2027

READY TO HELP

# Medicare Plus Blue[SM] PPO

## Value, Vitality, Signature and Assure

## Summary of Benefits

To get a complete list of services we cover, call Customer Service and ask for the *Evidence of Coverage* (phone numbers are printed on the back cover of this booklet).

To join Medicare Plus Blue PPO Value, Vitality, Signature or Assure, you must have both Medicare Part A and Medicare Part B, be a United States citizen or lawfully present in the United States and live in our geographic service area. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it. Our service area for Value includes certain counties in Michigan. Our service area for Vitality, Signature and Assure includes the state of Michigan.

Medicare Plus Blue PPO has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at **bcbsm.com/medicare**.

Out-of-network/non-contracted providers are under no obligation to treat Medicare Plus Blue PPO Value, Vitality, Signature or Assure members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.

# Premium/Cost-sharing Table for Medicare Plus Blue PPO

## Value

You must continue to pay your Medicare Part B premium. **Your monthly premium rate for Medicare Plus Blue Value is $0.**

| Counties | Value |
|---|---|
| Alcona, Alger, Alpena, Antrim, Arenac, Baraga, Bay, Benzie, Charlevoix, Cheboygan, Chippewa, Clare, Clinton, Crawford, Delta, Dickinson, Eaton, Emmet, Gladwin, Gogebic, Grand Traverse, Houghton, Huron, Ingham, Iosco, Iron, Isabella, Kalkaska, Keweenaw, Lake, Lapeer, Leelanau, Luce, Mackinac, Manistee, Marquette, Mason, Mecosta, Menominee, Midland, Missaukee, Montmorency, Newaygo, Oceana, Ogemaw, Ontonagon, Osceola, Oscoda, Otsego, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Tuscola, and Wexford counties | $0 |
| **Optional Supplemental Dental and Vision** | $27.10 (additional monthly premium) |

## Vitality, Signature, Assure

Premiums vary by county in which you permanently reside (rates are based on the use and cost of health care services in each regional segment). You must continue to pay your Medicare Part B premium.

1) Find the county and the region that you live in.
2) Look across the plan option column to find your monthly premium rate.

| | Medicare Plus Blue premium rates per month | | |
|---|---|---|---|
| **Regions with Counties** | **Vitality** | **Signature** | **Assure** |
| **Region 1**<br>Allegan, Barry, Ionia, Kalamazoo, Mason, Muskegon, Newaygo, Oceana, and Ottawa counties | $74.30 | $120 | $199.60 |
| **Region 2**<br>Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph, and Van Buren counties | $101.80 | $131 | $255.40 |

| Regions with Counties | Medicare Plus Blue premium rates per month<br>Vitality | Signature | Assure |
|---|---|---|---|
| **Region 3**<br>Alcona, Alger, Alpena, Arenac, Baraga, Bay, Charlevoix, Cheboygan, Chippewa, Clare, Crawford, Gladwin, Huron, Iosco, Kalkaska, Keweenaw, Luce, Mackinac, Montmorency, Ogemaw, Ontonagon, Oscoda, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee, and Tuscola counties | $100 | $168 | $299.30 |
| **Region 4**<br>Antrim, Benzie, Cass, Clinton, Delta, Dickinson, Emmet, Genesee, Gogebic, Grand Traverse, Houghton, Iron, Isabella, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Marquette, Mecosta, Menominee, Midland, Missaukee, Osceola, Otsego, St. Clair, and Wexford counties | $91 | $132 | $217.50 |
| **Region 6**<br>Macomb, Oakland, Washtenaw, and Wayne counties | $111 | $158 | $305.60 |
| **Optional Supplemental Dental and Vision** | $27.10 (additional monthly premium) | | |

Region 5 is not being used at this time.

