2027

READY TO HELP

Medicare Plus Blue[SM] PPO
Giveback

Summary of Benefits

To get a complete list of services we cover, call Customer Service and ask for the *Evidence of Coverage* (phone numbers are printed on the back cover of this booklet).

To join Medicare Plus Blue PPO Giveback, you must have both Medicare Part A and Medicare Part B, be a United States citizen or lawfully present in the United States and live in our geographic service area. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it. Our service area includes certain counties in the state of Michigan.

bcbsm.com/medicare

Medicare Plus Blue PPO Giveback has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at **bcbsm.com/medicare**.

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

Premium/Cost-sharing Table for Medicare Plus Blue PPO

Giveback

You must continue to pay your Medicare Part B premium. **A Medicare Part B premium reduction of $50 is provided. Your monthly premium rate for Medicare Plus Blue Giveback is $0.**

Regions with Counties	Medicare Plus Blue premium rates per month Giveback
Allegan, Barry, Berrien, Branch, Calhoun, Cass, Genesee, Gratiot, Hillsdale, Ionia, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Montcalm, Muskegon, Oakland, Ottawa, Shiawassee, St. Clair, St. Joseph, Van Buren, Washtenaw, and Wayne counties	$0
Optional Supplemental Dental and Vision	$27.10 (additional monthly premium)

Region 5 is not being used at this time.

Benefits	Giveback
Deductible	$650 annual In-network deductible for hospital and medical services.
	$0 deductible on Part D prescription drugs in Tiers 1 and 2. $600 total deductible per year for Tiers 3, 4 and 5.
Deductible - Optional Supplemental Dental and Vision	There is no deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$9,250 for services from in-network providers $11,000 for services from any provider

Note: Services with a [1] may require prior authorization	
Benefits	**Giveback**
Inpatient Hospital Coverage[1]	**For Medicare-covered inpatient hospital per admission:** **In-network:** Days 1-7: $385 copayment, after deductible, per day. Days 8-90: $0 copayment, after deductible, per day. **Out-of-network:** 50% coinsurance
Outpatient Hospital Coverage[1]	**In-network:** $425 copayment, after deductible **Out-of-network:** 50% coinsurance
Ambulatory Surgical Center (ASC) Services[1]	**In-network:** $325 copayment, after deductible **Out-of-network:** 50% coinsurance
Doctor Visits • Primary	**In-network:** $0 copayment **Out-of-network:** $25 copayment
• Specialists[1]	**In-network:** $55 copayment, after deductible **Out-of-network:** 50% coinsurance
• Telehealth	$0 copayment for each telehealth primary care physician medical visit through plan-approved vendor. $0 copayment for each telehealth mental health visit through plan-approved vendor.
Preventive Care (Any additional preventive services approved by Medicare during the contract year will be covered.)	**In- and Out-of-network:** $0 copayment Our plan covers many preventive services, including:
	• Abdominal aortic aneurysm screening

Benefits	Giveback
	• Alcohol misuse counseling • Annual physical exam • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings • Depression screening • Diabetes screenings • Diabetes self-management training • Glaucoma screening • HIV screening • Immunizations, including COVID-19, flu, hepatitis B, and pneumococcal vaccines • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and counseling • Pre-exposure prophylaxis (PrEP) for HIV prevention • Prostate cancer screenings (PSA) • Screening for lung cancer with low-dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • “Welcome to Medicare” preventive visit (one-time)

Benefits	Giveback
Emergency Care	**In-network:** $115 copayment **Note**: The copayment is waived if you are admitted to the hospital within three days for the same condition. You are covered for emergency medical care worldwide.
Urgently Needed Services You are covered for urgently needed services worldwide.	$40 copayment at urgent care center $0 copayment at primary care physician's office
Diagnostic Services/Labs/ Imaging[1] – Medicare-covered • Diagnostic radiology services	**In-network:** $150-$325 copayment, after deductible **Out-of-network:** 50% coinsurance
• Lab services	**In-network:** $0-$40 copayment, after deductible **Out-of-network:** 50% coinsurance
• Diagnostic tests and procedures including COVID-19 testing	**In-network:** $0-$150 copayment, after deductible **Out-of-network:** $0-$50 copayment/50% coinsurance for each covered service
• Outpatient X-rays	**In-network:** $35-$150 copayment, after deductible **Out-of-network:** 50% coinsurance
• Therapeutic radiology services	**In-network:** $45 copayment, after deductible **Out-of-network:** 50% coinsurance

