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Medicare Plus BlueSM Group PPO Medical Benefits with Prescription Drugs

Wayne County Medicare Stipend Retiree Group

Benefits-at-a-Glance

January 1, 2024 - December 31, 2024

The benefit information provided is a summary of what we cover and what you pay. A complete list of services is found in the *Evidence of Coverage and Medical Benefits Chart*. If you have any questions about this plan's benefits or costs, please call Medicare Plus Blue Group PPO Customer Service (phone numbers are on the back cover of this document). You can always view the most current *Evidence of Coverage* by requesting it from Customer Service.

To join Medicare Plus Blue Group PPO, you must meet all of the following requirements:

- Have both Medicare Part A and Medicare Part B
- Be a United States citizen or lawfully present in the United States.
- 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.

Comprehensive Enhanced Formulary
19591600

09/23

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

www.bcbsm.com/medicare

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Medicare Advantage Plans

| In-network and Out-of-network: | |
|---|--|
| Premium | In addition to the Medicare Part B premium, you may also be required to pay a premium contribution as defined by your employer, union group, or third-party administrator. |
| Deductible | \$200 |
| Medical/Hospital Out-of-Pocket Maximum | \$1,200 All medical and hospital care services below apply to this annual amount. |
| Pharmacy Out-of-Pocket Maximum | Not applicable All Part D drugs/prescriptions apply to this annual amount. |
| Coinsurance Maximum | Not applicable |
| Benefit | In-network and Out-of-network: |

Note: Services with a ¹ may require prior authorization.

| | |
|--|--|
| Ambulance services – medically necessary transport; coverage applies to each one-way trip | 20% of approved amount, after deductible |
| Cardiac rehabilitation services | 20% of approved amount, after deductible |
| Chiropractic care – covered services include manual manipulation of the spine to correct subluxation | \$20 |
| Dental services | Original Medicare covers very limited medically necessary dental services. Your Medicare Plus Blue Group PPO plan will cover those same medically necessary services. For cost sharing information for those services (e.g. surgery, office visits, X-rays), contact Customer Service. |

In-network and Out-of-network:

| | |
|---|---|
| <p>Diabetes services and supplies¹ (includes coverage for glucose monitors, test strips, lancets, and self-management training)</p> | <p>Services are covered up to 100% of the approved amount for diabetes-related durable medical equipment or supplies and self-management training.</p> <p>Diabetic shoes covered up to 100% of approved amount, after deductible.</p> |
| <p>Diagnostic Services/Labs/Imaging (include diagnostic tests and procedures, labs, diagnostic radiology, and X-rays)¹ (costs for these services may vary based on place of service)</p> | <p align="center">Covered up to 100% of approved amount</p> |
| <p>Durable medical equipment¹</p> | <p align="center">10% of approved amount</p> |
| <p>Emergency care – worldwide coverage for qualified medical emergencies and first aid services (copay waived if admitted to hospital within 3 days)</p> | <p align="center">\$100, not subject to the deductible</p> |
| <p>Hearing services</p> <ul style="list-style-type: none"> • Diagnostic testing | <p align="center">Covered up to 100% of approved amount</p> |
| <p>Home health agency care¹</p> | <p align="center">Covered – 100%</p> |
| <p>Hospice care</p> | <p>Services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. Member may have to pay part of the costs for respite care and hospice-related outpatient prescription drugs.</p> |
| <p>Inpatient facility evaluation and management¹</p> | <p align="center">Covered up to 100% of approved amount</p> |
| <p>Inpatient hospital care¹</p> | <p align="center">Covered up to 100% of approved amount</p> |
| <p>Inpatient Services in a Psychiatric Hospital¹</p> | <p align="center">Covered up to 100% of approved amount</p> |