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Deductible** | $525 annual In-network deductible for hospital and medical services. | This plan does not have a deductible for hospital and medical services. | | |
| | $0 deductible on Part D prescription drugs in Tier 1. $700 total deductible per year for Tiers 2, 3, 4 and 5. | $0 deductible on Part D prescription drugs in Tiers 1 and 2. $250 total deductible per year for Tiers 3, 4 and 5. | $0 deductible on Part D prescription drugs in Tiers 1 and 2. $200 total deductible per year for Tiers 3, 4 and 5. | $0 deductible on Part D prescription drugs in Tiers 1 and 2. $100 total deductible per year for Tiers 3, 4 and 5. |
| **Deductible - Optional Supplemental Dental and Vision** | There is no deductible. | | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Maximum Out-of-Pocket Responsibility**<br>(does not include prescription drugs) | $6,750 for services from in-network providers<br>$9,000 for services from any provider | $5,000 for services from in-network providers<br>$6,700 for services from any provider | $4,300 for services from in-network providers<br>$6,500 for services from any provider | $4,000 for services from in-network providers<br>$6,200 for services from any provider |

**Note:** Services with a [1] may require prior authorization

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Inpatient Hospital Coverage**[1] | **For Medicare-covered inpatient hospital per admission:**<br>**In-network:**<br>Days 1-7: $430 copayment, after deductible, per day, per admission.<br>Days 8-90: $0 copayment, after deductible, per day.<br>**Out-of-network:**<br>50% coinsurance | **For Medicare-covered inpatient hospital per admission:**<br>**In-network:**<br>Days 1-7: $250 copayment per day, per admission.<br>Days 8-90: $0 copayment per day.<br>**Out-of-network:**<br>40% coinsurance | **For Medicare-covered inpatient hospital per admission:**<br>**In-network:**<br>Days 1-7: $250 copayment per day, per admission.<br>Days 8-90: $0 copayment per day.<br>**Out-of-network:**<br>40% coinsurance | **For Medicare-covered inpatient hospital per admission:**<br>**In-network:**<br>Days 1-7: $225 copayment per day, per admission.<br>Days 8-90: $0 copayment per day.<br>**Out-of-network:**<br>30% coinsurance |
| **Outpatient Hospital Coverage**[1] | **In-network:**<br>$400 copayment, after deductible, for outpatient hospital services<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>$150 copayment for non-surgical services<br>$220 copayment for surgical services<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$125 copayment for non-surgical services<br>$205 copayment for surgical services<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$75 copayment for non-surgical services<br>$150 copayment for surgical services<br>**Out-of-network:**<br>30% coinsurance |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Ambulatory Surgical Center (ASC) Services**[1] | **In-network:**<br>$50 copayment, after deductible, for Medicare-covered arthroplasty knee and hip services in an ASC<br>$100 copayment, after deductible, for Medicare-covered non-surgical services<br>$300 copayment, after deductible, for Medicare-covered surgical services<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>$0 copayment for Medicare-covered arthroplasty knee and hip services in an ASC<br>$100 copayment for Medicare-covered non-surgical services<br>$125 copayment for Medicare-covered surgical services<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$0 copayment for Medicare-covered arthroplasty knee and hip services in an ASC<br>$75 copayment for Medicare-covered non-surgical services<br>$100 copayment for Medicare-covered surgical services<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$0 copayment for Medicare-covered arthroplasty knee and hip services in an ASC<br>$50 copayment for Medicare-covered non-surgical services<br>$75 copayment for Medicare-covered surgical services<br>**Out-of-network:**<br>30% coinsurance |
| **Doctor Visits**<br>• Primary | **In-network:**<br>$0 copayment<br>**Out-of-network:**<br>$25 copayment | **In-network:**<br>$0 copayment<br>**Out-of-network:**<br>40% coinsurance | | **In-network:**<br>$0 copayment<br>**Out-of-network:**<br>30% coinsurance |
| • Specialists[1] | **In-network:**<br>$50 copayment, after deductible<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>$30 copayment<br>**Out-of-network:**<br>40% coinsurance | | **In-network:**<br>$10 copayment<br>**Out-of-network:**<br>30% coinsurance |
| • Telehealth | $0 copayment for each telehealth primary care physician medical visit through plan-approved vendor.<br>$0 copayment for each telehealth mental health visit through plan-approved vendor. | | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Preventive Care**<br>(Any additional preventive services approved by Medicare during the contract year will be covered.) | **In- and Out-of-network:** $0 copayment<br>Our plan covers many preventive services, including: | | | |
| | • Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Annual physical exam<br>• Annual wellness visit<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease risk reduction visit<br>• Cardiovascular disease testing<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings<br>• Depression screening<br>• Diabetes screenings<br>• Diabetes self-management training<br>• Glaucoma screening<br>• HIV screening<br>• Immunizations, including COVID-19, flu, hepatitis B, and pneumococcal vaccines<br>• Medical nutrition therapy services<br>• Medicare Diabetes Prevention Program (MDPP)<br>• Obesity screening and counseling<br>• Pre-exposure prophylaxis (PrEP) for HIV prevention<br>• Prostate cancer screenings (PSA)<br>• Screening for lung cancer with low-dose computed tomography (LDCT)<br>• Screening for sexually transmitted infections (STIs) and counseling to prevent STIs | | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| | • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)<br>• "Welcome to Medicare" preventive visit (one-time) | | | |
| **Emergency Care** | **In-network:** $130 copayment<br>**Note**: The copayment is waived if you are admitted to the hospital within three days for the same condition.<br>You are covered for emergency medical care worldwide. | | | |