Benefits	Giveback
Hearing Services Medicare-covered hearing services • Hearing exam to diagnose and treat hearing and balance issues	**In-network:** $0-$55 copayment, after deductible **Out-of-network:** 50% coinsurance
Non-Medicare-covered hearing services Must be received from a TruHearing® provider. • Routine hearing exam – 1 per year. • Fitting and evaluation for hearing aids. Each hearing aid purchase includes one year of follow-up provider visits for fitting and adjustments. These visits are available for 12 months following hearing aid purchase and only with the purchase of a hearing aid. • One hearing aid per ear once a year. Up to two hearing aids, (limit one hearing aid per ear per year) from the applicable TruHearing catalog. All content ©2026 TruHearing, Inc. All Rights Reserved. TruHearing® is a registered trademark of TruHearing, Inc.	**In-network:** $0 copayment for routine hearing exam once per year $0 copayment for hearing aid fitting/evaluation. Each hearing aid purchase includes one year of follow-up provider visits for fitting and adjustments. These visits are available for 12 months following hearing aid purchase and only with the purchase of a hearing aid. Hearing aids (one hearing aid per ear once a year): $495 copayment per aid for Basic Aids $895 copayment per aid for Standard Aids $1,295 copayment per aid for Advanced Aids $1,695 copayment per aid for Premium Aids **Out-of-network:** Members who utilize out-of-network providers for supplemental hearing benefits may submit a reimbursement request through the plan-approved process to be reimbursed up to a plan-specified maximum amount. OTC hearing aids are excluded from coverage. Reimbursement: Routine hearing exam, once per year, reimbursed up to $5. Hearing aids, once per year, reimbursed, up to $25 per ear, per aid. No separate reimbursement is available for fitting and evaluation. Reimbursement form can be found online at: **bcbsm.com/medicare/find-care.**

Benefits	Giveback
Dental Services (Medicare-covered)	**In-network:** $0-$55 copayment, after deductible **Out-of-network:** 50% coinsurance
Enhanced dental services (Preventive only) • Preventive Services include oral exams, routine cleanings, certain dental X-rays and fluoride treatment	**In-network** $0 copayment **Out-of-network** 50% coinsurance
Dental – Optional Supplemental Dental (available at an additional monthly premium) Includes, but not limited to, dentures, bridges, onlays and implants	The Optional Supplemental Dental benefit provides a $1,500 annual maximum (in addition to the enhanced dental annual maximum) for combined in-network and out-of-network dental services per calendar year. **In-network:** 25% coinsurance **Out-of-network:** 50% coinsurance
Vision Services (Medicare-covered) • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) • Screening for diabetic retinopathy is covered once per year for those at risk	**In-network:** $0-$55 copayment, after deductible **Out-of-network:** 50% coinsurance
• Eyeglasses or contact lenses after cataract surgery	**In-network:** $0 copayment, after deductible **Out-of-network:** 50% coinsurance

