

# Blue Cross and Blue Shield of Nebraska Retiree Group MA PPO

2024

## BENEFITS-AT-A-GLANCE

**Jan. 1, 2024 - Dec. 31, 2024**

This information is not a complete description of benefits. Call **888-488-9850/TTY 711** for more information. A complete list of services is available in the Evidence of Coverage. You may review the Evidence of Coverage online or by calling Customer Service (The website and phone numbers are printed on the back cover of this booklet).

To join **Blue Cross Blue Shield of Nebraska Retiree Group MA PPO**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area of all 50 states and U.S. territories.

**Blue Cross Blue Shield Nebraska Retiree Group MA PPO** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

For more detailed information about our providers and our provider directory, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at **Medicare.NebraskaBlue.com**.

Blue Cross and Blue Shield of Nebraska is a PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of Nebraska Medicare Advantage depends on contract renewal.



**Medicare.NebraskaBlue.com**

## Blue Cross Blue Shield Nebraska Retiree Group MA PPO

| Premium              | In-network | Out-of-network | What You Should Know                                   |
|----------------------|------------|----------------|--|
| Monthly Plan Premium | \$175      |                | You must continue to pay your Medicare Part B premium. |

| Medical Benefits   | In-network  | Out-of-network  | What You Should Know   |
|--|---|---|--|
| Deductible   | \$0   |   | This plan does not have a deductible.  |
| Maximum Out-of-Pocket Responsibility (does not include prescription drugs) | \$4,500 annually  | \$6,900 combined in-network and out-of-network annually | If you reach the limit for Medicare-covered services on out-of-pocket costs, and you keep getting Medicare-covered hospital and medical services we will pay the full cost for the rest of the year.<br>You will still need to pay your monthly plan premiums, Medicare Part B premiums, and cost sharing for your Part D drugs. |
| Doctor Visits: primary care  | You pay a \$0 copay in-person and by telehealth   | You pay a \$15 copay in-person and by telehealth        |  |
| Doctor Visits: specialists   | You pay a \$30 copay in-person and by telehealth  | You pay a \$40 copay in-person and by telehealth        |  |
| Nurse Hotline  | You pay a \$0 copay for the Nurse Hotline   |   | Available 24 hours a day, 7 days a week.   |
| Dental   | You pay a \$40 copay for Medicare-covered dental services. Preventive and comprehensive services \$1,750 annual maximum reimbursement benefit for covered services. |   | Preventive and Comprehensive Dental Services are covered as a member-reimbursed benefit.   |

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| Medical Benefits         | In-network  | Out-of-network   | What You Should Know   |
|--------------------------|---|--|--|
| Vision                   | <p>You pay a \$30 copay for Medicare-covered vision eye exams.</p> <p>You pay a \$0 copay for routine eye or diabetic retinopathy exam</p> <p>\$200 allowance every two years</p> <p>Allowance amount inclusive of the In-network and Out-of-network goods and services.</p>  | <p>You pay a \$40 copay for Medicare-covered eye exams.</p> <p>You pay a 50% coinsurance for routine eye exam</p> <p>You pay a \$0 copay for diabetic retinopathy exam</p> <p>50% coinsurance allowance on eye wear (not to exceed \$200 annually subject to specific limits. Allowance amount inclusive of the In-network and Out-of-network goods and services.)</p> | VSP Vision Care providers represent the plan's vision network. Routine vision care must be provided by a VSP provider for services to be considered in-network. To locate a VSP provider you can access <b>VSP.com</b> or by calling 855-492-9028. |
| Hearing                  | <p>You pay a \$5-\$30 copay for Medicare-covered hearing exams.</p>   | <p>You pay a \$15-\$40 copay for Medicare-covered hearing exams.</p>   |  |
|                          | <p>You pay a \$0 copay for routine hearing exam; once per year</p> <p>\$500 hearing aid allowance, per ear, every three years</p>   |  |  |
| Urgently Needed Services | <p style="text-align: center;"><b>Within U.S.</b></p> <p>You pay a \$60 copay, in-person and telehealth services</p> <p style="text-align: center;"><b>Outside of the U.S.</b></p> <p>You pay a \$90 copay</p> <p>\$50,000 lifetime limit inclusive of worldwide emergency, urgent care and transportation</p>  |  |  |
| Emergency Care           | <p style="text-align: center;"><b>Within U.S.</b></p> <p>You pay a \$90 copay</p> <p>If you are admitted to the hospital within 3 days for the same condition, you will pay a \$0 copay for the emergency room visit.</p> <p style="text-align: center;"><b>Outside of the U.S.</b></p> <p>You pay a \$90 copay</p> <p>\$50,000 lifetime limit inclusive of emergency, urgent care and transportation outside of the U.S.</p> |  |  |
| Outpatient Services      | <p>You pay a \$200 copay for Medicare-covered ambulatory surgical center services</p> <p>You pay a \$350 copay for Medicare-covered outpatient hospital services</p>  |  | Services (including non-surgical services) may require prior authorization.  |