| **Urgently Needed Services**<br>You are covered for urgently needed services worldwide. | $50 copayment at urgent care center<br>$0 copayment at primary care physician's office | | | $40 copayment at urgent care center<br>$0 copayment at primary care physician's office |
| **Diagnostic Services/Labs/ Imaging[1] – Medicare-covered**<br>• Diagnostic radiology services | **In-network:**<br>$120-$175 copayment, after deductible<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>$100-$150 copayment<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$100-$125 copayment<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$75 copayment<br>**Out-of-network:**<br>30% coinsurance |
| • Lab services | **In-network:**<br>$40 copayment, after deductible<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>$0-$40 copayment<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$0-$30 copayment<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$0-$20 copayment<br>**Out-of-network:**<br>30% coinsurance |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| • Diagnostic tests and procedures including COVID-19 testing | **In-network:** $0-$155 copayment, after deductible **Out-of-network:** 50% coinsurance | **In-network:** $0-$150 copayment **Out-of-network:** $0-40% coinsurance | **In-network:** $0-$125 copayment **Out-of-network:** $0-40% coinsurance | **In-network:** $0-$75 copayment **Out-of-network:** $0-30% coinsurance |
| • Outpatient X-rays | **In-network:** $45-$155 copayment, after deductible **Out-of-network:** 50% coinsurance | **In-network:** $35-$150 copayment **Out-of-network:** 40% coinsurance | **In-network:** $35-$125 copayment **Out-of-network:** 40% coinsurance | **In-network:** $35-$75 copayment **Out-of-network:** 30% coinsurance |
| • Therapeutic radiology services | **In-network:** $80 copayment, after deductible **Out-of-network:** 50% coinsurance | **In-network:** $35 copayment **Out-of-network:** 40% coinsurance | | **In-network:** $35 copayment **Out-of-network:** 30% coinsurance |
| **Hearing Services Medicare-covered hearing services** • Hearing exam to diagnose and treat hearing and balance issues | **In-network:** $0-$50 copayment, after deductible **Out-of-network:** 50% coinsurance | **In-network:** $0-$30 copayment **Out-of-network:** 50% coinsurance | | **In-network:** $0-$10 copayment **Out-of-network:** 30% coinsurance |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Non-Medicare-covered hearing services**<br>Must be received from a TruHearing® provider.<br>• Routine hearing exam – 1 per year.<br>• Fitting and evaluation for hearing aids. Each hearing aid purchase includes one year of follow-up provider visits for fitting and adjustments. These visits are available for 12 months following hearing aid purchase and only with the purchase of a hearing aid.<br>• One hearing aid per ear once a year. Up to two hearing aids, (limit one hearing aid per ear per year) from the applicable TruHearing catalog. | **In-network:**<br>$0 copayment for routine hearing exam once per year<br>$0 copayment for hearing aid fitting/evaluation. Each hearing aid purchase includes one year of follow-up provider visits for fitting and adjustments. These visits are available for 12 months following hearing aid purchase and only with the purchase of a hearing aid.<br>Hearing aids (one hearing aid per ear once a year):<br>$495 copayment per aid for Basic Aids<br>$895 copayment per aid for Standard Aids<br>$1,295 copayment per aid for Advanced Aids<br>$1,695 copayment per aid for Premium Aids<br>**Out-of-network:**<br>Members who utilize out-of-network providers for supplemental hearing benefits may submit a reimbursement request through the plan-approved process to be reimbursed up to a plan-specified maximum amount. OTC hearing aids are excluded from coverage. Reimbursement: Routine hearing exam, once per year, reimbursed up | | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| registered trademark of TruHearing, Inc. | to $5. Hearing aids, once per year, reimbursed, up to $25 per ear, per aid. **No separate reimbursement is available for fitting and evaluation**. Reimbursement form can be found online at: **bcbsm.com/medicare/find-care.** | | | |
| **Dental Services (Medicare-covered)** | **In-network:**<br>$0-$50 copayment, after deductible<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>$0-$30 copayment<br>**Out-of-network:**<br>40% coinsurance | | **In-network:**<br>$0-$10 copayment<br>**Out-of-network:**<br>30% coinsurance |
| **Enhanced dental services (Preventive and Comprehensive)**<br>• Preventive Services include oral exams, routine cleanings, certain dental X-rays and fluoride treatment<br>• Comprehensive Services include brush biopsies, resin and amalgam fillings, crowns for permanent teeth only, crown repairs, root canals, deep cleaning, extraction and oral surgery | This benefit provides a $750 annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services.<br>**In-network**<br>$0 copayment<br>**Out-of-network**<br>25% coinsurance for preventive dental services.<br>50% coinsurance for comprehensive dental services. | This benefit provides a $1,500 annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services.<br>**In-network**<br>$0 copayment<br>**Out-of-network**<br>50% coinsurance | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Dental – Optional Supplemental Dental (available at an additional monthly premium)**<br>Includes, but not limited to, dentures, bridges, onlays and implants | The Optional Supplemental Dental benefit provides a $1,500 annual maximum (in addition to the enhanced dental annual maximum) for combined in-network and out-of-network dental services per calendar year.<br>**In-network:**<br>25% coinsurance<br>**Out-of-network:**<br>50% coinsurance | | | |
| **Vision Services (Medicare-covered)**<br>• Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)<br>• Screening for diabetic retinopathy is covered once per year for those at risk | **In-network:**<br>$0-$50 copayment, after deductible<br>**Out-of-network:**<br>50% coinsurance, | **In-network:**<br>$0-$30 copayment<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$0-$10 copayment<br>**Out-of-network:**<br>30% coinsurance |
| • Eyeglasses or contact lenses after cataract surgery | **In-network:**<br>$0 copayment, after deductible<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>$0 copayment<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$0 copayment<br>**Out-of-network:**<br>30% coinsurance |