Benefits	Giveback
Enhanced Vision Services • Routine eye exam through VSP Choice Network, one per calendar year	**In-network:** $0 copayment, after deductible **Out-of-network:** 50% coinsurance
Optional Supplemental Vision (available at an additional monthly premium) Standard eyeglass lenses are covered in full once every calendar year. You are eligible for ONE of the following, every calendar year: • Elective contact lenses OR • One frame	The benefit provides a $250 combined in- and out-of-network annual maximum (in addition to the enhanced vision benefit) once every calendar year and may be used for either (a) elective contact lenses or (b) one frame. Lens options for eyeglasses include polycarbonate lenses and/or anti-reflective coating covered in-network.
Inpatient Mental Health Care[1]– Medicare-covered 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 services provided in a general hospital.	**In-network:** Days 1-7: $295 copayment, after deductible, per day, per admission. Days 8-90: $0 copayment, after deductible, per day. **Out-of-network:** 50% coinsurance
Outpatient Mental Health Care Individual and group therapy	**In-network:** $50 copayment, after deductible **Out-of-network:** 50% coinsurance
Skilled Nursing Facility (SNF)[1]– Medicare-covered Our plan covers up to 100 days in a SNF. No prior hospital stay is required for a skilled nursing facility stay.	**In-network:** Days 1-20: $0 copayment, after deductible, per day. Days 21-100: $221 copayment, after deductible, per day. **Out-of-network:** 50% coinsurance

Benefits	Giveback
Outpatient Rehabilitation[1] • Occupational therapy • Physical therapy and speech therapy	**In-network:** $35 copayment, after deductible, for Occupational therapy $55 copayment, after deductible, for Physical/Speech therapy **Out-of-network:** 50% coinsurance
Ambulance Services • Ground or air transportation • Ambulance services without transportation	**In- and Out-of-network** $360 copayment, after deductible **In-network** $90 copayment **Out of network** 50% coinsurance
Transportation Services	Not offered
Medicare Part B Drugs[1] • Medicare Part B Insulin Drugs (one-month's supply)	**In-network:** 0%-20% coinsurance **Out-of-network:** 0%-50% coinsurance
	In-and Out-of network: Not more than $35 per month
• Chemotherapy drugs and other Part B drugs	**In-network:** 0%-20% coinsurance **Out-of-network:** 0%-50% coinsurance
Medical Equipment/ Supplies[1] • Durable Medical Equipment and Prosthetics and Orthotics	**In-network:** 20% coinsurance, after deductible **Out-of-network:** 50% coinsurance

Benefits	Giveback
• Diabetes supplies	**In-network:** 0%-20% coinsurance **Out-of-network:** 0%-40% coinsurance

Giveback

Medicare Part D: Prescription Drugs

Costs may differ based on pharmacy type (standard, preferred or mail-order).
Your provider may need to obtain prior authorization

Stage 1: Deductible Stage

$0 deductible on Part D prescription drugs in Tiers 1 and 2. $600 total deductible per year for Tiers 3, 4 and 5. Deductible does not apply to insulins.

Stage 2: Initial Coverage Stage

You pay the amounts listed in the table below until your out-of-pocket costs reach $2,400.

	Standard retail and standard mail-order cost sharing (in-network) 31-day supply	**Preferred retail and preferred mail-order cost sharing (in-network) 31-day supply**	**Standard retail and standard mail-order cost sharing(in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)**	**Preferred retail and preferred mail-order cost sharing (in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)**
Tier 1: Preferred Generic	$5	$0	$15	$0
Tier 2: Generic	$6	$0	$18	$0
Tier 3: Preferred Brand	20%	20%	20%	20%
Tier 4: Non-Preferred	21%	21%	21%	21%
Tier 5: Specialty	26%	26%	Not Offered	Not Offered

*Tier 1 drugs allow for a 100-day supply at the same cost share as a 90-day supply. If you are taking Tier 1 drug, talk to your doctor about whether it's appropriate to get a new prescription for a 100-day supply.

You won't pay more than $35 for a 31-day supply and no more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

Stage 3: Catastrophic Coverage Stage	You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your *Evidence of Coverage*. You can also see our plan's pharmacy directory at our website **bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit **bcbsm.com/formularymedicare**.

For more information, please call us at the phone number below or visit us at **bcbsm.com/medicare**.

If you are not a member of this plan, call toll-free 1-888-563-3307. TTY users should call 711.

If you are a member of this plan, call toll-free 1-877-241-2583. TTY users should call 711. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 9 p.m. Eastern time. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. Eastern time.

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 audio CD and large print. This document may be available in a non-English language.

Medicare PLUS Blue℠ PPO

Blue Cross Blue Shield of Michigan