Medicare PLUS Blue℠ Group PPO

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

Medical Benefits Chart

Your medical benefits and costs as a member of the State Health Plan MA Medicare Plus Blue Group PPO plan

This *Medical Benefits Chart* is a part of your 2020 *Evidence of Coverage* (EOC), Chapter 4. This is an important legal document. Please keep it in a safe place.

This plan is effective January 1, 2020 – December 31, 2020.

Section 2.1 Your medical benefits and costs as a member of the plan

This *Medical Benefits Chart* lists the services Medicare Plus Blue Group PPO covers and what you pay out-of-pocket for each service. Refer to chapters 3 and 4 in your EOC for more information about coverage for medical services.

Your medical benefits are listed alphabetically under the following categories: **Inpatient Services**, **Outpatient Services**, **Preventive Services**, and **Additional Benefits** (if applicable). A listing of benefits not covered by the plan immediately follows the medical benefits and are also listed in Chapter 4, Section 3 (*What benefits are not covered by the plan?*) of the EOC.

The services listed in this *Medical Benefits Chart* are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in this *Medical Benefits Chart* are covered as in-network services only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from Medicare Plus Blue Group PPO.
  - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*) in the *Medical Benefits Chart.*
  - You never need approval in advance for out-of-network services from out-of-network providers.

  - While you don’t need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s approved amount (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who accepts the Medicare Advantage card, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2020* Handbook. View it online at **https://www.medicare.gov** or ask for 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.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2020, either Medicare or our plan will cover those services.
- **In-network and Out-of-network providers**: The following types of providers may administer services under the State Health Plan MA plan.
  - In-network providers who participate in the BCBSM Medicare Advantage PPO network
  - Out-of-network providers who participate with Original Medicare and agree to submit their claim to Blue Cross for the Medicare reimbursement
  - Out-of-network providers that will not accept either your Medicare Advantage card or Original Medicare are only allowed to administer Emergency Services.

Annual out-of-pocket amounts that apply to your plan

Deductible: $400 per member, $800 per family

Cost share: After you have met your deductible, you are responsible for the coinsurance, a percentage of the BCBSM allowed amount. Coinsurance is not the same as your deductible, but your Medicare Advantage plan pays the Medicare coinsurance for services covered under the State Health Plan MA PPO.

Out-of-pocket maximum: $2,000 per member, $4,000 per family. The out-of-pocket maximum is the dollar amount you pay in deductible, copay, and coinsurance during the calendar year. Once you satisfy your out-of-pocket maximum, the State Health Plan MA PPO will cover 100% of the allowed amount for covered services, including coinsurances for behavioral health and substance abuse and prescription drug copays under the State Prescription Drug plan.

Certain coinsurance, deductible, and other charges cannot be used to meet your out-of-pocket maximum. These coinsurance, deductible, and other charges are:

- Charges for noncovered services
- Charges in excess of our approved amount
- Deductibles or copayments required under other BCBSM coverage

4th quarter carryover of in-network deductible: Any amount you accumulate toward your deductible for dates of service during the fourth quarter of each year (October through December) will carry over and be applied to your annual deductible the following year.

Note: This carryover does not apply to the following year's out-of-pocket maximum.

All Part A and Part B deductibles and cost-share amounts apply to the annual out-of-pocket maximum (OOPM).

Benefit provisions, including copays, deductibles and coinsurance may change based on new and/or changed regulatory guidance issued by the Centers for Medicare and Medicaid. Limitations and restrictions may apply. Please contact your health plan administrator for further information regarding your benefits.

Medical Benefits Chart

<table>
<tr><th>Services that are covered for you</th><th>What you must pay
when you get these services</th></tr>
<tr><td colspan="2">Inpatient Services</td></tr>
<tr><td>Home health agency care (non-DME)*

Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.

Covered services include, but are not limited to:

• Part-time or intermittent skilled nursing and home health aide services. (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.)
• Physical therapy, occupational therapy, and speech therapy
• Medical and social services
• Medical equipment and supplies

* Home health agency care services rendered by plan providers may require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.</td><td>In-network and Out-of-network providers who accept the Medicare Advantage card:

Services are covered up to 100% of the approved amount.

Medical supplies ordered by physicians, such as durable medical equipment are not covered under home health agency care. See Durable Medical Equipment.

Please Note: Custodial care is not the same as home health agency care. For information, see Custodial Care in the exclusion list in Chapter 4, Section 3.1 of your Evidence of Coverage and Section 3.1 of this document.</td></tr>
<tr><td>Hospice care

You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.

Covered services include:

• Drugs for symptom control and pain relief
• Short-term respite care
• Home care</td><td>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid by Original Medicare, not Medicare Plus Blue Group PPO.

