 copay for surgical services **Out-of-network:** 30% of approved amount

Benefits	Essential	Vitality	Signature	Assure
Ambulatory Surgical Center (ASC) Services[1]	**In-network** $0 copay for Medicare-covered arthroplasty knee and hip services in an ASC			
	$100 for non-surgical services $250 for surgical services **Out-of-network:** 50% of the approved amount	$100 for non-surgical services $125 for surgical services **Out-of-network:** 40% of the approved amount	$75 for non-surgical services $100 for surgical services **Out-of-network:** 40% of the approved amount	$50 for non-surgical services $75 for surgical services **Out-of-network:** 30% of the approved amount
Doctor Visits				
• Primary	**In-network:** $0 **Out-of-network:** $25 copay	**In-network:** $0 **Out-of-network:** 40% coinsurance	**In-network:** $0 **Out-of-network:** 40% coinsurance	**In-network:** $0 **Out-of-network:** 30% coinsurance
• Specialist	**In-network:** $45 copay **Out-of-network:** $50 copay	**In-network:** $30 copay **Out-of-network:** 40% coinsurance	**In-network:** $30 copay **Out-of-network:** 40% coinsurance	**In-network:** $0 **Out-of-network:** 30% coinsurance
• Telehealth	$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.			

Benefits	Essential	Vitality	Signature	Assure
Preventive Care (Any additional preventive services approved by Medicare during the contract year will be covered.)	**In- and Out-of-network:** $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 • Depression screening • Diabetes screenings • Diabetes self-management training		• 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) • 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)	
Emergency Care	**In-network:** $125 copay **Note:** 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.			

Benefits	Essential	Vitality	Signature	Assure
Urgently Needed Services You are covered for urgently needed services worldwide	**In- and Out-of-network:** $50 copay at urgent care center $0 copay at primary care physician's office	**In- and Out-of-network:** $50 copay at urgent care center $0 copay at primary care physician's office	**In- and Out-of-network:** $50 copay at urgent care center $0 copay at primary care physician's office	**In- and Out-of-network:** $40 copay at urgent care center $0 copay at primary care physician's office
Diagnostic Services/ Labs/Imaging[1]				
• Diagnostic radiology services	**In-network:** $100-$150 copay	**In-network:** $100-$150 copay	**In-network:** $100-$125 copay	**In-network:** $75 copay
• Lab services	**In-network:** $0-$40 copay	**In-network:** $0-$40 copay	**In-network:** $0-$30 copay	**In-network:** $0-$20 copay
• Diagnostic tests and procedures including COVID-19 testing	**In-network:** $0-$150 copay	**In-network:** $0-$150 copay	**In-network:** $0-$125 copay	**In-network:** $0-$75 copay
• Outpatient X-rays	**In-network:** $35-$150 copay	**In-network:** $35-$150 copay	**In-network:** $35-$125 copay	**In-network:** $35-$75 copay
• Therapeutic radiology services	**In-network:** $35 copay **Out-of-network:** 0-50% of approved amount	**In-network:** $35 copay **Out-of-network:** 0-40% of approved amount	**In-network:** $35 copay **Out-of-network:** 0-40% of approved amount	**In-network:** $35 copay **Out-of-network:** 0-30% of approved amount
Hearing Services				
• Hearing exam to diagnose and treat hearing and balance issues • Routine hearing exam (1 every year)	**In-network:** $0-$45 copay **Out-of-network:** $50 copay	**In-network:** $0-$30 copay **Out-of-network:** 50% of approved amount	**In-network:** $0-$30 copay **Out-of-network:** 50% of approved amount	**In-network:** $0 copay **Out-of-network:** 50% of approved amount

