Premiums and Benefits	BlueCross Blue Basic (PPO)
Preventive Care	**In-network:** You pay a $0 copay. **Out-of-network:** You pay 0% of the total cost. Preventive care includes: Abdominal aortic aneurysm; Alcohol misuse counseling; Bone mass measurement; Breast cancer screening (mammogram); Cardiovascular disease screenings; Colorectal cancer screenings (colonoscopy); Depression screenings; Diabetes Screening and training; Medicare Diabetes Prevention Program; HIV Screening; Obesity screening and counseling; Prostate cancer screenings (PSA); Vaccines, including flu shots and pneumococcal shots; Welcome to Medicare initial visit; Annual Wellness Visit; Annual Physical; and Health Coaching via Silver and Fit. Other preventive services are also available. There are some covered services that have a cost, refer to the EOC for complete details.
Emergency Care	You pay a $90 copay per visit, waived if admitted within 24 hours. You pay a $250 service specific deductible and then you pay 20% of the total cost for worldwide emergency care.
Urgently Needed Services	You pay a $40 copay per visit. You pay 0% of the total cost for worldwide urgent care.
Diagnostic Services/Labs/ Imaging*	*Prior authorization may be required for these services.
Diagnostic tests and procedures	**In-network:** You pay a $0 up to $100 copay per service. You pay a $0 copay for diagnostic EKG and diagnostic colorectal screening. **Out-of-network:** You pay 30% of the total cost.
Lab services	**In-network:** You pay a $0 copay per lab service. **Out-of-network:** You pay 30% of the total cost per lab service.
Diagnostic radiology service(e.g., MRI and CT scan)	**In-network:** You pay a $0 up to $150 copay per service. You pay a $0 copay for diagnostic mammogram and ultrasounds. **Out-of-network:** You pay 30% of the total cost.
Outpatient x-rays	**In-network:** You pay a $5 - $10 copay per x-ray. **Out-of-network:** You pay 30% of the total cost per x-ray.
Hearing Services	
Medicare-covered hearing exam	**In-network:** You pay a $45 copay. **Out-of-network:** You pay 30% of the total cost.
Routine hearing exam	**In-network:** You pay a $45 copay. **Out-of-network:** You pay a $45 copay using TruHearing providers.

Premiums and Benefits	BlueCross Blue Basic (PPO)
Hearing aids	**In-network:** You pay $699 - $999. using TruHearing network for up to 2 hearing aids per year (one per ear, each year). **Out-of-network:** You pay $699 - $999. A TruHearing provider must be used for this benefit. The copayment range is based on different types and styles of hearing aids. The lower range $699 is for the Advanced hearing aid type and the higher range $999 is for the Premium hearing aid type, a TruHearing provider must be used for in- and out-of-network hearing aid benefit.
Dental Services	
Preventive Dental (non-Medicare covered)	**In-network:** You pay a $0 copay.* **Out-of-Network:** You pay 0% - 50% of the total cost.* 2 preventive dental visits per year. Oral exam, cleaning, 1 dental bitewing x-ray (fluoride treatment not covered). **In-network services receive the BCBS discount (Going to an out of network dentist may cost you more than using a contracted in network dentist. We pay up to 50% for reasonable and customary charges for out of network claims.)** *Preventive dental services are included in your $1000 preventive/comprehensive limit per year. See your EOC for details.
Comprehensive Dental (Non-Medicare Covered)	**In-network:** You pay 50% of the total cost.* **Out-of-network:** You pay 0% - 50% of the total cost.* Non-routine services, diagnostic services, restorative services, endodontics, extractions, prosthodontics, other oral/maxillofacial surgery, periodontics, and other services (i.e., dentures, root canals). **In-network services receive the BCBS discount (Going to an out of network dentist may cost you more than using a contracted in network dentist. We pay up to 50% for reasonable and customary charges for out of network claims.)** *Comprehensive dental services are included in your $1000 preventive/comprehensive limit per year. See your EOC for details.
Comprehensive Dental (Medicare Covered)	**In-network:** You pay a $50 copay. **Out-of-network:** You pay 30% of the total cost. See your EOC for details.
Vision Services	
Diabetic eye exam	**In-network:** You pay a $0 copay. **Out-of-network:** You pay a $0 copay.
Glaucoma screening	**In-network:** You pay a $0 copay. **Out-of-network:** You pay a $0 copay.
Medicare-covered eye exam	**In-network:** You pay a $50 copay. **Out-of-network:** You pay a $50 copay.