You may be asked to provide your Original Medicare beneficiary identifier number off your red, white, and blue Medicare card.</td></tr>
</table>

Services that are covered for you	What you must pay when you get these services
For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services. For services that are covered by Medicare Plus Blue Group PPO but are not covered by Medicare Part A or B: Medicare Plus Blue Group PPO will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. You have an unlimited number of medically necessary inpatient hospital days. Medicare approved clinical lab services and preventive services are covered at 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
• Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. • Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Medicare Plus Blue Group PPO provides transplant services at a location outside the pattern of care for transplants in your community, and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Coverage is up to $10,000; travel and lodging is covered for only one year after the initial transplant (includes up to five additional days prior to the initial transplant). Outside of the service area is defined as 100 miles or more, one-way to the facility, from your home address.	

Services that are covered for you	What you must pay when you get these services
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services * Inpatient hospital care services rendered by plan providers may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the web at **https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. Your plan includes additional travel and lodging coverage. See **Additional Benefits** for a description and cost sharing.	

Services that are covered for you	What you must pay when you get these services
Inpatient mental health care* Covered services include mental health care services that require a hospital stay. * Inpatient mental health/behavioral health services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount. You have an unlimited number of medically necessary inpatient hospital days.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. Medicare-approved clinical lab services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy*, speech therapy*, and occupational therapy* * Physical, speech, and occupational therapy services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Inpatient substance abuse care Covered services include substance abuse care services that require a hospital stay. * Inpatient substance abuse services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount. You have an unlimited number of medically necessary inpatient hospital days.
Skilled nursing facility (SNF) care* (For a definition of "skilled nursing facility care," see Chapter 10 of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called "SNFs.") No prior hospital stay is required. Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services	**In-network and Out-of-network providers who accept the Medicare Advantage card:** **For days 1-20:** Services are covered up to 100% of the approved amount. **For days 21-120:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. Plan covers up to 120 days for each confinement period.

Services that are covered for you	What you must pay when you get these services
• Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital. * Skilled nursing facility care may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	

Services that are covered for you	What you must pay when you get these services
Outpatient Services	
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance* is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. • Covers transport of a hospice patient to their home before enrolling in a Medicare-certified hospice program. **Note:** Please see the Exclusions Chart in Chapter 4, Section 3.1 of your *Evidence of Coverage* or Section 3.1 of this *Medial Benefits Chart*. * In-network non-emergency services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Cardiac rehabilitation services* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
* Cardiac rehabilitation services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	

Chiropractic services*
Covered services include:
• Manual manipulation of the spine to correct subluxation
• Office visits
• Evaluation and management services
  o For new patients, one visit covered every 3 years
  o For established patients, one visit covered every year
Your plan includes additional chiropractic services. See **Additional Benefits** for a description and cost sharing.
 	
* Chiropractic services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.
	In-network and Out-of-network providers who accept the Medicare Advantage card:
	You pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. We cover ***Medicare-covered*** dental services ***only***. See the **Physician/Practitioner Services, including doctor's office visits** benefit for examples of Medicare-covered dental services.	Original Medicare covers very limited medically necessary dental services. Medicare Plus Blue Group PPO 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 this benefit chart. For more information, contact Customer Service.

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions • For all people who have diabetes and use insulin, covered services: therapeutic continuous glucose monitors and supply allowance for the therapeutic continuous glucose monitor as covered by Original Medicare Your plan offers additional coverage for most continuous blood glucose monitor (CGM) brands, including brands outside of those covered by Medicare. * Diabetic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount for diabetic services, diabetic shoes and inserts, and supplies. For diabetes self-management training, you pay 2% of the approved amount, after deductible. These services apply to the annual out-of-pocket maximum.

<table>
<tr><th>Services that are covered for you</th><th>What you must pay
when you get these services</th></tr>
<tr><td>Durable medical equipment (DME) and related supplies*

(For a definition of “durable medical equipment,” see Chapter 10 of the Evidence of Coverage.)

Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.

We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.bcbsm.com/providersmedicare.

Note: You must have a prescription or a Certificate of Medical Necessity from your doctor to obtain Durable Medical Equipment (DME) or Prosthetic and Orthotic (P&O) items and services.

* Durable medical equipment and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.</td><td>In-network and Out-of-network providers who accept the Medicare Advantage card:

Services are covered up to 100% of the approved amount.</td></tr>
<tr><td>Emergency care

Emergency care refers to services that are:
• Furnished by a provider qualified to furnish emergency services, and
• Needed to evaluate or stabilize an emergency medical condition.