<table>
<tr><th>Benefits</th><th>Value</th><th>Vitality</th><th>Signature</th><th>Assure</th></tr>
<tr><td rowspan="2">Enhanced Vision Services<ul><li>Routine eye exam through VSP Choice Network, one per calendar year</li><li>Eligible for one each calendar year:</li><li>Elective contacts, OR</li><li>One pair standard lenses, OR</li><li>One frame OR</li><li>One complete pair of eyeglasses</li></ul>For a complete pair of eyeglasses, the allowance can be used for the frame only.</td><td colspan="4">In-network: $0 copayment<br>Out-of-network: 50% coinsurance</td></tr>
<tr><td>In-network:<br>Eyewear benefit provides a combined in- and out-of-network maximum up to $100 every calendar year and may be used for either (a) elective contact lenses or, (b) one frame.<br>Out-of-network:<br>Eyewear benefit provides a combined in- and out-of-network maximum with 50% coinsurance up to $100 every calendar year and may be used for either (a) elective contact lenses or, (b) one frame.<br>Standard eyeglass lenses are reimbursed up to 50% of the allowed amount.</td><td colspan="3">In-network:<br>Eyewear benefit provides a combined in- and out-of-network maximum up to $150 every calendar year and may be used for either (a) elective contact lenses or, (b) one frame.<br>Out-of-network:<br>Eyewear benefit provides a combined in- and out-of-network maximum with 50% coinsurance up to $150 every calendar year and may be used for either (a) elective contact lenses or, (b) one frame.<br>Standard eyeglass lenses are reimbursed up to 50% of the allowed amount.</td></tr>
<tr><td>Optional Supplemental Vision (available at an additional monthly premium)</td><td colspan="4">The benefit provides a $250 combined in- and out-of-network annual maximum (in addition to the enhanced vision benefit) once every calendar year and may be used for either (a) elective contact lenses or (b) one frame.<br>Lens options for eyeglasses include polycarbonate lenses and/or anti-reflective coating.</td></tr>
</table>

