

Medicare PLUS Blue Group PPOSM

2013



Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Medicare Plus Blue Group PPOSM

Summary of Benefits

City of Hamtramck

January 1, 2013 - December 31, 2013

Medicare Plus Blue Group PPO is a health plan with a Medicare contract.

Open Formulary
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Please read this Important Information about Medicare Plus Blue Group PPOSM

I understand that:

- Medicare Plus Blue Group PPOSM is a Medicare Advantage plan that requires that I keep my Medicare Part A and Part B.
- I can only be in one Medicare Advantage plan at a time. My enrollment in this plan will automatically end my enrollment in any other Medicare Advantage 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 plans.
- 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 Member Services at 1-866-684-8216. We're available Monday through Friday, from 8:30 a.m. to 5 p.m. EST. (TTY/TDD 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.

If you have special needs, this document may be available in other formats.

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 1-877-241-2583. 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 1-877-241-2583. 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。如果您需要比翻译服务，请致电 1-877-241-2583。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 1-877-241-2583。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 pagsasalang-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasalang-wika, tawagan lamang kami sa 1-877-241-2583. Maaari kayong tulungan ng isang nakapagasalita 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 1-877-241-2583. 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 trình sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-241-2583. sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-241-2583. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-241-2583. 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 1-877-241-2583. 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 بالرقم 1-877-241-2583. ستقوم شخص ما بتحديث العربية بمساعدتك. هذه خدمة مجانية على

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 1-877-241-2583. Un nostro incaricato che parla italiano fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Disponmos 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 1-877-241-2583. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèrèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg pou an. Pou jwenn yon entèrèt, jis rele nou nan 1-877-241-2583. Yon moun ki pale Kreòl karab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usługi tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawki leków. Aby skorzystać z pomocy tłumacza znanego język polski, należy zadzwonić pod numer 1-877-241-2583. 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 1-877-241-2583 पर 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。ご了承ください。通訳をご用命になるには、1-877-241-2583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。

Thank you for your interest in **Medicare Plus Blue Group PPOSM**. Our plan is offered by Blue Cross Blue Shield of Michigan, a Medicare Advantage Preferred Provider Organization (PPO) that contracts with the federal government. This *Summary of Benefits* tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call **Medicare Plus Blue Group PPO** and ask for the *Evidence of Coverage*.

You have choices in your health care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is this Medicare Advantage plan, **Medicare Plus Blue Group PPO**, offered through your employer or union group. For more information about your Medicare options, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users may call 1-877-486-2048.

You may leave this plan at any time, but the timeframe in which you can enroll in another Medicare Advantage plan may be limited. Please call **Medicare Plus Blue Group PPO Member Services** at the telephone number listed on the inside front cover of this booklet for more information.

How can I compare my options?

You can compare **Medicare Plus Blue Group PPO** and the Original Medicare Plan using this *Summary of Benefits*. The charts in this booklet list some important health benefits. Our members receive all of the benefits that the Original Medicare Plan offers. Your group health plan may also offer more benefits, which may change from year to year.

Where is Medicare Plus Blue Group PPO available?

Medicare Plus Blue Group PPO is available to employer and union group members who live in our plan service area, which is the entire 50 states and territories of the United States. To stay a member of our plan, you must keep living in this service area. If you plan to move out of the service area, please contact Member Services.

Who is eligible to join Medicare Plus Blue Group PPO?

You can join **Medicare Plus Blue Group PPO** if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the United States or its territories. However, if you have End Stage Renal Disease, you are not eligible to enroll in **Medicare Plus Blue Group PPO** if you are within your 30-month coordination period.

Can I choose my doctors?

Medicare Plus Blue Group PPO has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at www.bcbsm.com/medicare/search.shtml. Our customer service number is listed at the end of this introduction.

What happens if I go to a doctor who's not in your network?

In Michigan, you may have to pay more for services you receive outside the network, and you may have to follow special rules prior to getting services in- or out-of-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 Member Services for more information.

Does my plan cover Medicare Part B or Part D drugs?

