2025

READY TO HELP

Medicare Plus Blue[SM] PPO
Part B Credit

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 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

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 premium reduction of $102 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.

Regions with counties	Part B Credit premium rates per month
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	$21.80 (additional monthly premium)

Region 5 is not being used at this time.

Benefits	Part B Credit
Deductible	$600 annual deductible for hospital and medical services, combined In- and Out-of-Network 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)*	$6,550 for services from in-network providers $9,000 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:** $375 copay per day, after deductible, days 1 through 7 $0 copay per day, after deductible, days 8 and beyond **Out-of-network:** 50% of approved amount, after deductible
Outpatient Hospital Coverage[1]	**In-network:** $350 copay, after deductible **Out-of-network:** 50% of the approved amount, after deductible
Ambulatory Surgical Center (ASC) Services[1]	**In-network:** $300 copay, after deductible **Out-of-network:** 50% of the approved amount, after deductible
Doctor Visits ○ Primary ○ Specialists Our plan also covers telehealth services including those for primary care physician services and behavioral health providers.	**In-network:** $0 copay **Out-of-network:** $25 copay **In-network:** $55 copay, after deductible **Out-of-network:** $55 copay, after deductible

<table>
<tr><th>Benefits</th><th colspan="2">Part B Credit</th></tr>
<tr><td rowspan="2">Preventive Care
(Any additional preventive services approved by Medicare during the contract year will be covered.)</td><td colspan="2">In- and Out-of-network:
$0 copay
Our plan covers many preventive services, including:</td></tr>
<tr><td>• 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
• Diabetes self-management training
• Glaucoma screening
• HIV screening
• Immunizations, including COVID-19, flu, hepatitis B, and pneumococcal vaccines</td><td>• 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)
• “Welcome to Medicare” preventive visit (one-time)</td></tr>
<tr><td>Emergency Care</td><td colspan="2">In- and Out-of-network:
$110 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.</td></tr>
<tr><td>Urgently Needed Services
You have coverage for worldwide urgently needed services.</td><td colspan="2">In- and Out-of-network:
$45 copay at urgent care center
$0 copay at primary care physician’s office</td></tr>
</table>

Benefits	Part B Credit
Diagnostic Services/Labs/ Imaging[1]	
○ Diagnostic radiology services	**In-network:** $150-$325 copay, after deductible
○ Lab services	**In-network:** $0-$40 copay, after deductible
○ Diagnostic tests and procedures including COVID-19 testing	**In-network:** $0-$150 copay, after deductible
○ Outpatient X-rays	**In-network:** $35-$150 copay, after deductible
○ Therapeutic radiology services	**In-network:** $45 copay, after deductible **Out-of-network:** 0-50% of approved amount for covered services, after deductible
Hearing Services	
○ Hearing exam to diagnose and treat hearing and balance issues	**In-network:** $0 copay from a primary care provider. $55 copay, after deductible, from a specialist. **Out-of-network:** $55 copay, after deductible.
○ Routine hearing exam (1 every year)	**In-network:** $0-$55 copay **Out-of-network:** $55 copay
Hearing aids Hearing aid fitting/evaluation (1 every three years)	$1,200 allowance maximum for both ears (up to $600 per ear) every three years for new hearing aids. **In-network:** $0 Copay **Out-of-network:** You pay 50% of approved amount
Dental Services (Medicare covered)	**In-network:** $0 copay from a primary care provider $55 copay, after deductible, from a specialist. **Out-of-network:** $55 copay, after deductible

Benefits	Part B Credit
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 $1,000 annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services. **In-network:** $0 copay **Out-of-network:** 50% of approved amount
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 $2,500 (combined in- and out-of-network) 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 copay from a primary care provider. $55 copay, after deductible, from a specialist. **Out-of-network:** $55 copay, after deductible
○ Eyeglasses or contact lenses after cataract surgery	**In-network:** $0 copay, after deductible **Out-of-network:** 50% of approved amount, after deductible

Benefits	Part B Credit
Enhanced Vision Services ○ Elective Lasik and RK surgery (not provided by VSP)	**In-network:** $55 copay **Out-of-network:** $55 copay
○ Routine eye exam through VSP Choice Network ○ 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 For a complete pair of eyeglasses, the allowance can be used for the frame only.	**In-network:** $0 copay **Out-of-network:** 50% of the allowed amount **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. **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 (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 $350) 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.

Benefits	Part B Credit
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:** $290 copay per day, after deductible, days 1-7 $0 copay per day, after deductible, days 8-90 **Out-of-network:** 50% of approved amount, after deductible
Outpatient Mental Health Care Individual and group therapy	**In-network:** $40 copay, after deductible **Out-of-network:** 50% of approved amount, after deductible
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 copay per day, for days 1-20, after deductible $214 copay per day, for days 21-100, after deductible **Out-of-network:** 50% of approved amount, after deductible
Outpatient Rehabilitation ○ Physical therapy ○ Speech therapy ○ Occupational therapy	**In-network:** $40 copay, after deductible **Out-of-network:** 50% of approved amount, after deductible **In-network:** $35 copay, after deductible **Out-of-network:** 50% of approved amount, after deductible
Ambulance • Ground or Air • Ambulance without transportation and non-emergency transportation	**In- and Out-of-network:** $360 copay, after deductible **In-network:** $90 copay 50% of approved amount
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.

Benefits	Part B Credit
Medicare Part B Drugs[1]	
○ Medicare Part B Insulin Drugs (one-month's supply)	**In-network:** Up to 20% coinsurance; however, no more than $35 per month **Out-of-network:** Up to 50% coinsurance; however, no more than $35 per month
○ Chemotherapy drugs and other Part B drugs	**In-network:** 0%-20% coinsurance, after deductible **Out-of-network:** 0-50% coinsurance, after deductible
Cardiac rehabilitation services	**In-network:** $20 copay, after deductible **Out-of-network:** 50% of the approved amount, after deductible
Pulmonary rehabilitation services	**In-network:** $15 copay, after deductible **Out-of-network:** 50% of the approved amount, after deductible
Medical Equipment/ Supplies[1]	
○ Durable Medical Equipment and Prosthetics and Orthotics	**In-network:** 20% of approved amount, after deductible **Out-of-network:** 50% of approved amount, after deductible
○ Diabetes supplies	**In- and Out-of-network:** $0 copay, after deductible
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.

Benefits	Part B Credit
Worldwide emergency coverage	
○ Worldwide emergency coverage	**In- and Out-of-Network:** $110 for worldwide emergency coverage.
○ Worldwide urgent coverage	**In- and Out-of-Network:** $45 for worldwide urgent coverage.
○ Worldwide emergency transportation	**In- and Out-of-Network:** $360 for worldwide emergency transportation.
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

Because there is no deductible for the plan, this stage does not apply to you.

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.

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	33%	33%

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:

	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

You won't pay more than $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

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: The Catastrophic Stage

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 information about your costs in this stage, look at Chapter 6 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.

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.

Medicare PLUS Blue℠ PPO

Blue Cross Blue Shield of Michigan