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| You are eligible for ONE of the following, every calendar year:<br>• Elective contact lenses<br>OR<br>• One frame | | | | |
| **Inpatient Mental Health Care[1]– Medicare-covered**<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. | **In-network:**<br>Days 1-7: $330 copayment, after deductible, per day, per admission.<br>Days 8-90: $0 copayment, after deductible, per day.<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>Days 1-7: $250 copayment per day, per admission.<br>$ Days 8-90: 0 copayment per day.<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>Days 1-7: $175 copayment per day, per admission.<br>Days 8-90: $0 copayment per day.<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>Days 1-7: $100 copayment per day, per admission.<br>Days 8-90: $0 copayment per day.<br>**Out-of-network:**<br>30% coinsurance |
| **Outpatient Mental Health Care**<br>Individual and group therapy | **In-network:**<br>$50 copayment, after deductible<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>$20 copayment<br>**Out-of-network:**<br>40% coinsurance | | **In-network:**<br>$20 copayment<br>**Out-of-network:**<br>30% coinsurance |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Skilled Nursing Facility (SNF)[1]– Medicare-covered**<br>Our plan covers up to 100 days in a SNF. No prior hospital stay is required for a skilled nursing facility stay. | **In-network:**<br>Days 1-20: $0 copayment, after deductible, per day.<br>Days 21-100: $221 copayment, after deductible, per day.<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>Days 1-20: $0 copayment per day.<br>Days 21-100: $221 copayment per day.<br>**Out-of-network:**<br>40% coinsurance | | **In-network:**<br>Days 1-20: $0 copayment per day.<br>Days 21-100: $221 copayment per day.<br>**Out-of-network:**<br>30% coinsurance |
| **Outpatient Rehabilitation[1]**<br>• Occupational therapy<br>• Physical therapy and speech therapy | **In-network:**<br>$50 copayment, after deductible, for Occupational therapy<br>$65 copayment, after deductible, for Physical/Speech therapy<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>$40 copayment<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$35 copayment<br>**Out-of-network:**<br>40% coinsurance | **In-network:**<br>$30 copayment<br>**Out-of-network:**<br>30% coinsurance |
| **Ambulance Services**<br>• Ground or air transportation | **In- and Out-of-network**<br>$400 copayment, after deductible, for each one-way ground or air ambulance trip for emergent Medicare-covered services.<br>50% coinsurance, after deductible, for non-emergency ambulance services. | **In- and Out-of-network**<br>$325 copayment for each one-way ground or air ambulance trip for emergent Medicare-covered services.<br>40% coinsurance for non-emergency ambulance services. | **In- and Out-of-network**<br>$285 copayment for each one-way ground or air ambulance trip for emergent Medicare-covered services.<br>40% coinsurance for non-emergency ambulance services. | **In- and Out-of-network**<br>$250 copayment for each one-way ground or air ambulance trip for emergent Medicare-covered services.<br>30% coinsurance for non-emergency ambulance service. |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| • Ambulance services without transportation | **In-network**<br>Not offered<br>**Out of network**<br>**Not offered** | **In-network**<br>$90 copayment<br>**Out of network**<br>**40% coinsurance** | **In-network**<br>$90 copayment<br>**Out of network**<br>**40% coinsurance** | **In-network**<br>$90 copayment<br>**Out of network**<br>**30% coinsurance** |
| **Transportation Services** | Not offered | | | |
| **Medicare Part B Drugs**[1]<br>• Medicare Part B Insulin Drugs (one-month's supply) | **In-network:**<br>0%-20% coinsurance; no more than $35 per month<br>**Out-of-network:**<br>0%-50% coinsurance; no more than $35 per month | **In-network:**<br>0%-20% coinsurance; no more than $35 per month<br>**Out-of-network:**<br>0%-40% coinsurance; no more than $35 per month | **In-network:**<br>0%-20% coinsurance; no more than $35 per month<br>**Out-of-network:**<br>0%-40% coinsurance; no more than $35 per month | **In-network:**<br>0%-20% coinsurance; no more than $35 per month<br>**Out-of-network:**<br>0%-30% coinsurance; no more than $35 per month |
| • Chemotherapy drugs and other Part B drugs | **In-network:**<br>0%-20% coinsurance<br>**Out-of-network:**<br>0%-50% coinsurance | **In-network:**<br>0%-20% coinsurance<br>**Out-of-network:**<br>0%-40% coinsurance | | **In-network:**<br>0%-20% coinsurance<br>**Out-of-network:**<br>0%-30% coinsurance |
| **Medical Equipment/ Supplies**[1]<br>• Durable Medical Equipment and Prosthetics and Orthotics | **In-network:**<br>20% coinsurance, after deductible<br>**Out-of-network:**<br>50% coinsurance | **In-network:**<br>20% coinsurance<br>**Out-of-network:**<br>40% coinsurance | | **In-network:**<br>20% coinsurance<br>**Out-of-network:**<br>30% coinsurance |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| • Diabetes supplies | **In-network:**<br>0%-20% coinsurance<br>**Out-of-network:**<br>0%-40% coinsurance | | | |
| **Health fitness program**<br>(SilverSneakers®) | **In-network:**<br>$0 copayment for the health fitness program.<br>**Out-of-network:**<br>**Out of network fitness facilities are not covered**.<br>**Out of network benefits only include:**<br>• SilverSneakers LIVE online classes and workshops taught by instructors trained in senior fitness<br>• SilverSneakers On-Demand online library with hundreds of workout videos<br>• SilverSneakers GO mobile app with on-demand videos and live classes<br>• Online fitness tips and healthy eating information<br>Members can also choose one kit per year (four options to choose from). Each kit includes a quick start guide. The at-home kits available include:<br>• Walking: includes a pedometer<br>• Toning: includes a SilverSneakers ball<br>• Strength: includes a resistance band<br>• Yoga: includes a yoga strap<br>Fitness services must be provided at SilverSneakers® participating locations. You can find a location or request information at silversneakers.com or 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call 711. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved. | | | |