Premiums and Benefits	BlueCross Blue Basic (PPO)
Routine eye exam	**In-network:** You pay a $0 copay using the VSP network, 1 exam per year. **Out-of-network:** You pay a $0 copay using the VSP network, 1 exam per year.
Eyeglasses (frames and lenses) and contacts	**In-network**: You pay a $0 copay for one pair of glasses to include frames and lenses or one pair of contact lenses every 2 years using the VSP network. **Out-of-network:** You pay a $0 copay for one pair of glasses to include frames and lenses or one pair of contact lenses every 2 years using the VSP network.
Eyeglasses or contact lenses after cataract surgery	**In-network:** You pay a $0 copay for Medicare-covered eyewear related to cataract surgery. **Out-of-network:** You pay a $0 copay for Medicare-covered eyewear related to cataract surgery.
Mental Health Services	
Inpatient visit*	**In-network:** You pay a $624 copay per day, days 1 through 3, you pay a $0 copay per day, days 4 through 90. **Out-of-network:** You pay 30% of the total cost. *Prior authorization may be required.
Outpatient group therapy/ individual therapy	**In-network:** You pay a $35 copay per visit. **Out-of-network:** You pay 30% of the total cost per visit.
Skilled Nursing Facility (SNF)*	**In-network:** You pay a $0 copay per day for days 1 – 20, you pay a $196 copay per day for days 21 - 100. **Out-of-network:** You pay 30% of the total cost. Our plan covers up to 100 days in a SNF. *Prior authorization may be required.
Physical Therapy*	**In-network:** You pay a $35 copay per visit. **Out-of-network:** You pay a $45 copay per visit. *Prior authorization may be required.
Ambulance*	**In-network:** You pay a $275 copay per one-way trip for ground ambulance.You pay a $275 copay per one-way trip for air ambulance. **Out-of-network:** You pay a $275 copay per one-way trip for ground ambulance.You pay a $275 copay per one-way trip for air ambulance. *Prior authorization may be required for non-emergency transportation.
Transportation	You pay $0 for 24 one-way trips per year to any health-related location. See your EOC for details.

Premiums and Benefits	BlueCross Blue Basic (PPO)
Medicare Part B Drugs*	**In-network:** You pay 20% of the total cost of chemotherapy drugs. **Out-of-network:** You pay 30% of the total cost of chemotherapy drugs. **In-network:** You pay 20% of the total cost for other Part B drugs. **Out-of-network:** You pay 30% of the total cost for other Part B drugs. **Effective 7/1/2023:** You pay a $35 copay in-network and out-of-network for a 1-month supply of Medicare Part B select insulins for use in home infusion pumps. *Prior authorization may be required.
Chiropractic Care (Medicare-covered)	**In-network:** You pay a $20 copay per visit. **Out-of-network:** You pay 30% of the total cost.
Dialysis*	**In-network:** You pay 20% of the total cost. **Out-of-network:** You pay 30% of the total cost. *Prior authorization may be required.
Foot Care (podiatry services)	
Medicare-covered foot exams and treatment	**In-network:** You pay a $35 copay per visit. **Out-of-network:** You pay 30% of the total cost.
Routine foot care	Not covered.
Home Health Care*	**In-network:** You pay 0% of the total cost. **Out-of-network:** You pay 30% of the total cost. *Prior authorization may be required.
Medical Equipment/Supplies	
Durable Medical Equipment(e.g., wheelchairs, oxygen) *	**In-network:** You pay 20% of the total cost. **Out-of-network:** You pay 30% of the total cost. *Prior authorization may be required.
Prosthetics (e.g., braces, artificial limbs) *	**In-network:** You pay 20% of the total cost. **Out-of-network:** You pay 30% of the total cost. *Prior authorization may be required.
Diabetic supplies	**In-network:** We only cover OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices for $0. Note: In case of an approved medical exception, other brands may be covered, and you pay 20% of the total cost. **Out-of-network:** You pay 30% of the total cost.
Occupational Therapy*	**In-network:** You pay a $35 copay per visit. **Out-of-network:** You pay a $45 copay per visit. *Prior authorization may be required.

Premiums and Benefits	BlueCross Blue Basic (PPO)
Outpatient Substance Abuse*	**In-network:** Individual and group therapy visits – You pay a $35 copay. **Out-of-network:** Individual and group therapy visits – You pay 30% of the total cost. *Prior authorization may be required.
Over-the-Counter Service	You receive $40 per quarter for a total of $160 per year in Over-the-Counter items with free shipping. Order placed once per quarter via phone, catalog, or vendor website. New for 2023 you can use an OTC Benefits Card at your pharmacy. See EOC for details.
Physical Exam - Annual	**In-network:** You pay a $0 copay for one physical exam per year. **Out-of-network:** You pay 30% of the total cost for one physical exam peryear.
Speech and Language Therapy*	**In-network:** You pay a $35 copay per visit. **Out-of-network:** You pay a $45 copay per visit. *Prior authorization may be required.
Visitor Travel	The Visitor/Travel Program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 48 states and 2 territories: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state. These areas are subject to change, see EOC for details.
Wellness Programs (e.g., fitness)	You pay $0 for basic membership to a Silver & Fit participating fitness center and a home fitness kit with fitness tracker.

Limitations, copayments, and restrictions may apply. Benefits, premiums, copayments, or coinsurance may change on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat BlueCross Blue Basic members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number, 1-855-204-2744, or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.