A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</td><td>In-network and Out-of-network providers who accept the Medicare Advantage card:

For emergency room care, you pay a $50 copayment (waived if admitted within three days). Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Emergency room physician services are covered up to 100% of the approved amount.</td></tr>
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Services that are covered for you	What you must pay when you get these services
Worldwide Coverage Medicare Plus Blue Group PPO includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories. _Outside the U.S.:_ You may be responsible for the difference between the approved amount and the provider's charge.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist or other qualified provider. Diagnostic hearing exam – 1 per year. **Your plan includes both the routine hearing exam and hearing aids benefits. See *Additional Benefits* for a description and cost sharing.**	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay a $20 copayment. Not subject to the deductible. These services apply to your annual out-of-pocket maximum.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services. • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. Services are covered up to 100% of the approved amount for drugs used in covered durable medical equipment, certain oral anti-cancer and anti-nausea drugs, and certain immunosuppressive drugs following a Medicare-covered transplant.

Services that are covered for you	What you must pay when you get these services
• Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Covered Part B drugs that may be subject to step therapy include: anti-cancer agents and cancer-supportive therapy agents, anti-gout agents, anti-inflammatory agent, antirheumatic agents, antispasticity agents, bisphosphonates, blood products, gastrointestinal agents, immunosuppressive agents, knee injections, ophthalmic agents, respiratory agents The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: **https://www.bcbsm.com/content/dam/public/Providers/Documents/ma-ppo-bcna-medical-drugs-prior-authorization.pdf** * Medicare Part B drugs may require prior authorization and/or step therapy; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests including sleep studies • High-tech radiology services (e.g. CAT scans, echocardiography, MRAs, MRIs, PET scans, echocardiography or nuclear medicine) rendered by plan providers require prior authorization. **Note**: For Medicare-covered diagnostic radiological services and Medicare-covered X-ray services, refer to Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers. * Outpatient diagnostic tests and therapeutic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. Services are covered up to 100% of the approved amount for Medicare-approved diagnostic lab services rendered at a preferred Joint Venture Hospital Lab (JVHL) or Quest Diagnostics Lab.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.
Outpatient hospital services* We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • X-rays and other radiology services billed by the hospital	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. For emergency room care, you pay a $50 copayment (waived if admitted within three days). Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

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<tr><th>Services that are covered for you</th><th>What you must pay
when you get these services</th></tr>
<tr><td>• Medical supplies such as splints and casts
• Certain drugs and biologicals that you can’t give yourself

Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

You may receive other services while in observation or an outpatient hospital facility. The cost for those services can be found in this document.

* Outpatient hospital services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.</td><td>Emergency room physician services are covered up to 100% of the approved amount.

For rural health clinic and Federally Qualified Health Clinic, you pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more.</td></tr>
<tr><td>Outpatient mental health care*

Covered services include:

Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.

Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.</td><td>In-network and Out-of-network providers who accept the Medicare Advantage card:

You pay 2% of the approved amount. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.</td></tr>
</table>