<table>
<tr><th>Benefits</th><th>Value</th><th>Vitality</th><th>Signature</th><th>Assure</th></tr>
<tr><td rowspan="3">Over-the-Counter (OTC): Advantage Dollars<br>Over-the-Counter (OTC) items are drugs and health-related products that do not need a prescription. This benefit covers certain approved non-prescription over-the-counter drugs and health-related items.</td><td colspan="4">Allowance Amount</td></tr>
<tr><td>You receive $25 per quarter.</td><td>You receive $40 per quarter.</td><td>You receive $50 per quarter.</td><td>You receive $50 per quarter.</td></tr>
<tr><td colspan="4">An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will not carry over quarter to quarter or year to year.<br>Note: All purchases must be made through plan-approved retailers.<br>Members who purchase OTC items out of network may submit to be reimbursed through the plan-approved process to be reimbursed for eligible OTC items. One OTC allowance applies to both in-network and out-of-network purchases.</td></tr>
<tr><td rowspan="3">Special supplemental benefits for the chronically ill<br>Food and Produce Allowance<br>This benefit will be available to plan-identified members with a history of one or more specified chronic conditions:<br>• Autoimmune disorders including polyarteritis nodosa, polymyalgia rheumatica, polymyositis, dermatomyositis, rheumatoid arthritis, systemic</td><td colspan="4">Allowance Amount</td></tr>
<tr><td>You receive $25 per quarter</td><td>You receive $40 per quarter</td><td>You receive $50 per quarter</td><td>You receive $50 per quarter</td></tr>
<tr><td colspan="4">Note: Your OTC account will be loaded automatically with the above amount on January 1, April 1, July 1 and October 1. Unused amounts will not carry over quarter to quarter or year to year.</td></tr>
</table>

