2026

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 the state of Michigan. Our service area for Vitality, Signature and Assure includes the state of Michigan.

**www.bcbsm.com/medicare**

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 **www.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. **A Medicare Part B premium reduction of $2 is provided.**

**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** | **$30.50 (additional monthly premium)** |

**Vitality, Signature and 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 region that you live in.

2) Look across the plan option columns 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 | $38.50 | $106.60 | $191.60 |
| **Region 2**<br>Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren counties | $66.80 | $117.50 | $247.40 |
| **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 | $81.70 | $154.20 | $291.30 |

| Regions with counties | Medicare Plus Blue premium rates per month<br>Vitality | Signature | Assure |
|---|---|---|---|
| **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 | $72.40 | $119.10 | $209.50 |
| **Region 6**<br>Macomb, Oakland, Washtenaw and Wayne counties | $84.70 | $145.20 | $298.60 |
| **Optional Supplemental Dental and Vision** | $30.50 (additional monthly premium) | | |

Region 5 is not being used at this time.

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Deductible** | **In-network:**<br>$675 deductible for hospital and medical services<br>$615 deductible for Tiers 2, 3, 4 and 5 for Part D prescription drugs | This plan does not have a deductible for hospital and medical services.<br>This plan does not have a deductible for Part D prescription drugs. | | |
| **Deductible - Optional Supplemental Dental and Vision** | There is no deductible. | | | |
| **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]<br><br>Our plan covers an unlimited number of days for an inpatient stay. | **In-network:**<br>$430 copay per day, after deductible, for days 1-7, per admission<br>$0 days 8-90<br>**Out-of-network:**<br>50% of approved amount | **In-network:**<br>$250 copay per day for days 1-7, per admission<br>$0 days 8-90<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$175 copay per day for days 1-7, per admission<br>$0 days 8-90<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$100 copay per day for days 1-7, per admission<br>$0 days 8-90<br>**Out-of-network:**<br>30% of approved amount |
| **Outpatient Hospital Coverage**[1] | **In-network:**<br>$400 copay, after deductible, for outpatient hospital services.<br>**Out-of-network:**<br>50% of approved amount | **In-network:**<br>$150 copay for non-surgical services.<br>$220 copay for surgical services<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$125 copay non-surgical services.<br>$205 copay for surgical services<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$75 copay for non-surgical services.<br>$150 copay for surgical services<br>**Out-of-network:**<br>30% of approved amount |
| **Ambulatory Surgical Center (ASC) Services**[1] | **In-network**<br>$50 copay, after deductible, for Medicare-covered arthroplasty knee and hip services in an ASC | **In-network**<br>$0 copay for Medicare-covered arthroplasty knee and hip services in an ASC | | |
| | $100 copay, after deductible, for non-surgical services<br>$300 copay, after deductible, for surgical services<br>**Out-of-network:**<br>50% of approved amount | $100 for non-surgical services<br>$125 for surgical services<br>**Out-of-network:**<br>40% of approved amount | $75 for non-surgical services<br>$100 for surgical services<br>**Out-of-network:**<br>40% of approved amount | $50 for non-surgical services<br>$75 for surgical services<br>**Out-of-network:**<br>30% of approved amount |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Doctor Visits** | | | | |
| • Primary | **In-network:** $0 copay<br>**Out-of-network:** $25 copay | **In-network:** $0 copay<br>**Out-of-network:** 40% of approved amount | **In-network:** $0 copay<br>**Out-of-network:** 40% of approved amount | **In-network:** $0 copay<br>**Out-of-network:** 30% of approved amount |
| • Specialist | **In-network:** $50 copay, after deductible<br>**Out-of-network:** 50% of approved amount | **In-network:** $30 copay<br>**Out-of-network:** 40% of approved amount | **In-network:** $30 copay<br>**Out-of-network:** 40% of approved amount | **In-network:** $10 copay<br>**Out-of-network:** 30% of approved amount |
| • Telehealth | $0 copay for each telehealth primary care physician medical visit through plan-approved vendor.<br>$0 copay for each telehealth mental health visit through plan-approved vendor. | | | |
| **Preventive Care** (Any additional preventive services approved by Medicare during the contract year will be covered.) | **In- and Out-of-network:** $0<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 | | • 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<br>• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)<br>• “Welcome to Medicare” preventive visit (one-time) | |

