BlueCross BlueShield of Texas

City of Austin

Blue Cross Group Medicare Advantage Open Access (PPO)[SM]

Evidence of Coverage Benefits Insert

January 1 – December 31, 2024

2024 Evidence of Coverage Benefits Insert

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This plan does not have a deductible for medical services.

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Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network and out-of-network medical services that are covered by our plan. The most you will have to pay out-of-pocket for covered in-network and out-of-network services is listed below.

Your combined maximum out-of-pocket amount is $0. This is the most you pay during the calendar year for covered plan services received from both in-network and out-of-network providers. The amounts you pay for deductibles (if your plan has a deductible), copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount for medical services. In addition, amounts you pay for some services, such as supplemental benefits and non-Medicare Part D drugs do not count toward your combined maximum out-of-pocket amount. If you have paid $0 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay

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

See also Section 2.1 of Chapter 4 in the *Evidence of Coverage* booklet for more information.

You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
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 ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. **Out-of-network** $0 copay for Medicare-covered services.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than	**In-network** $0 copay for each Medicare-covered visit. **Out-of-network** $0 copay for each Medicare-covered visit.

Services that are covered for you	What you must pay when you get these services
20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. ***Authorization rules may apply*** Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/ clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services • Covered ambulance services, whether for an emergency or non-emergency situation, 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.	**In-network** $0 copay for each one-way Medicare-covered ground transportation service. $0 copay for each one-way Medicare-covered air transportation service.

Services that are covered for you	What you must pay when you get these services
• If the covered ambulance services are not for an emergency situation, it should be 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. ***Authorization rules may apply***	**Out-of-network** $0 copay for each one-way Medicare-covered ground transportation service. $0 copay for each one-way Medicare-covered air transportation service.
Annual physical exam The routine physical examination is a comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, hands on examination, anticipatory guidance/ risk factor reduction interventions. ***Authorization rules may apply***	**In-network** $0 copay for an annual routine physical exam. **Out-of-network** $0 copay for an annual routine physical exam.
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 visit to be covered for annual wellness visits after you've had Part B for 12 months. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out-of-network** $0 copay for Medicare-covered services.
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 every 24 months or more frequently if medically necessary: procedures to	**In-network** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you get these services
identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. ***Authorization rules may apply***	**Out-of-network** $0 copay for Medicare-covered services.
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 ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for covered screening mammograms. **Out-of-network** $0 copay for Medicare-covered services.
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. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered cardiac rehabilitation services. $0 copay for Medicare-covered intensive cardiac rehabilitation services. **Out-of-network** $0 copay for Medicare-covered cardiac rehabilitation services. $0 copay for Medicare-covered intensive cardiac rehabilitation services.
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	**In-network** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy

Services that are covered for you	What you must pay when you get these services
disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. ***Authorization rules may apply***	cardiovascular disease preventive benefit. **Out-of-network** $0 copay for Medicare-covered 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). ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. **Out-of-network** $0 copay for Medicare-covered services.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 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 ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-network** $0 copay for Medicare-covered services.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
	Supplemental Chiropractic Services: **In-network and Out-of-network** $0 copay for up to 20 supplemental routine chiropractic visit(s) every year.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.	**In-network** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. $0 copay for each Medicare-covered barium enema. **Out-of-network** $0 copay for a Medicare-covered colorectal cancer screening exam. $0 copay for each Medicare-covered barium enema.

Services that are covered for you	What you must pay when you get these services
• Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. ***Authorization rules may apply***	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered services.
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. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for an annual depression screening visit. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
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. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests. **Out-of-network** $0 copay for Medicare-covered 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. ***Authorization rules may apply***	**In-network** 0% of the total cost for preferred test strips 0% of the total cost for non-preferred test strips 0% of the total cost for all other diabetes supplies 0% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered diabetes self-management training services. **Out-of-network** 0% of the total cost for preferred test strips 0% of the total cost for non-preferred test strips 0% of the total cost for all other diabetes supplies

Services that are covered for you	What you must pay when you get these services
	0% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered diabetes self-management training services.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of the *Evidence of Coverage* document.) 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. If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9 in the *Evidence of Coverage* booklet, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*.) ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered durable medical equipment and supplies. **Out-of-network** $0 copay for Medicare-covered durable medical equipment and supplies. **Authorization required if cost is greater than $2,500**