Services that are covered for you	What you must pay when you get these services
* Outpatient mental/behavioral health services rendered by plan providers may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Outpatient rehabilitation services* Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). * Outpatient rehabilitation services rendered by plan providers may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Outpatient substance abuse services* Coverage under Medicare Part B is available for treatment services provided in the outpatient department of a hospital. A coverage example is a patient who has been discharged from an inpatient stay for the treatment of substance abuse or who requires additional treatment but does not require services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
* Outpatient mental/substance abuse services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Outpatient substance abuse services* Coverage under Medicare Part B is available for treatment services provided in the outpatient department of a hospital. A coverage example is a patient who has been discharged from an inpatient stay for the treatment of substance abuse or who requires additional treatment but does not require services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. * Outpatient mental/substance abuse services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.
Outpatient surgery*, including services provided at hospital outpatient facilities and ambulatory surgical centers Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more. **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
* Outpatient surgery services, including services provided at hospital outpatient facilities and ambulatory surgical centers may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. * Partial hospitalization services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.
Physician/Practitioner services, including doctor's office visits Covered services include:	**In-network and Out-of-network providers who accept the Medicare Advantage card:**
• Medically necessary medical care or surgery services furnished in a physician's office, patient's home for evaluation and management, certified ambulatory surgical center, hospital outpatient department, or any other location	For medically necessary medical care or surgical services, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum
• Office Visits in a physician's office If a biopsy or removal of a lesion or growth is performed during an office visit, these procedures are considered diagnostic you will be responsible for the Medicare-covered surgical service cost-share in addition to your office visit copayment.	For office visits furnished in a physician's office, you pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• Office Visits in a certified ambulatory surgical center, hospital outpatient department, or any other location	For office visits furnished in a certified ambulatory surgical center, hospital outpatient department or any other location you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
• Routine Physical	An annual physical exam is covered up to 100% of the approved amount
• Diagnosis and treatment by a specialist	For medically necessary medical care or surgical services, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
• Diagnostic hearing and balance exams performed by your primary care provider or specialist, if your doctor orders it to see if you need medical treatment	For diagnostic hearing and balance exams performed by your primary care provider or specialist you pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.
• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	For medically necessary medical care or surgical services, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum
• Brief virtual (for example, via telephone or video chat) 5-10 minute check-ins with your doctor—if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment	**Telehealth services offered using your provider's online tool:** For mental health services, you pay 2% of the approved amount. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. For other services, you pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• Remote evaluation of pre-recorded video and/or images you send to your doctor, including your doctor's interpretation and follow-up within 24 hours—if you are an established patient and the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment Consultation your doctor has with other physicians via telephone, Internet, or electronic health record assessment—if you are an established patient. **Note:** Provider offices or outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more	**Telehealth services offered using the Blue Cross online tool powered by American Well®:** For mental health and substance abuse services, you pay $10 or 10% of the approved amount, whichever is less. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. For other services, you pay a $10 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. See **Telehealth services** on page 28 for details.
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs • One routine foot exam every six months for diabetes-related nerve damage and certain other conditions **Note:** For services other than office visits, refer to the following sections of this benefit chart for member cost-sharing: • Physician/Practitioner services, including doctor's office visits • Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• Outpatient diagnostic tests and therapeutic services and supplies * Podiatry services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery. See "Vision diagnostic services" later in this section for more details. Your plan offers additional coverage for orthopedic shoes and orthotic inserts beyond diabetic foot disease, based on medical necessity. A medical diagnosis is required to obtain the shoes and/or inserts. • Orthopedic shoes – covered one per year or two (individual) shoes per year • Shoe inserts - covered either two inserts every 3 years or two inserts every year, depending on type of insert **Note:** You must have a prescription or a Certificate of Medical Necessity from your doctor to obtain Prosthetic and Orthotic (P&O) items and services.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
* Prosthetic devices and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. * Pulmonary rehabilitation services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Services to treat kidney disease* Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the *Evidence of Coverage*) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	**In-network and Out-of-network providers who accept the Medicare Advantage card:** For dialysis services, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. Kidney disease education services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
• Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the listed benefit, “Medicare Part B prescription drugs.” * Dialysis services may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician’s office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Telehealth (Online Visits) Remote access technologies give you the opportunity to meet with a health care provider through electronic forms of communication (such as online). This does not replace an in-person visit but allows you to meet with a health care provider when it is not possible for you to meet with your doctor in the office. To access a participating provider, log on at **www.bcbsmonlinevisits.com** • Certain telehealth services including diagnosis and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare. • Telehealth services for monthly ESRD-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. • Telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** For mental health and substance abuse services, you pay $10 or 10% of the approved amount, whichever is less. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. For other services, you pay a $10 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

<table>
<tr><th>Services that are covered for you</th><th>What you must pay
when you get these services</th></tr>
<tr><td>Worldwide Coverage
Medicare Plus Blue Group PPO includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories.

<u>Outside the U.S.:</u>
You may be responsible for the difference between the approved amount and the provider’s charge.</td><td></td></tr>
<tr><td>Vision diagnostic services
Covered services include:
Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn’t cover routine eye exams (eye refractions) for eyeglasses/contacts.
For people with diabetes, screening for diabetic retinopathy is covered once per year.
One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)</td><td>In-network and Out-of-network providers who accept the Medicare Advantage card:
For diagnosis and treatment of conditions of the eye, you pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Routine eye exams and eyeglasses are not covered by this plan.

For corrective lenses following cataract surgery, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.</td></tr>
<tr><td colspan="2">Preventive</td></tr>
<tr><td colspan="2">Note: For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a contractual cost share may apply for the care received for the existing medical condition.</td></tr>
<tr><td>Abdominal aortic aneurysm screening
A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</td><td>There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.</td></tr>
</table>

Services that are covered for you	What you must pay when you get these services
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" preventive visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered once every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. If you have a medical condition or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and your contractual cost-sharing for Medicare-covered services will apply.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months See Chapter 10 (Glossary) in the *Evidence of Coverage* for a definition of a mammogram screening.	There is no coinsurance, copayment, or deductible for covered screening mammograms. If you have a medical condition, a follow-up (second) mammogram and/or biopsy on a separate day from the screening, the procedure is considered diagnostic and your contractual cost sharing for Medicare-covered services will apply.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you are eating healthy.	There is no coinsurance, copayment, or deductible for the cardiovascular disease risk reduction preventive benefit.