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|---|---|---|---|---|
| **Emergency Care** | **In-network:** $130 copay<br>**Note:** The copay 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 copay at urgent care center<br>$0 copay at primary care physician's office | | | $40 copay at urgent care center<br>$0 copay at primary care physician's office |
| **Diagnostic Services/ Labs/Imaging**[1] | | | | |
| • Diagnostic radiology services | **In-network:** $120-$175 copay, after deductible | **In-network:** $100-$150 copay | **In-network:** $100-$125 copay | **In-network:** $75 copay |
| • Lab services | **In-network:** $40 copay, after deductible | **In-network:** $0-$40 copay | **In-network:** $0-$30 copay | **In-network:** $0-$20 copay |
| • Diagnostic tests and procedures including COVID-19 testing | **In-network:** $0-$155 copay, after deductible | **In-network:** $0-$150 copay | **In-network:** $0-$125 copay | **In-network:** $0-$75 copay |
| • Outpatient X-rays | **In-network:** $45-$155 copay, after deductible | **In-network:** $35-$150 copay | **In-network:** $35-$125 copay | **In-network:** $35-$75 copay |
| • Therapeutic radiology services | **In-network:** $80 copay, after deductible | **In-network:** $35 copay | **In-network:** $35 copay | **In-network:** $35 copay |
| | **Out-of-network:** 50% of approved amount | **Out-of-network:** 0%-40% of approved amount | **Out-of-network:** 0%-40% of approved amount | **Out-of-network:** 0%-30% of approved amount |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Hearing Services**<br>**Medicare-covered hearing services**<br>• Hearing exam to diagnose and treat hearing and balance issues | **In-network:**<br>$0-$50 copay, after deductible<br>**Out-of-network:**<br>50% of approved amount | **In-network:**<br>$0-$30 copay<br>**Out-of-network:**<br>50% of approved amount | **In-network:**<br>$0-$30 copay<br>**Out-of-network:**<br>50% of approved amount | **In-network:**<br>$0-$10 copay<br>**Out-of-network:**<br>30% of approved amount |
| **Non-Medicare-covered hearing services**<br>**Must be received from a TruHearing® provider.**<br>• Routine hearing exam (1 every year)<br>• Hearing aid fitting/ evaluation<br>• Hearing aids<br>All content ©2026 TruHearing, Inc. All Rights Reserved. TruHearing® is a registered trademark of TruHearing, Inc. | **In-network:**<br>$0 copay<br>**Out-of-network:**<br>Not offered<br>$495 copay per aid for Basic Aids<br>$895 copay per aid for Standard Aids<br>$1,295 copay per aid for Advanced Aids<br>$1,695 copay per aid for Premium Aids | | | |
| **Dental Services (Medicare-covered)** | **In-network:**<br>$0-$50 copay, after deductible<br>**Out-of-network:**<br>50% of approved amount | **In-network:**<br>$0-$30 copay<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$0-$30 copay<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$0-$10 copay<br>**Out-of-network:**<br>30% of approved amount |

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|---|---|---|---|---|
| **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, extractions and oral surgery | **Preventive only**<br>**In-network:**<br>0% of approved amount<br>**Out-of-network:**<br>50% of approved amount | This benefit provides a $1,500 annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services.<br>**In-network:** 0% of approved amount<br>**Out-of-network:** 50% of approved amount | | |
| **Optional Supplemental Dental (available for additional monthly premium)**<br>Includes, but not limited to, dentures, bridges, onlays and implants | The benefit provides a $1,500 combined in- and out-of-network annual maximum (in addition to the enhanced dental annual maximum) for comprehensive dental services. No deductible.<br>**In-network:** 25% of approved amount<br>**Out-of-network:** 50% of the approved amount | | | |