Services that are covered for you	What you must pay when you get these services
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 (and, if you are a pregnant woman, loss of an unborn child), 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. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **Worldwide emergency/urgent care services are covered.**	**In-network and Out-of-network** $0 copay for Medicare-covered emergency room visits. Cost share is waived if admitted within three days for the same condition. **Worldwide Coverage** $0 copay for Worldwide emergency services. No annual limit. Cost share is waived if admitted within three days for the same condition.
Health and wellness education programs SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GO™. All you need to get started is your personal SilverSneakers ID number. Go to	**In-network coverage for all plans:** $0 copay for this wellness program.

Services that are covered for you	What you must pay when you get these services
SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. **1.** Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. **2.** Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc.© 2020 Tivity Health, Inc. All rights reserved.	
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. We cover: • Medicare-covered services • Supplemental hearing exam (non-Medicare-covered) (Premium and Value Plus Plans only) • Supplemental hearing aids (non-Medicare-covered) (Premium and Value Plus Plans only) ***Authorization rules may apply***	***Medicare-Covered Services:*** **In-network** $0 copay for each Medicare-covered hearing exam. **Out-of-network** $0 copay for each Medicare-covered hearing exam. ***Supplemental Hearing Exam Coverage:*** **In-network** $0 copay for 1 routine hearing exam each year. **Out-of-network** $0 copay for 1 routine hearing exam each year.

Services that are covered for you	What you must pay when you get these services
	Supplemental Hearing Aids Coverage:
	<u>In-network and Out-of-network</u> $5,000 allowance combined in-network and out-of-network on hearing aids every 3 years.
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 ***Authorization rules may apply***	**<u>In-network</u>** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
	<u>Out-of-network</u> $0 copay for Medicare-covered services.
Home health agency care 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	**<u>In-network</u>** $0 copay for Medicare-covered services. **<u>Out-of-network</u>** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
Authorization rules may apply	
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered professional services. $0 copay for Medicare-covered supplies. 0% of the total cost for Medicare-covered home infusion drugs. **Out-of-network** $0 copay for Medicare-covered professional services. $0 copay for Medicare-covered supplies. 0% of the total cost for Medicare-covered home infusion drugs.
Hospice care 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. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief	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 for by Original Medicare, not Blue Cross Group Medicare Advantage Open Access (PPO).

Services that are covered for you	What you must pay when you get these services
• Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. 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 your hospice provider 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. You will be billed Original Medicare cost sharing. 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 are the same whether or not you use a network provider. You may seek care from any provider that accepts Medicare. For services that are covered by Blue Cross Group Medicare Advantage Open Access (PPO) but are not covered by Medicare Part A or B: Blue Cross Group Medicare Advantage Open Access (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. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see the *Evidence of*	

Services that are covered for you	What you must pay when you get these services
Coverage booklet Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. **Out-of-network** $0 copay for Medicare-covered 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. Plan covers an unlimited number of days per benefit period. 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 • Costs of special care units (such as intensive care or coronary care units)	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-network** $0 copay per stay **Out-of-network** $0 copay per stay If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
• 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 • Inpatient substance abuse services • 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 Blue Cross Group Medicare Advantage Open Access (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. • 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 **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	

Services that are covered for you	What you must pay when you get these services
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/2021-10/11435-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. ***Authorization rules may apply***	
Inpatient services in a psychiatric hospital • Covered services include mental health care services that require a hospital stay. 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 health services provided in a general hospital. ***Authorization rules may apply***	**In-network** $0 copay per stay **Out-of-network** $0 copay per stay
Meal benefit **Post-Discharge Meal Delivery Benefit:** You are eligible for home-delivered meals immediately following inpatient hospitalization or skilled nursing facility stay when referred by your health plan case manager. Meals are sent in 1 shipment of 14 meals. The benefit can be used three times per year through the meal delivery provider, Mom's Meals. The meal delivery may take up to 72 business hours. Some restrictions and limitations may apply. ***Authorization rules may apply***	**In-network** 14 meals/7days Max 3 times per year (Authorization required after inpatient stay) **Out-of-network** Not Covered