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Hearing aids Hearing aid fitting/evaluation (1 every three years)	$1,500 allowance maximum for both ears (up to $750 per ear) every three years for new hearing aids. OTC allowance can be used toward OTC hearing aids. **In-network:** $0 Copay **Out-of-network:** You pay 50% of approved amount			
Dental Services (Medicare-covered)	**In-network:** $0-$45 copay **Out-of-network:** $50 copay	**In-network:** $0-$30 copay **Out-of-network:** 40% of approved amount	**In-network:** $0-$30 copay **Out-of-network:** 40% of approved amount	**In-network:** $0 copay **Out-of-network:** 30% of approved amount
Enhanced dental services (Preventive and Comprehensive) • Preventive Services include oral exams, routine cleanings, certain dental X-rays and fluoride treatment • Comprehensive Services include brush biopsies, resin and amalgam fillings, crowns for permanent teeth only, crown repairs, root canals, deep cleaning, extractions and oral surgery	This benefit provides a $1,500 annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services. **In-network:** 0% coinsurance **Out-of-network:** 50% of approved amount			

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Dental - Optional Supplemental Benefit (available at additional monthly premium) Includes, but not limited to, dentures, bridges, onlays and implants	The benefit provides an extra $1,500 combined in- and out-of-network benefit maximum (in addition to the enhanced dental benefit for a total of $3,000) for preventive and comprehensive dental services. No Deductible **In-network:** 25% coinsurance **Out-of-network:** 50% of approved amount			
Vision Services (Medicare-covered) • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening). • Screening for diabetic retinopathy is covered once per year for those at risk.	**In-network:** $0-$45 copay **Out-of-network:** $50 copay	**In-network:** $0-$30 copay **Out-of-network:** 40% of approved amount	**In-network:** $0-$30 copay **Out-of-network:** 40% of approved amount	**In-network:** $0 copay **Out-of-network:** 30% of approved amount
• Eyeglasses or contact lenses after cataract surgery	**In-network:** $0 copay **Out-of-network:** 50% of approved amount	**In-network:** $0 copay **Out-of-network:** 40% of approved amount	**In-network:** $0 copay **Out-of-network:** 40% of approved amount	**In-network:** $0 copay **Out-of-network:** 30% of approved amount

Benefits	Essential	Vitality	Signature	Assure
Enhanced Vision Services • Elective Lasik and RK surgery (not provided by VSP)	**In-network:** $45 copay **Out-of-network:** $50 copay	**In-network:** $30 copay **Out-of-network:** 40% of approved amount	**In-network:** $30 copay **Out-of-network:** 40% of approved amount	**In-network:** $0 copay **Out-of-network:** 30% of approved amount
• Routine eye exam through VSP Choice Network, one per calendar year	**In-network:** $0 copay **Out-of-network:** 50% of approved amount			
• Eligible for one each calendar year: ○ Elective contacts, OR ○ One pair standard lenses, OR ○ One frame OR ○ One complete pair of eyeglasses For a complete pair of eyeglasses, the allowance can be used for the frame only.	**In-network:** Eyewear benefit provides a combined in- and out-of-network maximum benefit up to $150 every calendar year and may be used for either (a) elective contact lenses or, (b) one frame. **Out-of-network:** Eyewear benefit provides a combined in- and out-of-network maximum benefit with 50% coinsurance up to $150 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			

Benefits	Essential	Vitality	Signature	Assure
Optional Supplemental Vision (available for additional monthly premium) 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 For a complete pair of eyeglasses, the allowance can be used for the frame only.	**In-network:** The benefit provides an extra $250 combined in- and out-of-network benefit maximum (in addition to the enhanced vision benefit for a total of $400) once every calendar year and may be used for either (a) elective contact lenses or (b) one frame. **Out-of-network:** The 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. For out-of-network services, you may be required to pay the cost up front and submit for reimbursement. Other limitations apply.			
Inpatient Mental Health Care[1] 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.	**In-network:** $300 days for 1-7 $0 days 8-90 **Out-of-network:** 50% of approved amount	**In-network:** $250 days 1-7 $0 days 8-90 **Out-of-network:** 40% of approved amount	**In-network:** $175 days 1-7 $0 days 8-90 **Out-of-network:** 40% of approved amount	**In-network:** $100 days 1-7 $0 days 8-90 **Out-of-network:** 30% of approved amount
Outpatient Mental Health Care Individual and group therapy	**In-network:** $20 copay **Out-of-network:** 50% of approved amount	**In-network:** $20 copay **Out-of-network:** 40% of approved amount	**In-network:** $20 copay **Out-of-network:** 40% of approved amount	**In-network:** $20 copay **Out-of-network:** 30% of approved amount