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|---|---|---|---|---|
| **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:** $0-$50 copay, after deductible<br>**Out-of-network:** 50% of approved amount | **In-network:** $0-$30 copay<br>**Out-of-network:** 40% of approved amount | **In-network:** $0-$30 copay<br>**Out-of-network:** 40% of approved amount | **In-network:** $0-$10 copay<br>**Out-of-network:** 30% of approved amount |
| • Eyeglasses or contact lenses after cataract surgery | **In-network:** $0 copay, after deductible<br>**Out-of-network:** 50% of approved amount | **In-network:** $0 copay<br>**Out-of-network:** 40% of approved amount | **In-network:** $0 copay<br>**Out-of-network:** 40% of approved amount | **In-network:** $0 copay<br>**Out-of-network:** 30% of approved amount |
| **Enhanced Vision Services**<br>• Routine eye exam through VSP Choice Network, one per calendar year | **In-network:** $0 copay<br>**Out-of-network:** 50% of approved amount | | | |
| • Eligible for one each calendar year:<br>○ Elective contacts, OR<br>○ One pair standard lenses, OR<br>○ One frame OR<br>○ One complete pair of eyeglasses<br>For a complete pair of eyeglasses, the allowance can be used for the frame only. | Not covered | **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. Standard eyeglass lenses are reimbursed up to 50% of the allowed amount | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Optional Supplemental Vision (available for additional monthly premium)**<br>You are eligible for ONE of the following, every calendar year:<br>• Elective contact lenses OR<br>• One pair of standard eyeglass lenses OR<br>• One frame OR<br>• One complete pair of eyeglasses<br>For a complete pair of eyeglasses, the allowance can be used for the frame only. | The benefit provides a $250 combined in- and out-of-network 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. | | | |
| **Inpatient Mental Health Care**[1]<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>$330 copay per day for days 1-7, after deductible, per admission<br>$0 days 8-90<br>**Out-of-network:**<br>50% of approved amount | **In-network:**<br>$250 copay per day for days 1-7, per admission<br>$0 days 8-90<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$175 copay per day for days 1-7, per admission<br>$0 days 8-90<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$100 copay per day for days 1-7, per admission<br>$0 days 8-90<br>**Out-of-network:**<br>30% of approved amount |
| **Outpatient Mental Health Care**<br>Individual and group therapy | **In-network:**<br>$50 copay, after deductible<br>**Out-of-network:**<br>50% of approved amount | **In-network:**<br>$20 copay<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$20 copay<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$20 copay<br>**Out-of-network:**<br>30% of approved amount |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Skilled Nursing Facility (SNF)[1]**<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>$0 for days 1-20, after deductible<br>$218 for days 21-100<br>**Out-of-network:**<br>50% of approved amount | **In-network:**<br>$0 for days 1-20<br>$218 for days 21-100<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$0 for days 1-20<br>$218 for days 21-100<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$0 for days 1-20<br>$218 for days 21-100<br>**Out-of-network:**<br>30% of approved amount |
| **Outpatient Rehabilitation**<br>Occupational therapy<br>Physical/Speech | **In-network:**<br>$50 copay, after deductible for Occupational therapy<br>$65 copay, after deductible, for Physical/ Speech therapy<br>**Out-of-network:**<br>50% of approved amount | **In-network:**<br>$40 copay<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$35 copay<br>**Out-of-network:**<br>40% of approved amount | **In-network:**<br>$30 copay<br>**Out-of-network:**<br>30% of approved amount |
| **Ambulance Services**<br>• Ground or air transportation<br>• Ambulance services without transportation | $400 copay, after deductible<br>Not offered | $325 copay<br>**In-network:**<br>$90 copay<br>**Out-of-network:**<br>40% of approved amount | $285 copay<br>**In-network:**<br>$90 copay<br>**Out-of-network:**<br>40% of approved amount | $250 copay<br>**In-network:**<br>$90 copay<br>**Out-of-network:**<br>30% of approved amount |
| **Transportation Services** | Not covered | | | |