Services that are covered for you	What you must pay when you get these services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 12 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months. • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy Outpatient surgery coinsurance apply to diagnostic colonoscopies (a colonoscopy performed to diagnose a medical problem), which are not considered colorectal cancer screenings.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If you have a medical condition, such as gastrointestinal symptoms, or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and your contractual cost sharing for Medicare-covered surgical services will apply. When a physician performs a screening colonoscopy and nothing is found, the deductible and procedure copay are waived; however, an office visit copay may apply if additional conditions are discussed at the visit.

Services that are covered for you	What you must pay when you get these services
If a physician performs a screening colonoscopy and a polyp or abnormality is found, the procedure is now considered a diagnostic procedure per Medicare guidelines. See Chapter 10 (Glossary) in the *Evidence of Coverage* for a definition of a colonoscopy screening.	
Complete blood count screening Covered once per calendar year	There is no coinsurance, copayment, or deductible for a complete blood count screening.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
EKG and ECG screenings Covered once per calendar year	There is no coinsurance, copayment, or deductible for EKG and ECG screenings.
Glaucoma screening Glaucoma screening once per year for people who fall into at least one of the following high-risk categories: • people with a family history of glaucoma • people with diabetes • African Americans who are age 50 and older • Hispanic Americans who are age 65 and older	There is no coinsurance, copayment, or deductible for Medicare-covered glaucoma screening for people at high risk.

Services that are covered for you	What you must pay when you get these services

Health and Wellness education programs
Supplemental programs designed to enrich the health and lifestyles of members.
The plan covers the following supplemental education and wellness programs:
• Telemonitoring Services
  o Members who are diagnosed with heart failure, COPD or diabetes may be targeted for the remote monitoring intervention.
  o Members in the program will be sent a symptom appropriate monitor and provided with the support needed to operate it.
• Tobacco Cessation Coaching is a 12-week telephone-based program administered by WebMD® Health Services that provides counseling and support for members suffering from all forms of tobacco addiction and empowers them to successfully quit using tobacco products. Program includes intervention via telephone-based coaching provided by specially trained health coaches. There is not a limit to the number of calls the member can make within the 12-week program.
• Tivity Health™ SilverSneakers® fitness program (available only if your plan includes this program as an additional benefit – see Additional Benefits)
	There is no coinsurance, copayment, or deductible for health and wellness education programs.

Hepatitis C screening For people who are at high risk for Hepatitis C infection, including persons with a current or history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992, we cover: • One screening exam • Additional screenings every 12 months for persons who have continued illicit injection drug use since the prior negative screening test For all others born between 1945 and 1965, we cover one screening exam.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive Hepatitis C screening.

Services that are covered for you	What you must pay when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.
Immunizations Dosage and frequency for immunizations follow Centers for Disease Control and Prevention guidelines. • Flu shots (vaccine) • Hepatitis B shots (vaccine) • Pneumococcal shots Your plan includes additional coverage for immunizations. See **Additional Benefits** for a description and cost sharing.	There is no coinsurance, copayment, or deductible for immunizations.
Lead screening Covered once per calendar year	There is no coinsurance, copayment, or deductible for lead screenings.
Lipid disorders screening Covered once per calendar year	There is no coinsurance, copayment, or deductible for lipid disorders screening.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew the order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay when you get these services
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test or digital rectal exam.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
Eligible enrollees are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefit.

Services that are covered for you	What you must pay when you get these services
If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable inpatient or outpatient cost sharing. Each counseling attempt includes up to four face-to-face visits. Tobacco Cessation Coaching is a 12-week telephone-based program administered by WebMD® Health Services that provides counseling and support for members suffering from all forms of tobacco addiction and empowers them to successfully quit using tobacco products. Program includes intervention via telephone-based coaching provided by specially trained health coaches. There is not a limit to the number of calls the member can make within the 12-week program.	
“Welcome to Medicare” preventive visit The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.	There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.
Additional Benefits	
Acupuncture Includes up to 20 visits in a calendar year when performed or supervised and billed by a licensed physician. Covers treatment of the following conditions only: • Sciatica • Neuritis • Postherpetic neuralgia • Tic douloureux	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 20% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• Chronic headaches such as migraines • Osteoarthritis • Rheumatoid arthritis • Myofascial complaints such as neck and lower back pain	
Adult briefs and incontinence liners We cover adult diapers and incontinence liners to provide effective bladder control protection. • There's a maximum count of 200 per month for adult diapers and briefs • There's no monthly maximum count for incontinence liners	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