Medicare Plus Blue Group PPO does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What is a prescription drug formulary?

Medicare Plus Blue Group PPO uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you. You can see our complete formulary on our website at

<http://www.bcbsm.com/medicare/medicare-group-ppo.shtml>.

How can I get extra help with my prescription drug plan costs or get extra help with other Medicare costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TTDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication *Medicare & You*.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TTDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

What are my protections in this plan?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of **Medicare Plus Blue Group PPO**, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If

your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the *Evidence of Coverage (EOC)* for the QIO contact information.

As a member of **Medicare Plus Blue Group PPO**, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision.

Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the *Evidence of Coverage (EOC)* for the QIO contact information.

What is a Medication Therapy Management (MTM) program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact **Medicare Plus Blue Group PPO** at 1-866-684-8216 (TTY users call 711) for more details.

What types of drugs may be covered under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs.

- Some Antigenes: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable osteoporosis drugs for some women.
- Erythropoietin (Epoetin Alfa or Epogen[®]): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer to your Medicare Part A coverage.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs administered through Durable Medical Equipment.

Contact **Medicare Plus Blue Group PPO** for more details.

Where can I find information on plan ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan at 1-866-684-8216 (TTY users call 711), Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time.

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

This document may be available in large print or other alternate formats.

SECTION 2 – Summary of Benefits

Your services must be medically necessary with the exception of those listed as preventive care. If you have any questions about this plan's benefits or costs, please call **Medicare Plus Blue Group PPO** Member Services at 1-866-684-8216, Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time. (TTY users call 711.)

Benefit

Original Medicare

Medicare Plus Blue Group PPO
In-network and Out-of-network

IMPORTANT INFORMATION

| 1 Premium and Other Important Information | | |
|---|---|--|
| <p>In 2012 the monthly Part B Premium was \$99.90 and may change for 2013 and the annual Part B deductible amount was \$140 and may change for 2013.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>General Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples).</p> <p>For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> | <p>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.</p> <p>For many covered services described below, the following cost share applies:</p> <p>There is no in-network deductible.</p> <p>Services are subject to a combined in-network and out-of-network annual deductible of \$500.</p> <p>There is an in-network annual out-of-pocket maximum of \$1,500. Once your in-network coinsurance, copayments and deductible equal \$1,500, all covered services will be paid at 100% of the approved amount for the remainder of the year.</p> <p>There is a combined in-network and out-of-network annual out-of-pocket maximum of \$4,500. Once your combined in-network and out-of-network coinsurance, copayments and deductible equal \$4,500, all covered services will be paid at 100% of the approved amount for the remainder of the year.</p> | |

| Benefit | | Original Medicare | Medicare Plus Blue Group PPO |
|--|---|---|---|
| | | In-network | Out-of-network |
| <p>2 Doctor and Hospital Choice</p> <p>(See "Emergency Care" (#16) and "Urgently Needed Care" (#17))</p> | <p>You may go to any doctor, specialist or hospital that accepts Medicare.</p> | <p>No referral required for in-network doctors, specialists and hospitals.</p> <p>Out-of-service Area Plan covers you when you travel in the U.S.</p> | <p>No referral required for out-of-network doctors, specialists and hospitals.</p> <p>Out-of-service Area Plan covers you when you travel in the U.S.</p> |
| INPATIENT CARE | | | |
| <p>3 Inpatient Hospital Care</p> <p>(Includes Substance Abuse and Rehabilitation Services)</p> | <p>In 2012 the amounts for each benefit period were:</p> <p>Days 1 - 60: \$1156 deductible</p> <p>Days 61 - 90: \$289 per day</p> <p>Days 91 - 150: \$578 per lifetime reserve day</p> <p>These amounts may change for 2013.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> | <p>For facility evaluation and management services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.</p> <p>For all other services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.</p> <p>Medicare-approved clinical lab services and preventive services are covered at 100% of the approved amount.</p> <p>You have unlimited days for inpatient care coverage.</p> | <p>For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.</p> <p>For all other services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.</p> <p>Medicare-approved clinical lab services and preventive services are covered at 100% of the approved amount.</p> <p>You have unlimited days for inpatient care coverage.</p> |