Benefits	Essential	Vitality	Signature	Assure
Skilled Nursing Facility (SNF)[1] Our plan covers up to 100 days in a SNF. No prior hospital stay is required for a skilled nursing facility stay.	**In-network:** $0 for days 1-20 $214 for days 21-100 **Out-of-network:** 50% of approved amount	**In-network:** $0 for days 1-20 $214 for days 21-100 **Out-of-network:** 40% of approved amount	**In-network:** $0 for days 1-20 $214 for days 21-100 **Out-of-network:** 40% of approved amount	**In-network:** $0 for days 1-20 $214 for days 21-100 **Out-of-network:** 30% of approved amount
Outpatient Rehabilitation Physical/Speech/ Occupational therapy	**In-network:** $40 copay **Out-of-network:** 50% of approved amount	**In-network:** $40 copay **Out-of-network:** 40% of approved amount	**In-network:** $35 copay **Out-of-network:** 40% of approved amount	**In-network:** $30 copay **Out-of-network:** 30% of approved amount
Ambulance • Ground or air transportation • Ambulance services without transportation • Non-emergency transportation	**In- or Out-of-network:** $350 copay **In- or Out-of-network:** $90 copay 50% coinsurance	**In- or Out-of-network:** $325 copay **In- or Out-of-network:** $90 copay 40% coinsurance	**In- or Out-of-network:** $285 copay **In- or Out-of-network:** $90 copay 40% coinsurance	**In- or Out-of-network:** $250 copay **In- or Out-of-network:** $90 copay 30% coinsurance
Transportation One round trip per calendar year to an annual physical exam within the state of Michigan	$0 copay for transportation to an annual physical exam for 1 round trip per calendar year within the state of Michigan; no referral needed. $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			
Medicare Part B Drugs[1] • Medicare Part B Insulin Drugs (one month's supply)	**In- and Out- of-network:** Not more than $35 per month			
• Chemotherapy drugs and other Part B drugs	**In-network:** 0%-20% coinsurance **Out-of-network:** 0%-50% coinsurance	**In-network:** 0%-20% coinsurance **Out-of-network:** 0%-40% coinsurance	**In-network:** 0%-20% coinsurance **Out-of-network:** 0%-40% coinsurance	**In-network:** 0%-20% coinsurance **Out-of-network:** 0%-30% coinsurance

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Cardiac and Pulmonary rehabilitation services	**In-network:** $0 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 copay **Out-of-network:** 40% coinsurance	**In-network:** $0 copay **Out-of-network:** 40% coinsurance	**In-network:** $0 copay **Out-of-network:** 30% coinsurance
Medical Equipment/ Supplies[1] • Durable Medical Equipment and Prosthetics and Orthotics • Diabetes supplies	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance **In- and Out- of-network:** $0 copay	**In-network:** 20% coinsurance **Out-of-network:** 40% coinsurance **In- and Out- of-network:** $0 copay	**In-network:** 20% coinsurance **Out-of-network:** 40%coinsurance **In- and Out- of-network:** $0 copay	**In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance **In- and Out- of-network:** $0 copay
Health fitness program (SilverSneakers)	**In-network:** You pay $0 for the health fitness program. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved.			
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.	**Allowance Amount**			
	You receive $95 per quarter	You receive $50 per quarter	You receive $65 per quarter	You receive $120 per quarter
	An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will not carry forward into the next quarter or the next calendar year. The final day to spend allowance dollars is December 31, 2025 and any unspent allowance will not carry over to 2026. Note: All purchases must be made through plan-approved retailers			

Benefits	Essential	Vitality	Signature	Assure
Special supplemental benefits for the chronically ill There is no coinsurance, copayment, or deductible.				
Food Allowance Allowance Amount Members with certain health conditions can use their quarterly over-the-counter (OTC) Advantage Dollars allowance to buy approved foods. The benefits described are Special Supplemental Benefits for the Chronically Ill. Those with qualifying chronic conditions can purchase food items with your allowance. Qualifying chronic conditions include hypertension, diabetes, chronic cardiovascular disorders, chronic lung disorders, and chronic heart failure. Other qualifying conditions may apply. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. Your plan will notify you when you're eligible. For details, please contact us.	**Allowance Amount**			
	You receive $95 per quarter	You receive $50 per quarter	You receive $65 per quarter	You receive $120 per quarter
	An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will not carry forward into the next quarter or the next calendar year. The final day to spend allowance dollars is December 31, 2025 and any unspent allowance will not carry over to 2026. Note: All purchases must be made through plan-approved retailers.			