Annual physical and gynecological exam
Covered services include:
One yearly routine physical exam (an annual preventive medical exam that is more comprehensive than an annual wellness visit)
• An examination performed by a primary care physician or other provider that collects health information. Services include:
  o An age and gender appropriate physical exam, including vital signs and measurements.
  o Guidance, counseling and risk factor reduction interventions.
  o Administration or ordering of immunizations, lab tests or diagnostic procedures.
One routine gynecological exam
For all women, including those at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: Pap and pelvic exams are covered once every 12 months.
	In-network and Out-of-network providers who accept the Medicare Advantage card:
	Services are covered up to 100% of the approved amount.
	However, you will be assessed a coinsurance, copayment or deductible if a covered service (e.g. a diagnostic test) is outside of the scope of the annual physical exam.
	Note: If a biopsy or removal of a lesion or growth is performed during an office visit, these procedures are considered diagnostic. You will be responsible for the Medicare-covered surgical service cost share in addition to your office visit copayment.

Services that are covered for you	What you must pay when you get these services
Behavioral health substance abuse – intensive outpatient programs* Intensive outpatient programs are a step-down level of care for individuals who have completed detox and residential treatment, so they can continue to receive the support of treatment programming without the need for 24-hour supervision. Covered services include: • Intensive outpatient psychiatric services • Intensive outpatient chemical dependency services * Behavioral health substance abuse – intensive outpatient programs may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.
Chiropractic services • Spine X-rays and chiropractic radiology services • Physical therapy o Physical therapy massage: Limits and restrictions apply. Services must be performed by a licensed provider	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. For physical therapy massage, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

<table>
<tr><th>Services that are covered for you</th><th>What you must pay
when you get these services</th></tr>
<tr><td>Determination of refractive state
Determination of refractive state is necessary for obtaining glasses and is covered under these circumstances:
• A provider must identify your refractive state to determine an injury, illness or disease
• An ophthalmologist or an optometrist must determine the refractive state for corrective lenses
• Your refractive state is determined as part of a surgical procedure.</td><td>In-network and Out-of-network providers who accept the Medicare Advantage card:
You pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.</td></tr>
<tr><td>Gradient compression stockings and sleeves
We cover gradient compression stockings that squeeze the leg to reduce and prevent swelling as well as improve blood flow.
We cover gradient compression sleeves that apply pressure to the arm, hand, or torso to keep lymph moving in the right direction.
There’s a maximum of:
• 4 pairs of stockings per 12-month period
• OR 8 individual stockings per 12-month period
• 2 compression sleeves per 12-month period</td><td>In-network and Out-of-network providers who accept the Medicare Advantage card:
Services are covered up to 100% of the approved amount.</td></tr>
<tr><td>Hearing aids
A medical evaluation to find the cause of the hearing loss and determine if it can be improved with a hearing aid is covered as an office visit when furnished by a physician, audiologist, or other qualified provider.

The following tests are covered under the hearing aids benefit:
• A hearing aid evaluation test to determine what type of hearing aid should be prescribed
• A test to evaluate the performance of a hearing aid

You are responsible for the difference between the plan’s benefit and the cost of the hearing aid(s).</td><td>In-network and Out-of-network providers who accept the Medicare Advantage card:
Standard (analog or basic) hearing aids are covered up to $2,500 every 36 months.</td></tr>
</table>

Services that are covered for you	What you must pay when you get these services
Hearing services Tests for hearing services when furnished by a physician, audiologist or other qualified provider: • An audiometric exam to measure hearing ability • An annual evaluation and conformity test	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

Home infusion therapy
Home infusion therapy is the continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy.
Coverage for additional home infusion therapy service components are provided based on the member's condition.
The additional Medicare Plus Blue home infusion therapy benefit provides coverage for the in-home administration of infusion therapy services when the Original Medicare coverage criteria are not met. Coverage is available when the infusion therapy is:
• Prescribed by a physician to:
  o Manage a chronic condition
  o Treat a condition that requires acute care if it can be managed safely at home
• Certified by the physician as medically necessary for the treatment of the condition
• Appropriate for use in the patient's home
• Medical IV therapy, injectable therapy or total parenteral nutrition therapy
• Chelation therapy, performed in the patient's home or a nursing home
Components of care available regardless of whether the patient is confined to the home:
• Nursing visits
• Durable medical equipment, medical supplies and solutions
• Catheter care
	In-network and Out-of-network providers who accept the Medicare Advantage card:
	You pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• Injectable therapy • Drugs	
Hospice respite care - cost share for respite and drugs Drugs and biologicals • You are liable for a coinsurance payment for each palliative drug and biological prescription furnished by the hospice while you are not an inpatient. • The amount of coinsurance for each prescription approximates five (5) percent of the cost of the drug or biological to the hospice determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed $5.00. Respite care • Your coinsurance for each respite care day is equal to five (5) percent of the payment made by CMS for a respite care day. • The amount of your coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.
Human organ transplants You have additional coverage for certain human organ transplants not covered by Original Medicare. These transplant procedures are included: • Skin	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Human organ transplants You have additional coverage for certain human organ transplants not covered by Original Medicare. These transplant procedures are included: • Cornea • Kidney	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services