| Benefit | Original Medicare | Medicare Plus Blue Group PPO | Out-of-network |
|---|--|--|--|
| | <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p> | <p>In-network</p> | <p>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 a hospital in network 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.</p> |
| <p>4 Inpatient Mental Health Care</p> | <p>In 2012 the amounts for each benefit period were: Days 1 - 60: \$1156 deductible Days 61 - 90: \$289 per day Days 91 - 150: \$578 per lifetime reserve day These amounts may change for 2013. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> | <p>For facility evaluation and management services, your coinsurance is 5% 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 5% 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 coverage.</p> | <p>For facility evaluation and management services, your coinsurance is 10% 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 10% 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.</p> |

| Benefit | Original Medicare | | Medicare Plus Blue Group PPO | |
|--|---|---|---|----------------|
| | | | In-network | Out-of-network |
| <p>5 Skilled Nursing Facility</p> <p>You must receive care in a Medicare-certified skilled nursing facility.</p> | <p>In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p>Days 1 - 20: \$0 per day.</p> <p>Days 21 - 100: \$144.50 per day.</p> <p>These amounts may change for 2013.</p> <p>100 days for each benefit period</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p> | <p>For facility evaluation and management services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.</p> <p>For all other services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.</p> <p>Plan covers up to 100 days for each benefit period.</p> | <p>For facility evaluation and management services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.</p> <p>For all other services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.</p> <p>Plan covers up to 100 days for each benefit period.</p> | |
| <p>6 Home Health Care</p> <p>(Includes medically necessary intermittent skilled nursing care, home health aide services, home infusion, rehabilitation services, etc.)</p> | <p>\$0 copay</p> | <p>Services are covered up to 100% of the approved amount.</p> | <p>Services are covered up to 100% of the approved amount.</p> | |

| Benefit | | Original Medicare | | Medicare Plus Blue Group PPO | |
|------------------------|--|--|--|---|--|
| | | In-network | | Out-of-network | |
| 7 | Hospice You must receive care from a Medicare-certified hospice. | You pay part of the cost for outpatient drugs and inpatient respite care. You must get 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. | When you enroll in a Medicare-certified hospice program, your hospice services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. | |
| OUTPATIENT CARE | | | | | |
| 8 | Doctor Office Visits | 20% coinsurance | For office visits, you pay a copayment of \$10. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. | For office visits, you pay a copayment of \$30. Not subject to a deductible. These services apply to the combined annual out-of-pocket maximum. | |
| 9 | Chiropractic Services (For manual manipulation of the spine to correct subluxation if you receive services from a chiropractor or other qualified provider.) | Supplemental routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers | You pay a copayment of \$10. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. | You pay a copayment of \$30. Not subject to a deductible. These services apply to the combined annual out-of-pocket maximum. | |
| 10 | Podiatry Services | Supplemental routine care not covered 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs | For office visits you pay a copayment of \$10. Not subject to a 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 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. | For office visits you pay a copayment of \$30. Not subject to a deductible. These services apply to the combined annual out-of-pocket maximum. For some medically necessary foot care services other than office visits, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. | |

| Benefit | | Original Medicare | | Medicare Plus Blue Group PPO | |
|-----------|--|---|---|--|--|
| | | In-network | | Out-of-network | |
| 11 | Outpatient Mental Health Care | 35% coinsurance for most outpatient mental health services Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. | For mental health services rendered at a mental health facility, your coinsurance is 5% 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, you pay a copayment of \$10. Not subject to a 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 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. For mental health services, you pay a copayment of \$30. Not subject to a deductible. These services apply to the combined annual out-of-pocket maximum. | |
| 12 | Outpatient Substance Abuse Care | 20% coinsurance | For substance abuse treatment services rendered at a facility, your coinsurance is 5% of the approved amount, after you meet the annual deductible. These services apply to the in-network annual out-of-pocket maximum. For substance abuse treatment services in an office setting, you pay a copayment of \$10. Not subject to a 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 10% of the approved amount, after you meet the annual deductible. These services apply to the combined annual out-of-pocket maximum. For substance abuse treatment services in an office setting, you pay a copayment of \$30. Not subject to a deductible. These services apply to the combined annual out-of-pocket maximum. | |