Services that are covered for you	What you must pay when you get these services
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 their order yearly if your treatment is needed into the next calendar year. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. **Out-of-network** $0 copay for Medicare-covered 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. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the MDPP benefit. **Out-of-network** $0 copay for Medicare-covered services.
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	Part B drugs ***may*** be subject to step therapy requirements. You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on,

Services that are covered for you	What you must pay when you get these services
• Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other 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 • 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 For a list of Part B Drugs that may be subject to Step Therapy, contact Customer Service. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 in the *Evidence of Coverage* booklet explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	even if you haven't paid your deductible. **In-network** 0% of the total cost for Medicare-covered chemo drugs. 0% of the total cost for other Medicare Part B drugs. **Out-of-network** 0% of the total cost for Medicare-covered chemo drugs. 0% of the total cost for other Medicare Part B drugs. ***Prior authorization and/or step therapy may be required***

Services that are covered for you	What you must pay when you get these services
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. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Out-of-network** $0 copay for Medicare-covered services.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered 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	**In-network** **Medicare-covered outpatient X-ray services:** $0 copay **Medicare-covered outpatient therapeutic radiology services** (such

Services that are covered for you	What you must pay when you get these services
• 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 ***Authorization rules may apply***	as radiation treatment for cancer):
	$0 copay
	Medicare-covered medical supplies:
	$0 copay
	Medicare-covered outpatient lab services:
	$0 copay
	Medicare-covered outpatient blood services:
	$0 copay
	Medicare-covered diagnostic procedures/ tests:
	$0 copay
	Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans):
	$0 copay
	Out-of-network
	Medicare-covered outpatient X-ray services:
	$0 copay
	Medicare-covered outpatient therapeutic radiology services (such

Services that are covered for you	What you must pay when you get these services
	as radiation treatment for cancer):
	$0 copay
	Medicare-covered medical supplies:
	$0 copay
	Medicare-covered outpatient lab services:
	$0 copay
	Medicare-covered outpatient blood services:
	$0 copay
	Medicare-covered diagnostic procedures/ tests:
	$0 copay
	Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans):
	$0 copay
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	**In-network** $0 copay for Medicare-covered observation services. **Out-of-network** $0 copay for Medicare-covered observation services.

Services that are covered for you	What you must pay when you get these services
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/2021-10/11435-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. ***Authorization rules may apply***	
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 • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts	**In-network** $0 copay for Medicare-covered outpatient hospital services. $0 copay for Medicare-covered ambulatory surgical services. **Out-of-network** $0 copay for Medicare-covered outpatient hospital services. $0 copay for Medicare-covered ambulatory surgical services.

Services that are covered for you	What you must pay when you get these services
• 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/2021-10/11435-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. ***Authorization rules may apply***	
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, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered individual visits with a psychiatrist. $0 copay for each virtual visit with a psychiatrist through MDLive. $0 copay for Medicare-covered group visits with a psychiatrist. $0 copay for Medicare-covered individual visits with a mental health specialist. $0 copay for each virtual visit with a mental health specialist through MDLive.

Services that are covered for you	What you must pay when you get these services
	$0 copay for Medicare-covered group visits with a mental health specialist. **Out-of-network** $0 copay for Medicare-covered individual visits with a psychiatrist. $0 copay for Medicare-covered group visits with a psychiatrist. $0 copay for Medicare-covered individual visits with a mental health specialist. $0 copay for Medicare-covered group visits with a mental health specialist.
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). ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered occupational therapy services. $0 copay for Medicare-covered physical, language and speech therapy services. **Out-of-network** $0 copay for Medicare-covered occupational therapy services. $0 copay for Medicare-covered

Services that are covered for you	What you must pay when you get these services
	physical, language and speech therapy services.
Outpatient substance abuse services Coverage under Medicare Part B is available for treatment services that are provided in the outpatient department of a hospital to patients who for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered individual substance abuse treatment. $0 copay for Medicare-covered group substance abuse treatment. $0 copay for Medicare-covered partial hospitalization services. **Out-of-network** $0 copay for Medicare-covered individual substance abuse treatment. $0 copay for Medicare-covered group substance abuse treatment. $0 copay for Medicare-covered partial hospitalization services.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **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	**In-network** $0 copay for Medicare-covered outpatient hospital services. $0 copay for Medicare-covered ambulatory surgical services.