In-network and Out-of-network:

| | |
|--|--|
| <p>Kidney disease</p> <ul style="list-style-type: none"> • Dialysis services¹ • Professional charges | <p>20% of approved amount, after deductible</p> <p>Covered up to 100% of approved amount</p> |
| <p>Office visits, including Diagnostic Hearing, Outpatient Substance Abuse, Podiatry, and Vision</p> | <p>\$20</p> |
| <p>Outpatient mental health care</p> <ul style="list-style-type: none"> • Facility and clinic services • Services in an office | <p>20% of approved amount, after deductible</p> <p>\$20</p> |
| <p>Outpatient physical, speech and occupational therapy</p> | <p>20% of approved amount, after deductible</p> |
| <p>Outpatient services¹</p> | <p>20% of approved amount, after deductible</p> |
| <p>Outpatient substance abuse services</p> <ul style="list-style-type: none"> • Facility and clinic services | <p>20% of approved amount, after deductible</p> |
| <p>Outpatient surgery¹, including services at hospital outpatient facilities and ambulatory surgery centers</p> | <p>Covered up to 100% of approved amount</p> |
| <p>Podiatry:</p> <ul style="list-style-type: none"> • Medically necessary foot care services other than office visits¹ | <p>Covered up to 100% of approved amount</p> |
| <p>Prosthetic and orthotic devices and supplies¹</p> | <p>10% of approved amount</p> |
| <p>Skilled nursing facility¹ – covers up to 100 days per benefit period</p> | <p>Covered up to 100% of approved amount</p> |

In-network and Out-of-network:

| | |
|---|--|
| Supervised exercise therapy | 20% of approved amount, after deductible |
| Urgent care visits – covered worldwide | \$20, not subject to the deductible |
| Vision services <ul style="list-style-type: none"> • Diagnosis and treatment of diseases and injuries of the eye | Covered up to 100% of approved amount |

Additional Benefits

| | |
|---|--|
| Annual physical exam | Covered up to 100% of approved amount |
| Chiropractic spinal X-rays, other chiropractic radiological, chiropractic physical therapy services, and evaluation and management services (must be provided by chiropractors or other qualified providers) | \$20 |
| Contraceptive devices | 20% of approved amount, after deductible |
| Determination of refractive state | 20% of approved amount, after deductible |
| Foreign travel health care - not restricted to emergency or urgent care | Cost share same as if services were provided in the U.S. |
| Gradient compression stockings ¹ | Covered up to 100% of approved amount |
| Home infusion therapy | Covered up to 100% of approved amount |
| Hospice respite care – cost share for respite and drugs | Covered up to 100% of approved amount |
| Human organ transplants– additional coverage There is no lifetime maximum for non-Medicare covered organs. | Covered up to 100% of approved amount |

In-network and Out-of-network:

| | |
|--|--|
| <p>Removal of Medicare therapy limits/thresholds for outpatient rehabilitation services</p> | <p>Medicare Part B therapy limits/thresholds do not apply to Outpatient Rehabilitation Services.</p> |
| <p>SilverSneakers® SilverSneakers is a registered trademark of Tivity Health, Inc. © 2023 Tivity Health, Inc. All rights reserved.</p> | <p>Covered up to 100%</p> <p>SilverSneakers is a comprehensive program that can improve overall well-being and social connections. Designed for all levels and abilities, SilverSneakers provides convenient access to a nationwide fitness network, a variety of programming options and activities beyond the gym that incorporate physical well-being and social interaction.</p> |
| <p>Travel and lodging for covered transplants and clinical trials</p> | <p>Covered up to 100% of approved amount (\$10,000 limit, for initial solid organ, \$5,000 for approved clinical trial or bone marrow transplant.)</p> |