Benefit

Original Medicare

Medicare Plus Blue Group PPO

In-network

Out-of-network

13 **Outpatient Services**

20% coinsurance for the doctor's services
 Specified copayment for outpatient hospital facility services
 Copay cannot exceed the Part A inpatient hospital deductible.

Your coinsurance is 5% 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 10% of the approved amount. These services apply to the combined annual out-of-pocket maximum.

14 **Outpatient Surgery provided at hospital outpatient facilities and ambulatory surgical centers**

20% coinsurance

Your coinsurance is 5% of the approved amount, after you meet your annual deductible, for outpatient surgery and related services. These services apply to the in-network annual out-of-pocket maximum.

Your coinsurance is 10% of the approved amount, after you meet your annual deductible for outpatient surgery and related services. These services apply to the combined annual out-of-pocket maximum.

15 **Ambulance Services**

(Medically necessary ambulance services)

20% coinsurance

Your coinsurance is 5% of the approved amount, after you meet your annual deductible, for Medicare-covered ambulance services. Cost sharing applies for each one-way trip. These services apply to the in-network annual out-of-pocket maximum.

Your coinsurance is 10% of the approved amount, after you meet your annual deductible, for Medicare-covered ambulance services. Cost sharing applies for each one-way trip. These services apply to the combined annual out-of-pocket maximum.

16 **Emergency Care**

(You may go to any emergency room if you reasonably believe you need emergency care.)

20% coinsurance for the doctor's services
 Specified copayment for outpatient hospital facility emergency services

You pay a \$50 copayment for Medicare-covered emergency room visits (waived if admitted within three days). Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum.

You pay a \$50 copayment for Medicare-covered emergency room visits (waived if admitted within three days). Not subject to a deductible. These services apply to the combined annual out-of-pocket maximum.

| Benefit | Original Medicare | | Medicare Plus Blue Group PPO | |
|--|---|---|---|--|
| | In-network | Out-of-network | In-network | Out-of-network |
| 17 Urgently Needed Care (This is NOT emergency care.) | Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances | 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 a hospital in network 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. | You pay a copayment of \$10. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. | You pay a copayment of \$30. Not subject to a deductible. These services apply to the combined annual out-of-pocket maximum. |
| 18 Outpatient Rehabilitation Services (Occupational therapy, physical therapy, speech, and language therapy) | 20% coinsurance | Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. Medicare therapy limits apply to rehabilitation services provided. | Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. Medicare therapy limits apply to rehabilitation services provided. | |

Benefit

Original Medicare

Medicare Plus Blue Group PPO

In-network

Out-of-network

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

| 19 Durable Medical Equipment (Includes wheelchairs, oxygen, etc.) | 20% coinsurance | Services are covered up to 100% of the approved amount. | Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. | |
|---|---|---|---|--|
| 20 Prosthetic and Orthotic Devices (Braces, artificial limbs and eyes, etc.) | 20% coinsurance | Services are covered up to 100% of the approved amount. | Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. | |
| 21 Diabetes Programs and Supplies (Includes coverage for glucose monitors, test strips, lancets, screening tests and self-management training.) | 20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts | Services are covered up to 100% of the approved amount for diabetes screenings, diabetes-related durable medical equipment or supplies, 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. | |

Benefit

Original Medicare

Medicare Plus Blue Group PPO

In-network

Out-of-network

22

Diagnostic Tests, X-rays, Lab Services and Radiology Services

20% coinsurance for diagnostic tests and X-rays
\$0 copay for Medicare-covered lab services
Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare.
Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.
20% coinsurance for digital rectal exam and other related services
Covered once a year for all men with Medicare over age 50