Services that are covered for you	What you must pay when you get these services
you stay in the hospital overnight, you might still be considered an outpatient. ***Authorization rules may apply***	$0 copay for Medicare-covered observation services. **Out-of-network** $0 copay for Medicare-covered outpatient hospital services. $0 copay for Medicare-covered ambulatory surgical services. $0 copay for Medicare-covered observation services.
Over-the-counter items Over-the-Counter (OTC) items are drugs and health-related products that do not need a prescription. There are two ways to access your benefit so that the items can be shipped for free to your home: **1.** Call our OTC fulfillment center to place an order. **2.** Place orders online at www.mytxotc.com. Orders can be placed one time each month.	**In-network** $20 allowance every month for specific over-the-counter drugs and other health-related products. Unused monthly allowance will rollover to the next month but does not rollover to the next year. Member selects item(s) from catalog and item(s) are shipped to members. No card is issued and no cash is exchanged. Contact Blue Cross Blue Shield of Texas vendor, Convey Health Solutions, at 1-855-828-8300. **Out-of-network** Not Covered

Services that are covered for you	What you must pay when you get these services
Partial hospitalization services and Intensive outpatient 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. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered partial hospitalization services. **Out-of-network** $0 copay for Medicare-covered partial hospitalization services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Telehealth services for monthly end-stage renal disease-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 to diagnose, evaluate, or treat symptoms of a stroke regardless of your location	**In-network** $0 copay for Medicare-covered primary care physician services. $0 copay for Medicare-covered physician specialist services. $0 copay for Medicare-covered services provided by other health care professionals such as nurse practitioners, physician assistants, etc. **Out-of-network** $0 copay for Medicare-covered primary care physician services.

Services that are covered for you	What you must pay when you get these services
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and** ◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient • Second opinion by another network provider prior to surgery	$0 copay for Medicare-covered physician specialist services. $0 copay for Medicare-covered services provided by other health care professionals such as nurse practitioners, physician assistants, etc.

Services that are covered for you	What you must pay when you get these services
• 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) • Supplemental telehealth for urgent care and behavioral services available through MDLive. Please refer to Telehealth section for additional information. ***Authorization rules may apply***	
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 ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered services.
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 ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for an annual Medicare-covered digital rectal exam. **Out-of-network** $0 copay for Medicare-covered services. $0 copay for an annual Medicare-covered digital rectal exam.

Services that are covered for you	What you must pay when you get these services
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 Care later in this section for more detail. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered prosthetics. $0 copay for Medicare-covered medical supplies. **Out-of-network** $0 copay for Medicare-covered prosthetics. $0 copay for Medicare-covered medical supplies. **Authorization required if cost is greater than $2,500**
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. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered services.
Rewards Program *Rewards Program for Healthy Activities* You can earn rewards for completing selected screenings, managing chronic conditions, or seeing your physician for a physical. Members can potentially receive rewards for completing eligible health activities during the calendar year (January 1 - December 31). The amount of the reward is up to a maximum of $100 annually and will be triggered by submission of a claim.	Earn up to $100 annually for completing healthy activities* such as the examples below: • Welcome to Medicare/Annual Physical or Qualified Wellness Visits • Annual Flu Vaccine • Colorectal Screening • Retinal Exam

Services that are covered for you	What you must pay when you get these services
Most Healthy Action completions reward members $25 in the form of a gift card. The Annual Wellness Visit will reward members $50 upon completion. These rewards can be redeemed for a variety of gift cards that can be used at select pharmacies or national retailers. Members can opt to obtain a gift card for the completion of each individually completed healthy activity or they can opt to pool their reward amounts for numerous completed healthy activities. A maximum of one payment for each specific healthy activity per year will be rewarded until you reach the $100 maximum. ***Authorization rules may apply***	• Mammogram Additional healthy activities may be identified and provided to members after the beginning of the plan year via mail, email, or through the member portal. *This list is subject to change. The Rewards Program offers the above healthy activities for all members as well as additional healthy activities based on your unique needs. To register and determine the current list of healthy activities, go to www.BlueRewardsTX.com. You will need your member ID card, date of birth and email address to register online if you have not already. You can also call the number on the back of your member ID card to learn more about the program and register. Customer Service will take your information to begin the process to set up your account. **REGISTRATION IS REQUIRED**

