Blue Medicare Advantage

# Drexel University

## 2024 Summary of Benefits

### PPO Plan 10H

**Bluemedadv.com**

Blue Medicare Advantage gives you the tools and resources you need to make the best decisions for your health, like this summary of benefits. It's a snapshot of your plan's covered benefits and services and what they cost. For more details about your benefits and services, please review your *Evidence of Coverage* (EOC).

**Medicare & You 2024 resource:** For more information, we encourage you to read Medicare & You 2024. 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**.

**How much is the monthly premium?** Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

| | In-network: | Out-of-network: |
|---|---|---|
| **Annual medical deductible:** | $0 | |
| **Maximum out-of-pocket responsibility: (Does not include prescription drugs)** | $6,700 | $10,000 |

| Covered medical benefits | In-network, members pay: | Out-of-network, members pay: |
|---|---|---|
| **Inpatient hospital care*** | $0 copay per admission | 20% coinsurance |
| **Outpatient Hospital Care** Facility or ambulatory surgical center visit for surgery* | $0 copay per visit | 20% coinsurance |

| Covered medical benefits | In-network, members pay: | Out-of-network, members pay: |
| --- | --- | --- |
| **Observation Room** | $0 copay per visit | 20% coinsurance |
| **Primary care office visit** | $10 copay per visit | 20% coinsurance |
| **Specialty care office visit** | $15 copay per visit | 20% coinsurance |
| **Video doctor visits**<br>LiveHealth Online | $0 copay per visit | |
| **Preventive care** | $0 copay per visit | 20% coinsurance |
| **Emergency room visit** | $40 copay per visit,<br>72 hours cost share waived if admitted for the same condition | |
| **Urgently needed services** | $15 copay per visit,<br>72 hours cost share waived if admitted for the same condition | |
| **Diagnostic services, labs, and imaging**<br>Diagnostic lab services* | $0 copay per visit | $0 copay per visit |
| Diagnostic radiology services, such as MRIs and CT scans* | $0 copay per visit | 20% coinsurance |
| Outpatient X-rays* | $0 copay per visit | 20% coinsurance |
| **Hearing services***<br>Medicare-covered diagnostic hearing and balance evaluations | $15 copay per visit | 20% coinsurance |

| Covered medical benefits | In-network, members pay: | Out-of-network, members pay: |
| --- | --- | --- |
| Routine hearing exams | **Routine hearing exams and fitting evaluations limit**<br>$70 per ear with a maximum benefit of<br><br>**Hearing Exams**<br>$0 copay for routine hearing exams,<br>1 exam every calendar year<br><br>**Hearing Aids Fitting Evaluations**<br>$0 copay for hearing aid fitting evaluations,<br>1 evaluation per covered hearing aid<br><br>**Hearing Aids**<br>$0 copay for hearing aids, supplied by hearing care solutions,<br>$500 per ear with a maximum benefit of,<br>$1,000 every three calendar years combined in-network and out-of-network | **Routine hearing exams and fitting evaluations limit**<br>$70 per ear with a maximum benefit of<br><br>**Hearing Exams**<br>$0 copay for routine hearing exams,<br>1 exam every calendar year<br><br>**Hearing Aids Fitting Evaluations**<br>$0 copay for hearing aid fitting evaluations,<br>1 evaluation per covered hearing aid<br><br>**Hearing Aids**<br>$0 copay for hearing aids, supplied by hearing care solutions,<br>$500 per ear with a maximum benefit of,<br>$1,000 every three calendar years combined in-network and out-of-network |
| **Medicare Covered Dental***<br>Non-routine care covered by Medicare | $15 copay per visit | 20% coinsurance |
| **Vision services**<br>Medicare-covered exams given by a specialist to diagnose and treat eye diseases and conditions | $15 copay per visit | 20% coinsurance |
| Medicare-covered eyewear following cataract surgery | $0 copay per surgery | 20% coinsurance |
| Routine vision eye exam | $0 copay per visit,<br>1 visit every calendar year,<br>$70 maximum, every calendar year | $0 copay per visit,<br>1 visit every calendar year,<br>$70 maximum, every calendar year |
| Routine vision eyewear | $0 copay for eyewear, maximum benefit,<br>$100 every two calendar years | $0 copay for eyewear, maximum benefit,<br>$100 every two calendar years |
| **Mental Health Services**<br>Inpatient visit* | $0 copay per admission | 20% coinsurance |