Preventive Services and Wellness/Education Programs

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Annual "Wellness" visit
- Bone mass measurement (bone density)
- Breast cancer screening (mammograms)
- Cardiovascular disease screening (behavioral therapy)
- Cervical and vaginal cancer screenings
- Colorectal cancer screenings
 - o Screening fecal occult blood test
 - o Screening flexible sigmoidoscopy
 - o Screening colonoscopy
 - o Screening barium enema
 - o DNA based colorectal screening every 3 years
- Depression screenings
- Diabetes screening
- Diabetes self-management training
- Flu shots (vaccine)
- Glaucoma screening
- Hepatitis B shots (vaccine)
- Hepatitis C screening test
- HIV screening
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and counseling
- Pneumococcal shot
- Prostate cancer screening
 - o Digital rectal exam
 - o Prostate specific antigen (PSA) test
- Screening for lung cancer with low dose computed tomography (LDCT)
- Sexually transmitted infections screening and counseling
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Welcome to Medicare prevention visits (initial preventive physical exam)

Any additional preventive services approved by Medicare during the contract year will be covered.

In-network and Out-of-network:

Covered – 100%

Prescription Drugs

Formulary Type: Comprehensive Enhanced Formulary

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible (if applicable). Call Customer Service for more information.

Important Message About What You Pay for Insulin - You won't pay more than \$35 for a 1-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible (if applicable).

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 following until your out-of-pocket costs reach \$8,000. See Chapter 6 Section 5.5 of the *Evidence of Coverage* for information about how Medicare counts your out-of-pocket costs.

| Up to a 31-day supply | Preferred retail and preferred mail-order pharmacies | Standard retail and standard mail-order pharmacies |
|-----------------------------|--|--|
| Tier 1 – Preferred Generic | \$3 | \$8 |
| Tier 2 – Generic | \$16 | \$21 |
| Tier 3 – Preferred Brand | \$45 | \$50 |
| Tier 4 – Non-Preferred Drug | \$95 | \$100 |
| Tier 5 – Specialty Tier | 29.50% | 30% |

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.

| Tier | Standard retail cost sharing (in-network) (32- to 90-day supply) | Preferred retail cost sharing (in-network) (32- to 90-day supply) | Standard mail-order 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 | \$6 | \$6 | \$6 | \$6 |
| Tier 2 – Generic | \$31.50 | \$32 | \$31.50 | \$32 |
| Tier 3 – Preferred Brand | \$90 | \$90 | \$90 | \$90 |
| Tier 4 – Non-Preferred Drug | \$190 | \$190 | \$190 | \$190 |
| Tier 5 – Specialty Tier | Not offered | Not offered | Not offered | Not offered |

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.

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

Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.

For plans with a coverage gap:

During the Coverage Gap Stage, you receive a discount on brand-name drugs and pay no more than 25% of the costs for generic drugs.

For plans without a coverage gap:

There is no coverage gap for most Medicare Plus Group PPO plans.

During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D Drugs:

You enter the Catastrophic Coverage stage when your out-of-pocket costs have reached the \$8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Information about your costs in these stages, can also be located in Chapter 6, Sections 6 and 7, of the *Evidence of Coverage* or by contacting Customer Service. Phone numbers are on the back cover of this document.

Medicare Plus Blue Group PPO has a network of doctors, hospitals, pharmacies, and other providers. Using providers that do not accept Medicare may cost you more.

Outside Michigan, your costs are the same as in-network and out-of-network services when you use providers that accept Medicare. Using providers that do not accept Medicare may cost you more. To locate a provider in our network, use the Find a Doctor tool on our website at:

www.bcbsm.com/providersmedicare.

Non-contracted providers are under no obligation to treat Medicare Plus Blue Group PPO members, except in emergency situations. Please call our customer service number or see the *Evidence of Coverage* for more information.

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**). Or, call us and we will send you a copy of a *Provider/Pharmacy Directory* or, for members outside of Michigan, a *Provider/Pharmacy Locator* (phone numbers are on the back cover of this booklet).

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **www.bcbsm.com/formularymedicare**.

For more information, please call us at 1-866-684-8216, Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time. From October 1 through March 31, hours are from 8 a.m. to 9 p.m., seven days a week. TTY users should call 711.

Or you can visit us at www.bcbsm.com/medicare.

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.

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