Blue Medicare Advantage

Drexel University

2026 Summary of Benefits

PPO Plan 10L

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.bluemedadvgrhs.com**, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, D.C., and all United States territories.

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Secure Preferred (PPO) Benefits Effective: 01/01/2026 – 12/31/2026

Plan Features	In-network:	Out-of-network:
Annual medical deductible:	$0 combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$6,700	$10,000

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care* No limit to the number of days covered by the plan	$250 copay per day for days 1-5 per admission	20% coinsurance per admission
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$100 copay per visit	20% coinsurance per visit
Outpatient hospital services observation room	$100 copay per visit	20% coinsurance per visit
Primary care office visit	$10 copay per visit	20% coinsurance per visit
Specialty care office visit	$40 copay per visit	20% coinsurance per visit
Preventive care, screenings, and tests	$0 copay per visit	20% coinsurance per visit
Emergency care	$100 copay per visit $100 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
Urgently needed services	$50 copay per visit $50 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
X-ray visit and/or simple diagnostic test*	$10 copay per visit	20% coinsurance per visit
Complex diagnostic test and/or radiology visit*	$80 copay per visit	20% coinsurance per visit
Radiation therapy treatment*	$40 copay per visit	20% coinsurance per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit
Medicare-covered basic hearing and balance exams performed by your specialist*	$40 copay per visit	20% coinsurance per visit
Routine hearing services We have partnered with TruHearing to bring you these discounts and services.	Must use a TruHearing participating provider. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year **Hearing aids fitting evaluations** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $699 copay for advanced digital hearing aids $999 copay for premium digital hearing aids 1 per ear every calendar year	Out-of-network providers must order hearing aids through TruHearing. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year **Hearing aids fitting evaluations** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $699 copay for advanced digital hearing aids $999 copay for premium digital hearing aids 1 per ear every calendar year
Medicare-covered dental is non-routine care performed by your specialist*	$40 copay per visit	20% coinsurance per visit
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$40 copay per visit	20% coinsurance per visit
Medicare-covered glaucoma screening	$0 copay per visit	20% coinsurance per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Medicare-covered eyewear following cataract surgery	20% coinsurance per surgery	20% coinsurance per surgery
Routine vision services	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $0 copay for eyewear $100 maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** $0 copay for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network	Member must submit a claim form for reimbursement **Exams** $70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** 100% reimbursement for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network
Inpatient services in a psychiatric hospital* No limit to the number of days covered by the plan	$250 copay per day for days 1-5 per admission	20% coinsurance per admission
Mental health professional individual therapy visit	$40 copay per visit	20% coinsurance per visit
Substance use disorder professional individual therapy visit	$40 copay per visit	20% coinsurance per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Skilled nursing facility (SNF) care*	$0 copay for days 1-20 per benefit period $40 copay per day for days 21-100 per benefit period 100-day limit per benefit period	20% coinsurance for days 1-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	$40 copay per visit	20% coinsurance per visit
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $75 copay per one-way trip for ambulance services	
Medicare Part B drugs*	20% coinsurance for Part B drugs	20% coinsurance for Part B drugs
Chiropractic services Medicare-covered	$15 copay per visit	20% coinsurance per visit
Acupuncture for chronic low back pain Medicare-covered	$10 copay per visit	20% coinsurance per visit
Cardiac rehabilitation services*	$0 copay per visit	20% coinsurance per visit
Pulmonary rehabilitation services*	$35 copay per visit	20% coinsurance per visit
Blood glucose test strips, lancets, lancet devices, and glucose control solutions For a 30 day supply	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** 10% coinsurance per purchase

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Blood glucose monitors	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** 10% coinsurance per purchase
Therapeutic shoes	$0 copay per purchase	10% coinsurance per purchase
Diabetes self-management training	$0 copay per visit	20% coinsurance per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom	20% coinsurance per purchase for FreeStyle Libre® (made by Abbott) and Dexcom
Durable medical equipment (DME) and related supplies*	10% coinsurance per purchase	10% coinsurance per purchase
Opioid treatment program services*	$40 copay per visit	20% coinsurance per visit
Podiatry services*	$10 copay per visit	20% coinsurance per visit
Routine foot care Includes the cutting or removal of corns and calluses, the trimming, cutting, clipping, or debriding of nails, and other hygienic and preventive maintenance care.	$10 copay per visit 12 visits per year combined in-network and out-of-network	20% coinsurance per visit 12 visits per year combined in-network and out-of-network
Home health agency care*	$0 copay per visit	20% coinsurance per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Hospice care	$40 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	20% coinsurance for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.

Additional covered benefits and services	Member pays unless specified:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness education programs SilverSneakers® Membership† Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel (outside U.S. and its territories) Emergency care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Emergency care** $100 copay for emergency care $100 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Urgently needed services** $50 copay for urgently needed services $50 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Emergency Inpatient Care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Inpatient care** $250 copay per day for days 1-5 per admission 60 days per lifetime
Healthy Meals†§* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition and qualify under Special Supplemental Benefits for the Chronically Ill	$0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the benefits chart.

This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage (EOC).

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. 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.

Medicare & You 2026 resource: For more information, we encourage you to read Medicare & You 2026. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.gov.** Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

Hearing benefit management administered by TruHearing, an independent company.