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| Medical Benefits  | In-network  | Out-of-network   | What You Should Know  |
|---|---|--|---|
| Ambulance services (ground & air)   | <p><b>Within U.S.</b><br/>You pay a \$325 copay</p> <p><b>Outside of the U.S.</b><br/>You pay \$90 copay<br/>\$50,000 lifetime limit inclusive of worldwide emergency, urgent care and transportation</p> |  | Non-emergency ambulance trips may require prior authorization. Copay is for each one-way trip for Medicare-covered services.  |
| Inpatient acute hospital care   | <p>You pay a \$420 copay for days 1-4<br/>You pay a \$0 copay for days 5-90+</p>  |  | Services may require prior authorization.   |
| Skilled nursing facility (in a Medicare-certified skilled nursing facility) | <p>Days 1-20: \$0 copay<br/>Days 21-46: \$179 copay<br/>Days 47-100: \$0 copay</p>  | <p>Days 1-20: \$0 copay<br/>Days 21-59: \$179 copay<br/>Days 60-100: \$0 copay</p> | Services may require prior authorization.   |
| Durable medical equipment   | You pay a 20% coinsurance   |  | Medical equipment/supplies may require prior authorization.   |
| Diabetic Supplies and Services  | You pay a 0%-20%  |  | No cost-share for preferred brands.   |
| Annual Physical Exam  | You pay a \$0 copay   |  | Coverage for one physical exam per year.  |
| Preventive services   | You pay a \$0 copay   |  | There is no coinsurance, copayment, or deductible for Medicare-covered preventive services.   |
| Chiropractic care   | <p>You pay a \$20 copay for Medicare-covered services and routine care</p> <p>You pay a \$0 copay annually for one set of X-rays; up to three views</p>   |  |   |
| Acupuncture services  | You pay a \$20 copay for Medicare-covered services  |  | Services may require prior authorization.   |
| Over-the-Counter (OTC) Items  | <p>You pay a \$50 quarterly allowance</p> <p>The quarterly allowance balance does not rollover into the next quarter.</p>   |  | Members may obtain authorized OTC items using a prepaid card and from vendor at retail locations and via mail, phone and website. Members may access their OTC benefit through a program that delivers to their home. |

Not a complete description of benefits. Please see Evidence of Coverage for details.

## Blue Cross Blue Shield Nebraska Retiree Group MA PPO

| Part D Prescription Drugs*             |   |                                |
|--|---|--------------------------------|
| Deductible Stage                       | \$0 Deductible  |                                |
| Initial Coverage Stage                 | Standard Retail Rx<br>30-day supply   | Mail Order Rx<br>90-day supply |
| <b>TIER 1</b><br>Preferred generic     | You pay \$0 for 30-day<br>Preferred Retail  | You pay \$0                    |
| <b>TIER 2</b><br>Generic               | You pay \$14  | You pay \$0                    |
| <b>TIER 3</b><br>Preferred brand       | You pay \$47  | You pay \$141                  |
| <b>TIER 4</b><br>Non-preferred         | You pay \$100   | You pay \$300                  |
| <b>TIER 5</b><br>Specialty             | You pay 33%   | N/A                            |
| <b>Catastrophic<br/>Coverage Stage</b> | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$8,000, you pay nothing for covered Part D drugs. |                                |

\* You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier. You won't pay more than \$105 for a 90-day supply of each covered insulin product regardless of the cost-sharing tier.

## Need more information?

For more information, please call us at the phone number below or visit us at **Medicare.NebraskaBlue.com**.

If you are a member of this plan, call toll-free **888-488-9850 (TTY users should call 711)**.

- From Oct. 1 to March 31, you can call us 7 days a week, 8 a.m. to 9 p.m. CT.
- From April 1 to Sept. 30, you can call us Monday through Friday, 8 a.m. to 9 p.m. CT.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **Medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. **TTY users should call 1-877-486-2048.**

This document is available in other formats such as large print by calling the customer service phone number.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Blue Shield Nebraska Retiree Group MA PPO members, except in emergency situations. Please call our customer service number or see the Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.



An independent licensee of the Blue Cross and Blue Shield Association