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| lupus erythematosus, psoriatic arthritis and scleroderma<br>• **Cancer**<br>• **Cardiovascular disorders** including cardiac arrhythmias, coronary artery disease, peripheral vascular disease and valvular heart disease<br>• **Chronic alcohol use disorder and other substance use disorders (**SUDs)<br>• **Chronic and disabling mental health conditions** including bipolar disorders, major depressive disorders, paranoid disorder, schizophrenia, schizoaffective disorder, post-traumatic stress disorder (PTSD), | | | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| eating disorders and anxiety disorders<br>• **Chronic gastrointestinal disease** including chronic liver disease, non-alcoholic fatty liver disease (NAFLD), hepatitis B, hepatitis C, pancreatitis, irritable bowel syndrome, inflammatory bowel disease<br>• **Chronic heart failure**<br>• **Chronic hypertension**<br>• **Chronic kidney disease** (CKD) including CKD requiring dialysis/End-stage renal disease (ESRD) and CKD not requiring dialysis<br>• **Chronic lung disorders** | | | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| including cystic fibrosis, emphysema, pulmonary fibrosis, pulmonary hypertension and chronic obstructive pulmonary disease (COPD)<br>• **Conditions with functional challenges** including spinal cord injuries, paralysis, limb loss, stroke and arthritis<br>• **Dementia**<br>• **Diabetes Mellitus**<br>• **HIV/AIDS**<br>• **Neurologic disorders** including amyotrophic lateral sclerosis (ALS), epilepsy, extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington's | | | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| disease, multiple sclerosis, Parkinson's disease, polyneuropathy, fibromyalgia, chronic fatigue syndrome, spinal cord injuries, spinal stenosis and stroke-related neurologic deficit<br>• **Pre-diabetes**<br>• **Severe hematologic disorders** including aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease (excluding sickle-cell trait) and chronic venous thromboembolic disorder<br>**Note:** This benefit works with the over-the-counter | | | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| (OTC) Advantage Dollars allowance and is limited to the maximum OTC allowance amount. See Chapter 4, Section 2 *Over-the-Counter Allowance (OTC): Advantage Dollars* for more information. | | | | |

**Medicare Part D: Prescription Drugs**

Costs may differ based on pharmacy type (standard, preferred or mail-order).
Your provider may need to obtain prior authorization

**Stage 1: Deductible Stage**

$0 deductible on Part D prescription drugs in Tier 1. $700 total deductible per year for Tiers 2, 3, 4 and 5. Deductible does not apply to insulins.

**Stage 2: Initial Coverage Stage**

You pay the amounts listed in the table below until your out-of-pocket costs reach $2,400.

| | **Standard retail and standard mail-order cost sharing (in-network) 31-day supply** | **Preferred retail and preferred mail-order cost sharing (in-network) 31-day supply** | **Standard retail and standard mail-order cost sharing(in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)** | **Preferred retail and preferred mail-order cost sharing (in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)** |
|---|---|---|---|---|
| Tier 1: Preferred Generic | $9 | $2 | $27 | $6 |
| Tier 2: Generic | $12 | $7 | $36 | $21 |
| Tier 3: Preferred Brand | 23% | 23% | 23% | 23% |
| Tier 4: Non-Preferred | 25% | 25% | 25% | 25% |
| Tier 5: Specialty | 25% | 25% | Not Offered | Not Offered |

*Tier 1 drugs allow for a 100-day supply at the same cost share as a 90-day supply. If you are taking Tier 1 drug, talk to your doctor about whether it's appropriate to get a new prescription for a 100-day supply.

You won't pay more than $35 for a 31-day supply and no more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

| | |
|---|---|
| **Stage 3: Catastrophic Coverage Stage** | You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your *Evidence of Coverage*. You can also see our plan's pharmacy directory at our website **bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit **bcbsm.com/formularymedicare**. |

*Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website (**bcbsm.com/formularymedicare**).*

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website (**bcbsm.com/pharmaciesmedicare**).

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online at **bcbsm.com/medicare-evidence-of-coverage**.

# Vitality

**Medicare Part D: Prescription Drugs**

Costs may differ based on pharmacy type (standard, preferred or mail-order).
Your provider may need to obtain prior authorization

**Stage 1: Deductible Stage**

$0 deductible on Part D prescription drugs in Tiers 1 and 2. $250 total deductible per year for Tiers 3, 4 and 5. Deductible does not apply to insulins.

**Stage 2: Initial Coverage Stage**

You pay the amounts listed in the table below until your out-of-pocket costs reach $2,400.

| | **Standard retail and standard mail-order cost sharing (in-network) 31-day supply** | **Preferred retail and preferred mail-order cost sharing (in-network) 31-day supply** | **Standard retail and standard mail-order cost sharing(in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)** | **Preferred retail and preferred mail-order cost sharing (in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)** |
|---|---|---|---|---|
| Tier 1: Preferred Generic | $5 | $0 | $15 | $0 |
| Tier 2: Generic | $16 | $5 | $48 | $0 |
| Tier 3: Preferred Brand | 22% | 20% | 22% | 20% |
| Tier 4: Non-Preferred | 25% | 25% | 25% | 25% |
| Tier 5: Specialty | 30% | 30% | Not Offered | Not Offered |

*Tier 1 drugs allow for a 100-day supply at the same cost share as a 90-day supply. If you are taking Tier 1 drug, talk to your doctor about whether it's appropriate to get a new prescription for a 100-day supply.