Human organ transplants – additional coverage
You have additional coverage for certain human organ transplants not covered by Original Medicare. These transplant procedures are included:
• Bone marrow and hematopoietic stem cell transplants when required for the following conditions:
• Allogeneic (from a donor) transplants for:
  o Osteopetrosis
  o Renal cell cancer
  o Primary amyloidosis
• Autologous (from the patient) transplants for:
  o Renal cell cancer
  o Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
  o Neuroblastoma (stage III or IV)
  o Primitive neuroectodermal tumors
  o Ewing's sarcoma
  o Medulloblastoma
  o Wilms' tumor
  o Primary amyloidosis
  o Rhabdomyosarcoma
• A second bone marrow transplant for multiple myeloma after a failed first bone marrow transplant.
When directly related to a covered transplant, we cover immunosuppressive drugs and other transplant–related prescription drugs, during and after the benefit period.
For non–covered transplants, your prescription drug plan is responsible for immunosuppressive drugs and other transplant–related prescription drugs.
There is no lifetime maximum for non-Medicare covered organs.
	In-network and Out-of-network providers who accept the Medicare Advantage card:
	Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Immunizations Dosage and frequency for immunizations follow Centers for Disease Control and Prevention guidelines. Immunizations are covered in a physician's office with no restrictions when provided by a licensed physician under Part B. • Meningococcal vaccine • Shingles vaccine • Yellow fever vaccine • Immunizations	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.
Non-medically necessary sterilization Sterilization is defined as the process of rendering barren. This is accomplished by surgical removal of testes or ovaries or inactivation by irradiation or by tying off or removing a portion of reproductive ducts (ductus deferens or uterine tubes).	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Private duty nursing We provide nursing to individuals who need skilled care and require individualized continuous 24-hour nursing care that's more intense than what is available under other benefits when ordered by a physician (M.D. or D.O.) who is involved with your ongoing care. • At least two trained caregivers (a family member, a friend, etc.) must be trained and competent to give care when the nurse is not in attendance. • The family or caregivers must provide at least 8 hours of skilled care/day. • Generally, more than 16 hours per day of Private Duty Nursing will not be approved • However, up to 16 hours per day may be approved for up to 30 days while you are being transitioned from an inpatient setting to home	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 20% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Private duty nursing does **not** cover services provided by, or within the scope or practice of, medical assistants, nurse's aides, home health aides, or other non-nurse level caregivers. This benefit is not intended to supplement the care-giving responsibility of the family, guardian or other responsible parties.	
Self-administered drugs Self-administered drugs are medications that are usually self-administered by the patient, such as pills or those used for self-injection. These drugs are covered only when obtained in inpatient, outpatient and skilled nursing facility settings.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible.
Temporomandibular joint dysfunction treatment services The following services are covered to treat temporomandibular joint dysfunction (TMJ): • Surgery directly related to the temporomandibular joint (jaw joint) and related anesthesia services • Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction • Diagnostic X-rays (including MRIs) • Trigger point injections • Physical therapy (See Physical therapy services) • Reversible appliance therapy (mandibular orthotic repositioning device, such as a bite splint)	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible.
Tivity Health™ SilverSneakers® The SilverSneakers benefit doesn't include gym or health club memberships other than for those facilities that participate in the SilverSneakers fitness program. Benefits include: • Fitness program membership at any participating location across the country • Customized SilverSneakers classes and seminars • A trained Senior Advisor℠ at the fitness center to show you around and help get you started	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered at 100%. The SilverSneakers Fitness Program is a specialized program designed for seniors. Silver Sneakers provides access to exercise equipment, classes and fun social activities at thousands of locations nationwide.