<table>
<tr><th>Benefits</th><th>Value</th><th>Vitality</th><th>Signature</th><th>Assure</th></tr>
<tr><td rowspan="2">Medicare Part B Drugs[1]<br>• Medicare Part B Insulin Drugs (one month’s supply)</td><td>In-network:<br>0%-20% of approved amount<br>Out-of-network:<br>0%-50% of approved amount</td><td colspan="2">In-network:<br>0%-20% of approved amount<br>Out-of-network:<br>0%-40% of approved amount</td><td>In-network:<br>0%-20% of approved amount<br>Out-of-network:<br>0%-30% of approved amount</td></tr>
<tr><td colspan="4">In- and Out-of-network: Not more than $35 per month</td></tr>
<tr><td>• Chemotherapy drugs and other Part B drugs</td><td>In-network:<br>0%-20% of approved amount<br>Out-of-network:<br>0%-50% of approved amount, after deductible</td><td colspan="2">In-network:<br>0%-20% of approved amount<br>Out-of-network:<br>0%-40% of approved amount</td><td>In-network:<br>0%-20% of approved amount<br>Out-of-network:<br>0%-30% of approved amount</td></tr>
<tr><td rowspan="2">Medical Equipment/ Supplies[1]<br>• Durable Medical Equipment and Prosthetics and Orthotics</td><td>In-network:<br>20% of approved amount, after deductible<br>Out-of-network:<br>50% of approved amount</td><td>In-network:<br>20% of approved amount<br>Out-of-network:<br>40% of approved amount</td><td>In-network:<br>20% of approved amount<br>Out-of-network:<br>40% of approved amount</td><td>In-network:<br>20% of approved amount<br>Out-of-network:<br>30% of approved amount</td></tr>
<tr><td>• Diabetes supplies</td><td colspan="4">In-network: 0%-20% of approved amount<br>Out-of-network: 0%-40% of approved amount</td></tr>
</table>

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Health fitness program (SilverSneakers®)** | **In-network:**<br>You pay $0 for the health fitness program.<br>SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved. | | | |
| **Over-the-Counter (OTC) Allowance: Advantage Dollars**<br><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. | **Allowance Amount** | | | |
| | You receive $25 per quarter. | You receive $50 per quarter. | You receive $65 per quarter. | You receive $50 per quarter. |
| | 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. | | | |

<table>
<tr><th>Benefits</th><th>Value</th><th>Vitality</th><th>Signature</th><th>Assure</th></tr>
<tr><td rowspan="4">Special supplemental benefits for the chronically ill<br><br>Food and Produce Allowance<br><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 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)</td><td colspan="4"></td></tr>
<tr><td colspan="4">Allowance Amount</td></tr>
<tr><td>You receive $25 per quarter.</td><td>You receive $50 per quarter.</td><td>You receive $65 per quarter.</td><td>You receive $50 per quarter.</td></tr>
<tr><td colspan="4">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 |
|---|---|---|---|---|
| **Special supplemental benefits for the chronically ill** (continued)<br>• Chronic and disabling mental health conditions including bipolar disorders, major depressive disorders, paranoid disorder, schizophrenia, schizoaffective disorder, post-traumatic stress disorder (PTSD), 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 | | | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Special supplemental benefits for the chronically ill** (continued)<br>• Chronic lung disorders 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 disease, multiple sclerosis, Parkinson's disease, polyneuropathy, fibromyalgia, chronic fatigue syndrome, spinal cord injuries, spinal stenosis and stroke-related neurologic deficit | | | | |

| Benefits | Value | Vitality | Signature | Assure |
|---|---|---|---|---|
| **Special supplemental benefits for the chronically ill** (continued)<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 (OTC) Advantage Dollars allowance and is limited to the maximum OTC allowance amount.<br>See Chapter 4, Section 2.1 Over-the-Counter Allowance (OTC): Advantage Dollars for more information. | | | | |

| **Medicare Part D: Prescription Drugs**<br>Costs may differ based on pharmacy type (standard, preferred or mail-order).<br>Your provider may need to obtain prior authorization | | | | |
|---|---|---|---|---|
| **Stage 1: Annual Deductible**<br>No deductible for Tier 1. $615 total deductible per year for Tiers 2, 3, 4 and 5. Deductible does not apply to insulins. | | | | |
| **Phase 2: The Initial Coverage Stage**<br>You pay the amounts listed in the table below until your out-of-pocket costs reach $2,100. | | | | |
| | **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** | **Preferred retail and preferred mail-order cost sharing (in-network) 32- to 90-day supply** |
| Tier 1: Preferred Generic | $7 | $2 | $21 | $6 |
| Tier 2: Generic | $20 | $15 | $60 | $45 |
| Tier 3: Preferred Brand | 20% | 20% | 20% | 20% |
| Tier 4: Non-Preferred Drugs | 31% | 31% | 31% | 31% |
| Tier 5: Specialty | 25% | 25% | Not offered | Not offered |
| Phase 3: Catastrophic Coverage Stage | 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. 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 **www.bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit (**www.bcbsm.com/formularymedicare**). | | | |