| Covered medical benefits | In-network, members pay: | Out-of-network, members pay: |
| --- | --- | --- |
| Outpatient group therapy professional visit | $15 copay per visit | 20% coinsurance |
| Outpatient individual therapy professional visit | $15 copay per visit | 20% coinsurance |
| Professional partial hospitalization* | $15 copay per visit | 20% coinsurance |
| **Skilled nursing facility (SNF)*** | $0 copay per day,<br>1-100 days per benefit period | 20% coinsurance,<br>1-100 days per benefit period |
| **Outpatient rehabilitation services**<br>Physical, occupational, and speech therapy visits* | $15 copay per visit | 20% coinsurance |
| **Ambulance services** | $0 copay per one way trip | |
| **Part B Drugs**<br>Medicare-covered* | $0 copay per visit | 15% coinsurance |
| **Chiropractic services**<br>Medicare-covered* | $10 copay per visit | 20% coinsurance |
| **Additional chiropractic services** | $10 copay per visit,<br>6 visits per year | 20% coinsurance,<br>6 visits per year |
| **Acupuncture**<br>for chronic low back pain. Medicare-covered | $10 copay per visit | 20% coinsurance |
| **Diabetes management**<br>Supplies, including blood glucose test strips, lancet devices, lancets, and glucose control solutions | **Through the Pharmacy: Medicare-Covered Purchase Of OneTouch®**<br>$0 copay per purchase,<br>30 days per supply<br><br>**Through the Pharmacy: Medicare-Covered Purchase Of ACCU-CHECK®**<br>$0 copay per purchase,<br>30 days per supply<br><br>**Through the Pharmacy: Medicare-Covered Purchase Of All Other Brands**<br>$10 copay per purchase,<br>30 days per supply | 20% coinsurance,<br>30 days per supply |

| Covered medical benefits | In-network, members pay: | Out-of-network, members pay: |
|---|---|---|
| Blood glucose monitor | **Through the Pharmacy: Medicare-Covered Purchase Of OneTouch®**<br>$0 copay per purchase<br><br>**Through the Pharmacy: Medicare-Covered Purchase Of ACCU-CHECK®**<br>$0 copay per purchase<br><br>**Through the Pharmacy: Medicare-Covered Purchase Of All Other Brands**<br>$10 copay per purchase | 20% coinsurance |
| Therapeutic shoes | $0 copay per purchase | 20% coinsurance |
| Self-management training | $0 copay per visit | 15% coinsurance |
| Continuous glucose monitor* | $0 copay per purchase | 20% coinsurance |
| **Durable medical equipment (DME)*** | $0 copay per visit | 20% coinsurance |
| **Podiatry services**<br>Medicare-covered | $10 copay per visit | 20% coinsurance |
| Routine foot care | $10 copay per visit,<br>12 visits per year | 20% coinsurance,<br>12 visits per year |
| **Home health care*** | $0 copay per visit | 20% coinsurance |

## Additional supplemental benefits, services, and discounts

| Additional covered benefits and services | Members pay: |
|---|---|
| **Foreign travel emergency (outside U.S. territories)**<br>Emergency care | $40 copay per visit,<br>72 hours cost share waived if admitted for the same condition |
| Urgently needed services | $15 copay per visit,<br>72 hours cost share waived if admitted for the same condition |
| Inpatient emergency care | $0 copay per admission,<br>60 days per lifetime |
| **Health and wellness programs SilverSneakers®**<br>Take virtual fitness classes at home or visit us at a participating gym. | $0 copay per visit |
| **Healthy Meals**<br>Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition* | $0 copay per qualifying event,<br>14 meals per qualifying event,<br>four (4) events per year,<br>56 meals in total |
| **Medicare Community Resource Support** | $0 copay per visit |

* 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.

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