You won't pay more than $35 for a 31-day supply and no more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

| | |
|---|---|
| **Stage 3: Catastrophic Coverage Stage** | You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your *Evidence of Coverage*. You can also see our plan's pharmacy directory at our website **bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit **bcbsm.com/formularymedicare**. |

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## Signature

**Medicare Part D: Prescription Drugs**

Costs may differ based on pharmacy type (standard, preferred or mail-order).
Your provider may need to obtain prior authorization

**Stage 1: Deductible Stage**

$0 deductible on Part D prescription drugs in Tiers 1 and 2. $200 total deductible per year for Tiers 3, 4 and 5. Deductible does not apply to insulins.

**Stage 2: Initial Coverage Stage**

You pay the amounts listed in the table below until your out-of-pocket costs reach $2,400.

| | **Standard retail and standard mail-order cost sharing (in-network) 31-day supply** | **Preferred retail and preferred mail-order cost sharing (in-network) 31-day supply** | **Standard retail and standard mail-order cost sharing(in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)** | **Preferred retail and preferred mail-order cost sharing (in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)** |
|---|---|---|---|---|
| Tier 1: Preferred Generic | $5 | $0 | $15 | $0 |
| Tier 2: Generic | $18 | $5 | $54 | $0 |
| Tier 3: Preferred Brand | 24% | 20% | 24% | 20% |
| Tier 4: Non-Preferred | 28% | 28% | 28% | 28% |
| Tier 5: Specialty | 31% | 31% | Not Offered | Not Offered |

*Tier 1 drugs allow for a 100-day supply at the same cost share as a 90-day supply. If you are taking Tier 1 drug, talk to your doctor about whether it's appropriate to get a new prescription for a 100-day supply.

You won't pay more than $35 for a 31-day supply and no more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

| | |
|---|---|
| **Stage 3: Catastrophic Coverage Stage** | You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your Evidence of Coverage. You can also see our plan's pharmacy directory at our website **bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit **bcbsm.com/formularymedicare**. |

*Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website (**bcbsm.com/formularymedicare**).*

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Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online at **bcbsm.com/medicare-evidence-of-coverage**.

# Assure

**Medicare Part D: Prescription Drugs**
Costs may differ based on pharmacy type (standard, preferred or mail-order).
Your provider may need to obtain prior authorization

**Stage 1: Deductible Stage**
$0 deductible on Part D prescription drugs in Tiers 1 and 2. $100 total deductible per year for Tiers 3, 4 and 5. Deductible does not apply to insulins.

**Stage 2: Initial Coverage Stage**
You pay the amounts listed in the table below until your out-of-pocket costs reach $2,400.

| | **Standard retail and standard mail-order cost sharing (in-network) 31-day supply** | **Preferred retail and preferred mail-order cost sharing (in-network) 31-day supply** | **Standard retail and standard mail-order cost sharing(in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)** | **Preferred retail and preferred mail-order cost sharing (in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)** |
|---|---|---|---|---|
| Tier 1: Preferred Generic | $5 | $0 | $15 | $0 |
| Tier 2: Generic | $12 | $5 | $36 | $0 |
| Tier 3: Preferred Brand | 24% | 20% | 24% | 20% |
| Tier 4: Non-Preferred | 28% | 28% | 28% | 28% |
| Tier 5: Specialty | 32% | 32% | Not Offered | Not Offered |

*Tier 1 drugs allow for a 100-day supply at the same cost share as a 90-day supply. If you are taking Tier 1 drug, talk to your doctor about whether it's appropriate to get a new prescription for a 100-day supply.

You won't pay more than $35 for a 31-day supply and no more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

| | |
|---|---|
| **Stage 3: Catastrophic Coverage Stage** | You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your Evidence of Coverage. You can also see our plan's pharmacy directory at our website **bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit **bcbsm.com/formularymedicare**. |

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For more information, please call us at the phone number below or visit us at **bcbsm.com/medicare**.

If you are not a member of this plan, call toll-free 1-888-563-3307. TTY users should call 711.

If you are a member of this plan, call toll-free 1-877-241-2583. TTY users should call 711. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 9 p.m. Eastern time. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. Eastern time.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as audio CD and large print. This document may be available in a non-English language. For additional information, call us at 1-800-450-3680. TTY users should call 711.