Services that are covered for you	What you must pay when you get these services
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. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-network** $0 copay for Medicare-covered services.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and 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. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
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 two 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. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **Out-of-network** $0 copay for Medicare-covered services
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* booklet, or when your provider for this service is temporarily unavailable or inaccessible) • 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) • Home dialysis equipment and supplies	**In-network** $0 copay for Medicare-covered dialysis services. $0 copay for Medicare-covered kidney disease education. **Out-of-network** $0 copay for Medicare-covered dialysis services. $0 copay for Medicare-covered kidney disease education.

Services that are covered for you	What you must pay when you get these services
• 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 section, Medicare Part B prescription drugs. ***Authorization rules may apply***	
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 12 of the Evidence of Coverage. Skilled nursing facilities are sometimes called SNFs.) Plan covers 100 days per benefit period. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing 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	**<u>In-network</u>** $0 copay per day for days 1-100 (days 101 and beyond are supplemental). **<u>Out-of-network</u>** $0 copay per day for days 1-100 (days 101 and beyond are supplemental).

Services that are covered for you	What you must pay when you get these services
• 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 or domestic partner is living at the time you leave the hospital ***Authorization rules may apply***	
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. 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 cost sharing. Each counseling attempt includes up to four face-to-face visits. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-network** $0 copay for Medicare-covered services.
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.	**In-network** $0 copay for Medicare-covered supervised exercise therapy.

Services that are covered for you	What you must pay when you get these services
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 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. ***Authorization rules may apply***	**Out-of-network** $0 copay for Medicare-covered supervised exercise therapy.
Supplemental telehealth services Covered services include: • Certain telehealth services, including: urgent care and behavioral health services. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.	**In-network** $0 copay for urgent care; $0 copay for Outpatient Mental Health; $0 copay for Outpatient Mental Health Psychiatric visit through MDLive.

Services that are covered for you	What you must pay when you get these services
◦ This telehealth service is offered through MDLive. Members will need to complete registration and be directed to complete a medical questionnaire upon first visit to the MDLive portal. Please contact MDLive at 1-888-680-8646 or visit the MDLive website at www.mdlive.com. Access to telehealth service can be completed through computer, tablet, smartphone, traditional phone and can include web-based video.	**Out-of-network** Not Covered
Transportation services We cover plan approved transportation services to plan approved locations(s). Contact the plan for details on how to access this benefit. ***Authorization rules may apply***	**In-network** $0 copay for up to 12 one-way trips every year to plan-approved locations. **Out-of-network** Not Covered
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition, and is not a medical emergency, or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. In these examples, your plan will cover the urgently needed services from a provider out-of-network. **Worldwide emergency/urgent care services are covered.**	**In-network** $0 copay for Medicare-covered services. $0 copay for each virtual visit through MDLive. **Out-of-network** $0 copay for Medicare-covered services. **Worldwide coverage** $0 copay for each visit.

Services that are covered for you	What you must pay when you get these services
Vision care 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 who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • 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.) ***Authorization rules may apply***	***Medicare-Covered Services:*** **In-network** $0 copay for Medicare-covered services. $0 copay for an annual glaucoma screening. $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery. **Out-of-network** $0 copay for Medicare-covered services. $0 copay for an annual glaucoma screening. $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery.
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	**In-network** There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.

Services that are covered for you	What you must pay when you get these services
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.	**Out-of-network** $0 copay for Medicare-covered services.

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, except under the specific conditions listed 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.