Your coinsurance is 5% 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 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.

| Benefit | | Original Medicare | | Medicare Plus Blue Group PPO | |
|--|--|---|--|------------------------------|--|
| | | In-network | | Out-of-network | |
| <p>23 Cardiac and Pulmonary Rehabilitation Services</p> | <p>20% coinsurance for cardiac rehabilitation services 20% coinsurance for pulmonary rehabilitation services 20% coinsurance for intensive cardiac rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.</p> | <p>Your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.</p> | <p>Your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.</p> | | |
| <p>24 Kidney Disease and Conditions</p> | <p>20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services</p> | <p>Your coinsurance is 5% of the approved amount, after you meet your annual deductible, for dialysis services. 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.</p> | <p>Your coinsurance is 10% of the approved amount, after you meet your annual deductible, for dialysis services. 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.</p> | | |

Benefit

Original Medicare

Medicare Plus Blue Group PPO

In-network

Out-of-network

PREVENTIVE SERVICES

| <p>25 Preventive Services and Wellness/ Education Programs</p> | <p>No coinsurance, copayment or deductible for the following:</p> <ul style="list-style-type: none">- Abdominal Aortic Aneurysm Screening- Bone Mass Measurement <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions</p> <ul style="list-style-type: none">- Cardiovascular Screening- Cervical and Vaginal Cancer Screening <p>Covered once every 2 years</p> <p>Covered once a year for women with Medicare at high risk</p> <ul style="list-style-type: none">- Colorectal Cancer Screening- Diabetes Screening- Influenza Vaccine- Hepatitis B Vaccine <p>for people with Medicare who are at risk</p> <ul style="list-style-type: none">- HIV Screening <p>\$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> | <p>Services are covered up to 100% of the approved amount.</p> | <p>Services are covered up to 100% of the approved amount.</p> |
|---|--|--|--|

Benefit

Original Medicare

Medicare Plus Blue Group PPO

In-network

Out-of-network

25

Preventive Services and Wellness/ Education Programs (continued)

- Breast Cancer Screening (Mammogram)
Medicare covers screening mammograms once every 12 months for all women with Medicare, age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39.
- Medical Nutrition Therapy Services
Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor.
These services can be given by a registered dietician and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.
- Personalized Prevention Plan Services (Annual Wellness Visits)
- Pneumococcal Vaccine
You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.
- Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only)
Covered once a year for all men with Medicare over age 50

Benefit

Original Medicare

Medicare Plus Blue Group PPO

In-network

Out-of-network

25
Preventive Services/Wellness/ Education Programs (continued)

- Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use)
Covered if ordered by your doctor
 - Includes two counseling attempts within a 12-month period.
Each counseling attempt includes up to four face-to-face visits.
 - Screening and behavioral counseling interventions in primary care to reduce alcohol misuse
 - Screening for depression in adults
 - Screening and sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs
 - Intensive behavioral counseling for Cardiovascular Disease (bi-annual)
 - Intensive behavior therapy for obesity
 - Welcome to Medicare Physical Exam (initial preventive physical exam)
- When you join Medicare Part B, then you are eligible as follows:
 During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.

Benefit

Original Medicare

Medicare Plus Blue Group PPO

In-network

Out-of-network

OTHER SERVICES

| 26 Dental Services | Preventive dental services (such as cleaning) not covered | Original Medicare covers very limited medically necessary dental services. Your Medicare Advantage plan will cover those same medically necessary services. The cost sharing for those services (e.g. surgery, office visits, X-rays) is referenced in other areas of the benefit chart. For more information, contact Member Services. | Original Medicare covers very limited medically necessary dental services. Your Medicare Advantage plan will cover those same medically necessary services. The cost sharing for those services (e.g. surgery, office visits, X-rays) is referenced in other areas of the benefit chart. For more information, contact Member Services. |
|-------------------------------|---|--|---|
| 27 Hearing Services | Supplemental routine hearing exams and hearing aids not covered 20% coinsurance for diagnostic hearing exams | For diagnostic testing services, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum. For diagnostic hearing office visits, you pay a copayment of \$10. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum. Routine hearing exams and hearing aids are not covered. | For diagnostic testing services, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum. For diagnostic hearing office visits, you pay a copayment of \$30. Not subject to a deductible. These services apply to the combined annual out-of-pocket maximum. Routine hearing exams and hearing aids are not covered. |