Services that are covered for you	What you must pay when you get these services
• Conditioning classes, exercise equipment, pool, sauna and other available amenities • SilverSneakers Steps in-home fitness program for members without convenient access to a SilverSneakers facility	
Travel and lodging for covered transplants • The benefit period begins five days prior to the initial transplant and extends through the patient's transplant episode of care. The transplant surgery must be performed at a Medicare-approved transplant facility. • Coverage includes expenses for the patient and one other person eligible to accompany the patient and two persons if the patient is a child under age 18 or if the transplant involves a living donor. The maximum amount payable for travel and lodging services related to the initial solid organ transplant is $10,000.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.
Weight Loss For services to be covered, you must be at least fifty percent over your ideal weight * with a diagnosis of obesity or must be at least twenty five percent over your ideal body weight with a diagnosis of one of the following: • Diabetes • Fasting hyperglycemia • Cardiac insufficiency • Angina pectoris • History of myocardial infarction • Congestive heart failure • Respiratory disease • Chronic obstructive pulmonary disease with decreased P02 tension • Pickwickian syndrome • Documented hypertension	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Covered services will be reimbursed up to 100% until the $300 lifetime allowance is met.

Services that are covered for you	What you must pay when you get these services
Endogenous Obesity Secondary to: • Hypothyroidism • Cushings disease (adrenal hyperfunction) • Hypothalamic dysfunction due to tumors or trauma • Testicular or ovarian dysfunction due to decreased testosterone level, polycystic ovaries, Polycythmia, renal insufficiency *% over ideal weight is calculated using established Weight Charts. Services rendered by one of the following clinics or centers** are payable if medical criteria are met and the services are referred or prescribed by a physician: • Diet Center • Diet Weight Loss • Family Medical Weight Loss Center • Formu-3 • Jenny Craig • Medical Weight Loss Clinic • Michigan Doctors Diet Control • Nutri-System • Optitrim • Physicians Weight Loss Center • Quick Weight Loss Center • Tops • Weight Watchers ** This list is not all inclusive Approved services that are applied to the $300 lifetime maximum include office visits, nutritional supplements, rice supplements, special diet supplements, vitamins, B-12 injections, HCG, vitamin injections, weight reduction program, and whole-body calorimeter. Office visits and lab tests are also paid under the basic health plan.	

Services that are covered for you	What you must pay when you get these services
Wigs, wig stand, adhesive Wigs must be prescribed by a physician and one of the following conditions is required: • Hair loss due to chemotherapy; or • Alopecia or disease that caused hair loss Additional replacements for children due to growth are not limited to the lifetime maximum.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount until the $300 lifetime limit is met.

Section 2.2 Medicare Plus Blue Group PPO covers services nationwide

This plan's service area includes the entire United States and its territories. You have coverage for health care services regardless of the provider's network affiliation. This plan also covers emergency and urgent care services worldwide (see Chapter 3, Section 3 in the Evidence of Coverage).

Note: You are responsible for your deductible and/or copayment, if applicable.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and, therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in the *Evidence of Coverage*.)

All exclusions or limitations on services are described in the *Medical Benefits Chart* or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	**Not covered under any condition**	**Covered only under specific conditions**
Care provided in conjunction with an ambulance call when no transport is provided. Ambulance service is a transport benefit, and it is only payable when you're transported to a hospital. If an ambulance is called and you receive care, but decide not to be transported to a hospital, we do not cover those services. (See *Ambulance Services* section of the *Medical Benefits Chart*.)		✓
Cosmetic surgery or procedures		✓ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Medicare Part B covered prescription drugs beyond 90-day supply limit including early refill requests	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 of the enclosed *Evidence of Coverage* for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments).	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Non-routine dental care.		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Phase III cardiac rehabilitation programs are considered maintenance programs, do not require physician supervision and monitoring, and are not considered medically necessary.	✓	
Prescriptions written by prescribers who are subject to the plan's Prescription Prescriber Block policy For more information, see Prescriber Block policy definition in Chapter 10 of the enclosed *Evidence of Coverage*.	✓	
Private room in a hospital.		✓ Covered only when medically necessary.
Radial keratotomy (RK) and LASIK surgery.	✓	

Services not covered by Medicare	**Not covered under any condition**	**Covered only under specific conditions**
Reversal of sterilization procedures, non-prescription contraceptive supplies, including Intrauterine Devices (IUDs), and/or any contraceptive method not payable under your Part D benefit.	✓	
Routine dental care, such as cleanings, fillings or dentures.	✓	
Routine eye examinations, eyeglasses, and other low vision aids. Services considered not reasonable and necessary, according to the standards of Original Medicare		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, e.g. if you have diabetes.
Services considered not reasonable and necessary according to the standards of Original Medicare	✓	
Services from providers who appear on the CMS Preclusion List. *For more information, see CMS Preclusion List definition in Chapter 12 of the enclosed* Evidence of Coverage.	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

Call Medicare Plus Blue Group PPO at 1-800-843-4876, Monday through Friday from 8:30 a.m. to 5:00 p.m. Eastern time for more information. TTY users should call 711.