The only exception we will pay is if the service is appealed and decided 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 9, Section 5.3 in the *Evidence of Coverage* document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by 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 Evidence of Coverage for more information on clinical research studies.)
Private room in a hospital		• Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition**	
Full-time nursing care in your home.	**Not covered under any condition**	
*Custodial care. (Care that helps with activities of daily living that does not require professional skills or training. e.g. bathing and dressing.)	**Not covered under any condition**	
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	**Not covered under any condition**	
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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.
Routine dental care, such as fillings or dentures.	**Not covered under any condition**	
Non-routine dental care		• **Dental care required to treat illness or injury may be covered as inpatient or outpatient care.**
Routine chiropractic care		• **Manual manipulation of the spine to correct a subluxation is covered.**
Routine foot care		• Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Home-delivered meals	**Not covered under any condition**	
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Radial keratotomy, LASIK surgery, and other low vision aids.	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	**Not covered under any condition**	
Acupuncture		• Available for people with chronic low back pain under certain circumstances.
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	

*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.

Chapter 6. What you pay for your Part D prescription drugs

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for Blue Cross Group Medicare Advantage Open Access (PPO) members?

There are four "drug payment stages" for your prescription drug coverage under Blue Cross Group Medicare Advantage Open Access (PPO). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

Important Message About What You Pay for Insulin

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

SECTION 4 During the Deductible Stage, you pay the full cost of your Part D drugs

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription for the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is $50 (Tiers 2-3) for 2024. The**"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid $50 (Tiers 2-3) for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Retail cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see the *Evidence of Coverage* Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Generic)	$10	$10	$10	$10
Cost-Sharing Tier 2 (Preferred Brand)	20% $30 min $60 max	20% $30 min $60 max	20% $30 min $60 max	20% $30 min $60 max
Cost-Sharing Tier 3 (Non-Preferred Drug)	20% $50 min $100 max	20% $50 min $100 max	20% $50 min $100 max	20% $50 min $100 max

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Retail cost sharing (in-network) (up to a 90-day supply)	Mail-order cost sharing (up to a 90-day supply)
Cost-Sharing Tier 1 (Generic)	$30	$20
Cost-Sharing Tier 2 (Preferred-Brand)	20% $90 min $180 max	20% $60 min $120 max
Cost-Sharing Tier 3 (Non-Preferred Drug)	20% $150 min $300 max	20% $100 min 200 max

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$5,030 limit for the Initial Coverage Stage**.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan, Payments made for these drugs will not count toward your initial coverage limit or total out-of-pocket costs.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $5,030 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 of the EOC on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

The tables below show what you pay for prescription drugs during the Coverage Gap Stage.

Coverage Gap Stage Tier	**Retail cost sharing (in-network)** (30-day supply)	**Retail cost sharing (in-network)** (90-day supply)
Cost-Sharing Tier 1 (Generic)	$10	$30
Cost-Sharing Tier 2 (Preferred Brand)	20% $30 min $60 max	20% $90 min $180 max
Cost-Sharing Tier 3 (Non-Preferred Drug)	20% $50 min $100 max	20% $150 min $300 max

Coverage Gap Stage Tier	**Mail-order cost sharing** (30-day supply)	**Mail-order cost sharing** (90-day supply)
Cost-Sharing Tier 1 (Generic)	**Standard:** $10	**Standard:** $20
Cost-Sharing Tier 2 (Preferred Brand)	**Standard:** 20% $30 min $60 max	**Standard:** 20% $60 min $120 max
Cost-Sharing Tier 3 (Non-Preferred Drug)	**Standard:** 20% $50 min $100 max	**Standard:** 20% $100 min $200 max

Medicare has rules about what counts and what does not count toward your out-of-pocket costs (Section 1.3).

SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. For excluded drugs covered under our enhanced benefits, you continue to pay the same cost share.

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List." Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Refer to your plan's "Drug List" or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. (See the *Medical Benefits Chart (what is covered and what you pay)* in Chapter 4).
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist may give the vaccine in the pharmacy or another provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Drug Stage you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get your vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.)
- You will pay the pharmacy your copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.
- When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in the Evidence of Coverage.
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at your pharmacy, and then take it to your doctor's office where they give you the vaccine.
- You will have to pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in the Evidence of Coverage.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Group Medicare Advantage Open Access (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage Benefits Insert for more information, including the cost sharing that applies to out-of-network services.