2025

READY TO HELP

Medicare Plus Blue℠ Group PPO

Medical Benefits with Prescription Drugs

Saginaw Valley State University

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 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.

Comprehensive Formulary
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	In-network:	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 group plan administrator.	
Combined Deductible	$1,000	
Medical/Hospital Out-of-Pocket Maximum	$2,500 In-network medical and hospital care services below apply to this annual amount.	Not Applicable
Pharmacy Out-of-Pocket Maximum	Not applicable All Part D drugs/prescriptions apply to this annual amount.	
Combined Out-of-Pocket Maximum	$3,500 All medical and hospital care services below apply to this annual amount.	
Coinsurance Maximum	Not applicable	
Benefit	**In-network:**	**Out-of-network:**
Note: Services with a [1] may require prior authorization.		
Ambulance services – medically necessary transport; coverage applies to each one-way trip	$65	$65
Cardiac rehabilitation services	20% of approved amount, after deductible	30% of approved amount, after deductible
Chiropractic care – covered services include manual manipulation of the spine to correct subluxation	$20	$40
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.	

Benefit	In-network:	Out-of-network:
Diabetes services and supplies[1] (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.	Services are covered up to 100% of the approved amount for diabetes-related durable medical equipment or supplies and self-management training. Diabetic shoes covered up to 100% of approved amount, after deductible.
Diagnostic tests, lab services, and radiology services[1] (costs for these services may vary based on place of service)	20% of approved amount, after deductible	30% of approved amount, after deductible
Durable medical equipment[1]	Covered up to 100% of approved amount	30% of approved amount, after deductible
Emergency care – worldwide coverage for qualified medical emergencies and first aid services (copay waived if admitted to hospital within 3 days)	$70, not subject to the deductible	$70, not subject to the deductible
Hearing services • Diagnostic testing	20% of approved amount, after deductible	30% of approved amount, after deductible
Home health agency care[1]	Covered – 100%	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[1]	20% of approved amount, after deductible	30% of approved amount, after deductible

Benefit	In-network:	Out-of-network:
Inpatient hospital care[1]	20% of approved amount, after deductible	30% of approved amount, after deductible
Inpatient Services in a Psychiatric Hospital[1]	20% of approved amount, after deductible	30% of approved amount, after deductible
Kidney disease • Dialysis services[1] • Professional charges	 20% of approved amount, after deductible 20% of approved amount, after deductible	 30% of approved amount, after deductible 30% of approved amount, after deductible
Office visits, including Diagnostic Hearing, Outpatient Substance Use Disorder, Podiatry, and Vision	$30	$45
Outpatient mental health care • Facility and clinic services • Services in an office	 20% of approved amount, after deductible $30	 30% of approved amount, after deductible $45
Outpatient physical, speech and occupational therapy	20% of approved amount, after deductible	30% of approved amount, after deductible
Outpatient services[1]	20% of approved amount, after deductible	30% of approved amount, after deductible
Outpatient substance use disorder services[1] • Facility and clinic services	20% of approved amount, after deductible	30% of approved amount, after deductible

Benefit	In-network:	Out-of-network:
Outpatient surgery[1], including services at hospital outpatient facilities and ambulatory surgery centers	20% of approved amount, after deductible	30% of approved amount, after deductible
Podiatry: • Medically necessary foot care services other than office visits[1]	20% of approved amount, after deductible	30% of approved amount, after deductible
Prosthetic and orthotic devices and supplies[1]	Covered up to 100% of approved amount	30% of approved amount, after deductible
Skilled nursing facility[1] – covers up to 100 days per benefit period	20% of approved amount, after deductible	30% of approved amount, after deductible
Supervised exercise therapy	20% of approved amount, after deductible	30% of approved amount, after deductible
Urgent care visits – covered worldwide	$30, not subject to the deductible	$30, not subject to the deductible
Vision services • Diagnosis and treatment of diseases and injuries of the eye	20% of approved amount, after deductible	30% of approved amount, after deductible
Additional Benefits		
Foreign travel health care - not restricted to emergency or urgent care	Cost share same as if services were provided in the U.S.	Cost share same as if services were provided in the U.S.
Hearing aids	Standard (analog or basic digital) hearing aids are covered up to $2,500 every 36 months.	Standard (analog or basic digital) hearing aids are covered up to $2,500 every 36 months.

Benefit	In-network:	Out-of-network:
Hearing services – routine exam	$30	$45
Home infusion therapy[1]	Covered up to 100% of approved amount	Covered up to 100% of approved amount
Removal of Medicare therapy limits/thresholds for outpatient rehabilitation services	Medicare Part B therapy limits/thresholds **do not** apply to Outpatient Rehabilitation Services.	Medicare Part B therapy limits/thresholds **do not** apply to Outpatient Rehabilitation Services.
SilverSneakers® SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved.	Covered up to 100% 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.	

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 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	$40	$45
Tier 4 – Non-Preferred Drug	$55	$65
Tier 5 – Specialty Tier	$55	$65

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	$45	$20	$45	$20
Tier 2 – Generic	$45	$20	$45	$20
Tier 3 – Preferred Brand	$135	$80	$135	$80
Tier 4 – Non-Preferred Drug	$195	$110	$195	$110
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 total out-of-pocket costs have reached the $2000 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**.

Out-of-network/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, including the cost-sharing that applies to out-of-network services.

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 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**.

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 large print.

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

Medicare PLUS Blue℠ Group PPO

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