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Worldwide emergency coverage				
• Worldwide emergency coverage	**In- and Out-of-Network** $125 copay	**In- and Out-of-Network** $125 copay	**In- and Out-of-Network** $125 copay	**In- and Out-of-Network** $125 copay
• Worldwide urgent coverage	**In- and Out-of-Network** $50 copay	**In- and Out-of-Network** $50 copay	**In- and Out-of-Network** $50 copay	**In- and Out-of-Network** $40 copay
• Worldwide emergency transportation	**In- and Out-of-Network** $350 copay	**In- and Out-of-Network** $325 copay	**In- and Out-of-Network** $285 copay	**In- and Out-of-Network** $250 copay

Essential and Vitality

Medicare Part D: Prescription Drugs Costs may differ based on pharmacy type (standard, preferred or mail-order). Your provider may need to obtain prior authorization					
Stage 1: Annual Deductible Since you have no deductible for Part D drugs, this payment stage doesn't apply.					
Phase 2: The Initial Coverage Stage You pay the amounts listed in the tables below, and on the next page, until your out-of-pocket costs reach $2,000.					
	Standard retail and standard mail-order cost sharing (in-network)-31-day supply	**Preferred retail and preferred mail-order cost sharing (in-network) 31-day supply**	**Standard retail and standard mail-order cost sharing (in-network) 32- to 90-day supply**	**Preferred retail cost sharing (in-network) 32- to 90-day supply**	**Preferred mail-order cost sharing (in-network) 32- to 90-day supply**
Tier 1: Preferred Generic	$5	$0	$15	$0	$0
Tier 2: Generic	$20	$11	$60	$0	$0
Tier 3: Preferred Brand	$47	$42	$141	$126	$84
Tier 4: Non-Preferred Drugs	50%	50%	50%	50%	50%
Tier 5: Specialty	33%	33%	Not offered	Not offered	Not offered
Phase 3: Catastrophic Coverage Stage	You won't pay more than $35 for a 31-day supply and no more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier. You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your *Evidence of Coverage*. You can also see our plan's pharmacy directory at our website **www.bcbsm.com/pharmaciesmedicare**. For the most current information about which covered drugs visit (**www.bcbsm.com/formularymedicare**).				

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Tier 1: Preferred Generic	$5	$0	$15	$0	$0
Tier 2: Generic	$18	$10	$54	$0	$0
Tier 3: Preferred Brand	$47	$42	$141	$126	$84
Tier 4: Non-Preferred Drugs	50%	50%	50%	50%	50%
Tier 5: Specialty	33%	33%	Not offered	Not offered	Not offered
Phase 3: Catastrophic Coverage Stage	You won't pay more than $35 for a 31-day supply and no more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier. You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your *Evidence of Coverage*. You can also see our plan's pharmacy directory at our website **www.bcbsm.com/pharmaciesmedicare**. For the most current information about which covered drugs visit (**www.bcbsm.com/formularymedicare**).				

Assure

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Tier 1: Preferred Generic	$5	$0	$15	$0	$0
Tier 2: Generic	$12	$7	$36	$0	$0
Tier 3: Preferred Brand	$42	$37	$126	$111	$74
Tier 4: Non-Preferred Drugs	50%	50%	50%	50%	50%
Tier 5: Specialty	33%	33%	Not offered	Not offered	Not offered
Phase 3: Catastrophic Coverage Stage	You won't pay more than $35 for a 31-day supply and no more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier. You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your *Evidence of Coverage*. You can also see our plan's pharmacy directory at our website **www.bcbsm.com/pharmaciesmedicare**. For the most current information about which covered drugs visit (**www.bcbsm.com/formularymedicare**).				

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. For additional information, call us at 1-800-450-3680. TTY users should call 711.

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