Benefit

Original Medicare

Medicare Plus Blue Group PPO

In-network

Out-of-network

28

Vision Services

| | | | |
|--|---|---|--|
| <p>28</p> <p>Vision Services</p> | <p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye</p> <p>Supplemental routine eye exams and glasses not covered</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk</p> | <p>For diagnosis and treatment of diseases and conditions of the eye, your coinsurance is 5% of the approved amount, after you meet your annual deductible. These services apply to the in-network annual out-of-pocket maximum.</p> <p>For medical vision office visits, you pay a copayment of \$10. Not subject to a deductible. These services apply to the in-network annual out-of-pocket maximum.</p> <p>Services are covered up to 100% of the approved amount for corrective lenses following cataract surgery.</p> <p>Services are covered up to 100% of the approved amount for annual glaucoma screenings for those members at risk.</p> <p>Routine eye exams and glasses are not covered by this plan.</p> | <p>For diagnosis and treatment of diseases and conditions of the eye, your coinsurance is 10% of the approved amount, after you meet your annual deductible. These services apply to the combined annual out-of-pocket maximum.</p> <p>For medical vision office visits, you pay a copayment of \$30. Not subject to a deductible. These services apply to the combined annual out-of-pocket maximum.</p> <p>Services are covered up to 100% of the approved amount for corrective lenses following cataract surgery.</p> <p>Services are covered up to 100% of the approved amount for annual glaucoma screenings for those members at risk.</p> <p>Routine eye exams and glasses are not covered by this plan.</p> |
|--|---|---|--|

PRESCRIPTION DRUGS

Drugs covered under Medicare Part D — General

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.bcbsm.com/medicare. Different out-of-pocket costs may apply for people who have limited incomes, live in long-term care facilities or have access to Indian/Tribal/Urban (Indian Health Service) providers.

The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance, when you travel).

Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs may have quantity limits. Your provider must get prior authorization from **Medicare Plus Blue Group PPO** for certain drugs.

You must go to certain pharmacies for a very limited number of drugs due to special handling, provider coordination or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary and printed materials.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. You may have to pay more than your normal cost-sharing amount if you choose to use a higher-cost drug when a lower-cost drug is available. This may also occur if a new, lower-cost generic version of a brand-name drug is added to the plan's formulary after you enroll.

After you have paid \$4,750 out of pocket, called the "Catastrophic Coverage Limit," you will generally pay the greater of \$2.65 or 5 percent for generic drugs, and \$6.60 or 5 percent for all other drugs until the end of the calendar year.

SECTION 3

Prescription Benefits At-a-Glance

Part D Prescription Drug Deductible: There is no deductible for prescription drugs.

| Tier | Description | Up to 90-day supply* | | |
|--------|--------------------------------|----------------------|--|---|
| | | Up to 31-day supply | Preferred retail or mail-order network pharmacies | Non-preferred retail or mail-order network pharmacies |
| Tier 1 | Preferred generic drugs | \$10 | \$25 | \$30 |
| Tier 2 | Non-preferred generic drugs | \$10 | \$25 | \$30 |
| Tier 3 | Preferred brand-name drugs | \$60 | \$150 | \$180 |
| Tier 4 | Non-preferred brand-name drugs | \$60 | \$150 | \$180 |
| Tier 5 | Specialty drugs | \$60 | These drugs are not covered for supplies greater than 31 days. | |

***Many retail pharmacies, but not all, will fill a 90-day supply of medication. Check with your pharmacist.**

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.

Member Services for

Medicare Plus Blue Group PPO

1-866-684-8216

(TTY/TTDD users, call 711)

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

www.bcbsm.com/medicare

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