# Vitality

| **Medicare Part D: Prescription Drugs**<br>Costs may differ based on pharmacy type (standard, preferred or mail-order).<br>Your provider may need to obtain prior authorization | | | | |
|---|---|---|---|---|
| **Stage 1: Annual Deductible**<br>Since you have no deductible for Part D drugs, this payment stage doesn't apply. | | | | |
| **Phase 2: The Initial Coverage Stage**<br>You pay the amounts listed in the table below until your out-of-pocket costs reach $2,100. | | | | |
| | **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** | **Preferred retail and mail-order cost sharing (in-network) 32- to 90-day supply** |
| Tier 1: Preferred Generic | $5 | $0 | $15 | $0 |
| Tier 2: Generic | $16 | $11 | $48 | $0 |
| Tier 3: Preferred Brand | 20% | 20% | 20% | 20% |
| Tier 4: Non-Preferred Drugs | 25% | 25% | 25% | 25% |
| Tier 5: Specialty | 33% | 33% | Not offered | Not offered |
| Phase 3: Catastrophic Coverage Stage | 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. 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 **www.bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit (**www.bcbsm.com/formularymedicare**). | | | |

| **Medicare Part D: Prescription Drugs**<br>Costs may differ based on pharmacy type (standard, preferred or mail-order).<br>Your provider may need to obtain prior authorization | | | | |
|---|---|---|---|---|
| **Stage 1: Annual Deductible**<br>Since you have no deductible for Part D drugs, this payment stage doesn't apply. | | | | |
| **Phase 2: The Initial Coverage Stage**<br>You pay the amounts listed in the table below until your out-of-pocket costs reach $2,100. | | | | |
| | **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** | **Preferred retail and mail-order cost sharing (in-network) 32- to 90-day supply** |
| Tier 1: Preferred Generic | $5 | $0 | $15 | $0 |
| Tier 2: Generic | $18 | $10 | $54 | $0 |
| Tier 3: Preferred Brand | 20% | 20% | 20% | 20% |
| Tier 4: Non-Preferred Drugs | 25% | 25% | 25% | 25% |
| Tier 5: Specialty | 33% | 33% | Not offered | Not offered |
| Phase 3: Catastrophic Coverage Stage | 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. 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 **www.bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit (**www.bcbsm.com/formularymedicare**). | | | |

# Assure

| **Medicare Part D: Prescription Drugs**<br>Costs may differ based on pharmacy type (standard, preferred or mail-order).<br>Your provider may need to obtain prior authorization | | | | |
|---|---|---|---|---|
| **Stage 1: Annual Deductible**<br>Since you have no deductible for Part D drugs, this payment stage doesn't apply. | | | | |
| **Phase 2: The Initial Coverage Stage**<br>You pay the amounts listed in the table below until your out-of-pocket costs reach $2,100. | | | | |
| | **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** | **Preferred retail and mail-order cost sharing (in-network) 32- to 90-day supply** |
| Tier 1: Preferred Generic | $5 | $0 | $15 | $0 |
| Tier 2: Generic | $12 | $7 | $36 | $0 |
| Tier 3: Preferred Brand | 20% | 20% | 20% | 20% |
| Tier 4: Non-Preferred Drugs | 25% | 25% | 25% | 25% |
| Tier 5: Specialty | 33% | 33% | Not offered | Not offered |
| Phase 3: Catastrophic Coverage Stage | 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. 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 **www.bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit (**www.bcbsm.com/formularymedicare**). | | | |

For more information, please call us at the phone number below or visit us at **www.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 **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

**Medicare PLUS Blue℠ PPO**

Blue Cross Blue Shield of Michigan