

2025

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# Medicare Plus Blue<sup>SM</sup> Group PPO

Medical Benefits with Prescription Drugs

Trust VEBA Groups-Ruby with PDP – Option 1

## Benefits-at-a-Glance

January 1, 2025 - December 31, 2025

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* and *Medical Benefits Chart* by requesting them from Customer Service.

To join Medicare Plus Blue Group PPO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area of the United States and its territories. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it. You must be a United States citizen or lawfully present in the United States.

Comprehensive Enhanced Formulary

0070416420006, 0070233390060, 0070416440008, 0070416430005

Blue Cross Blue Shield of Michigan is a PPO plan with a Medicare contract.  
Enrollment in Blue Cross Blue Shield of Michigan depends on contract renewal.



<b>In-network and Out-of-network:</b>	
<b>Premium</b>	In addition to the Medicare Part B premium, you may also be required to pay a premium contribution as defined by your group plan administrator.
<b>Deductible</b>	\$0
<b>Medical/Hospital Out-of-Pocket Maximum</b>	\$4,500  All medical and hospital care services below apply to this annual amount.
<b>Pharmacy Out-of-Pocket Maximum</b>	Not applicable All Part D drugs/prescriptions apply to this annual amount.
<b>Coinsurance Maximum</b>	Not applicable

<b>Benefit</b>	<b>In-network and Out-of-network:</b>
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**Note:** Services with a <sup>1</sup> may require prior authorization.

Ambulance services – medically necessary transport; coverage applies to each one-way trip	20% of approved amount
Cardiac rehabilitation services	20% of approved amount
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.
Diabetes services and supplies <sup>1</sup> (includes coverage for glucose monitors, test strips, lancets, and self-management training)	Services are covered up to 100% of the approved amount for diabetes-related durable medical equipment or supplies and self-management training.

Benefit	In-network and Out-of-network:
Diagnostic tests, lab services, and radiology services <sup>1</sup> (costs for these services may vary based on place of service)	20% of approved amount
Durable medical equipment <sup>1</sup>	Covered up to 100% of approved amount
Emergency care – worldwide coverage for qualified medical emergencies and first aid services (copay waived if admitted to hospital within 3 days)	\$90, not subject to the deductible
Hearing services <ul style="list-style-type: none"> <li>• Diagnostic testing</li> </ul>	20% of approved amount
Home health agency care <sup>1</sup>	Covered – 100%
Hospice care	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.
Inpatient facility evaluation and management <sup>1</sup>	20% of approved amount
Inpatient hospital care <sup>1</sup>	20% of approved amount
Inpatient Services in a Psychiatric Hospital <sup>1</sup>	20% of approved amount
Kidney disease <ul style="list-style-type: none"> <li>• Dialysis services<sup>1</sup></li> <li>• Professional charges</li> </ul>	20% of approved amount  20% of approved amount
Office visits, including Diagnostic Hearing, Outpatient Substance Use Disorder, Podiatry, and Vision	\$20  \$40 with a specialist

Benefit	In-network and Out-of-network:
Outpatient mental health care <ul style="list-style-type: none"> <li>• Facility and clinic services</li> <li>• Services in an office</li> </ul>	20% of approved amount \$25
Outpatient physical, speech and occupational therapy	20% of approved amount
Outpatient services <sup>1</sup>	20% of approved amount
Outpatient substance use disorder services <sup>1</sup> <ul style="list-style-type: none"> <li>• Facility and clinic services</li> </ul>	20% of approved amount
Outpatient surgery <sup>1</sup> , including services at hospital outpatient facilities and ambulatory surgery centers	20% of approved amount
Podiatry: <ul style="list-style-type: none"> <li>• Medically necessary foot care services other than office visits<sup>1</sup></li> </ul>	20% of approved amount
Prosthetic and orthotic devices and supplies <sup>1</sup>	Covered up to 100% of approved amount
Skilled nursing facility <sup>1</sup> – covers up to 100 days per benefit period	20% of approved amount
Supervised exercise therapy	20% of approved amount
Urgent care visits – covered worldwide	\$50, not subject to the deductible
Vision services <ul style="list-style-type: none"> <li>• Diagnosis and treatment of diseases and injuries of the eye</li> </ul>	20% of approved amount

Benefit	In-network and Out-of-network:
<b>Additional Benefits</b>	
Adult briefs and incontinence liners	Covered up to 100% of approved amount
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
Determination of refractive state	20% of approved amount
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 <sup>1</sup>	Covered up to 100% of approved amount
Hearing aids	Standard (analog or basic digital) hearing aids are covered up to \$500 every 36 months.
Hearing services – routine exam	\$20 \$40 with a specialist
Home infusion therapy <sup>1</sup>	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.	20% of approved amount

Benefit	In-network and Out-of-network:
Private duty nursing – services <b>do not</b> apply to the out-of-pocket maximum	<p>50% of approved amount.</p> <p>Services <b>do not</b> apply to out-of-pocket maximum.</p>
<p>SilverSneakers®</p> <p>SilverSneakers is a registered trademark of Tivity Health, Inc.</p> <p>© 2024 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>
Travel and lodging for covered transplants and clinical trials	<p>Covered up to 100% of approved amount</p> <p>(\$10,000 limit, for initial solid organ, \$5,000 for approved clinical trial or bone marrow transplant.)</p>
Wigs, wig stand, adhesive	Covered up to 100% of approved amount

## 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

## Phase 1: The Deductible Stage

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

## Phase 2: The Initial Coverage Stage

You pay the following until your total out-of-pocket costs reach \$2,000. 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	\$10	\$15
Tier 2 – Generic	\$10	\$15
Tier 3 – Preferred Brand	\$45	\$50
Tier 4 – Non-Preferred Drug	\$90	\$100
Tier 5 – Specialty Tier	30%	30%

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

*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	\$30	\$20	\$30	\$20
Tier 2 – Generic	\$30	\$20	\$30	\$20
Tier 3 – Preferred Brand	\$100	\$90	\$100	\$90
Tier 4 – Non-Preferred Drug	\$200	\$180	\$200	\$180
Tier 5 – Specialty Tier	Not offered	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.**

*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.*

## Phase 3: The Catastrophic Coverage Stage

Most members do not reach the Catastrophic Coverage Stage.

You enter the Catastrophic Coverage stage when your out-of-pocket costs have reached the \$2,000 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.
- You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

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](http://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](http://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 document).

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

This document may be available in a non-English language.

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## Medicare PLUS Blue<sup>SM</sup> Group PPO



**Blue Cross  
Blue Shield**  
of Michigan

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