

2026

READY
TO HELP



Medicare Plus BlueSM 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.

www.bcbsm.com/medicare

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

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 www.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 \$70 is provided.**

- 1) Find the county that you live in.
- 2) Look across the column to find your monthly premium rate.

Counties	Medicare Plus Blue Giveback premium rates per month
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	\$30.50

Benefits	Medicare Plus Blue Giveback
Deductible	\$650 annual deductible for hospital and medical services In-Network \$150 annual deductible for Tiers 3, 4 and 5 for Part D prescription drugs
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		Medicare Plus Blue Giveback	
Inpatient Hospital Coverage¹ Our plan covers an unlimited number of days for an inpatient stay.		In-network: \$385 copay per day, after deductible, for days 1-7, per admission \$0 copay per day, after deductible, for days 8 and beyond Out-of-network: 50% of approved amount for days 1-7, per admission \$0 copay for days 8-90	
Outpatient Hospital Coverage¹		In-network: \$425 copay, after deductible Out-of-network: 50% of the approved amount	
Ambulatory Surgical Center (ASC) Services¹		In-network: \$325 copay, after deductible Out-of-network: 50% of the approved amount	
Doctor Visits ○ Primary ○ Specialists ○ Telehealth		In-network: \$0 copay Out-of-network: \$25 copay In-network: \$55 copay, after deductible Out-of-network: 50% of the approved amount \$0 copay for each telehealth primary care physician medical visit through Teladoc Health. \$0 copay for each telehealth mental health visit through Teladoc Health.	

Benefits		Medicare Plus Blue Giveback	
Preventive Care (Any additional preventive services approved by Medicare during the contract year will be covered.)	In- and Out-of-network: \$0 copay Our plan covers many preventive services, including:		
	• Abdominal aortic aneurysm screening • 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 (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • 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)	
Emergency Care You are covered for emergency medical care worldwide.	\$115 copay The copay is waived if you are admitted to the hospital within three days for the same condition.		
Urgently Needed Services You have coverage for worldwide urgently needed services.	\$40 copay at urgent care center \$0 copay at primary care physician’s office		

Benefits	Medicare Plus Blue Giveback
Diagnostic Services/Labs/Imaging¹ ○ Diagnostic radiology services ○ Lab services ○ Diagnostic tests and procedures including COVID-19 testing ○ Outpatient X-rays ○ Therapeutic radiology services	In-network: \$150-\$325 copay, after deductible In-network: \$0-\$40 copay, after deductible In-network: \$0-\$150 copay, after deductible In-network: \$35-\$150 copay, after deductible In-network: \$45 copay, after deductible Out-of-network: \$0/\$55/50% of approved amount for covered services listed above
Hearing Services Medicare-covered hearing services ○ Hearing exam to diagnose and treat hearing and balance issues Non-Medicare-covered hearing services Must be received from a TruHearing[®] provider. ○ Routine hearing exam (1 every year) ○ Hearing aid fitting/evaluation (1 every year) ○ Hearing aids (1 per ear, per year) from applicable TruHearing catalog All content ©2026 TruHearing, Inc. All Rights Reserved. TruHearing[®] is a registered trademark of TruHearing, Inc.	In-network: \$0 copay from a primary care provider \$55 copay, after deductible, from a specialist Out-of-network: 50% of approved amount for covered services In-network: \$0 copay \$0 copay \$495 copay per aid for Basic Aids \$895 copay per aid for Standard Aids \$1,295 copay per aid for Advanced Aids \$1,695 copay per aid for Premium Aids

Benefits		Medicare Plus Blue Giveback	
Dental Services (Medicare-covered)		In-network: \$0 copay from a primary care provider \$55 copay, after deductible, from a specialist Out-of-network: 50% of the approved amount for covered services	
Enhanced Dental Services (Preventive) Preventive services include oral exams, routine cleanings, certain dental X-rays and fluoride treatment		In-network: \$0 copay Out-of-network: 50% of the approved amount for covered services	
Optional Supplemental Dental (available for additional monthly premium) Includes, but not limited to, dentures, bridges, onlays and implants		The benefit provides a \$1,500 combined in- and out-of-network annual maximum for comprehensive dental services. No deductible. In-network: 25% of the approved amount Out-of-network: 50% of the approved amount	
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. - Eyeglasses or contact lenses after cataract surgery		In-network: \$0 copay from a primary care provider \$55 copay, after deductible, from a specialist Out-of-network: 50% of the approved amount for covered services In-network: \$0 copay Out-of-network: 50% of the approved amount	
Enhanced Vision Services Routine eye exam through VSP Choice Network, once per year		In-network: \$0 copay Out-of-network: 50% of the approved amount	

Benefits	Medicare Plus Blue Giveback
Optional Supplemental Vision (available for additional monthly premium) You are eligible for ONE of the following, every calendar year: • Elective contact lenses OR • One pair of standard eyeglass lenses OR • One frame OR • One complete pair of eyeglasses For a complete pair of eyeglasses, the allowance can be used for the frame only. Routine vision care must be from a participating VSP Choice Network provider. To locate a VSP Choice Network provider, call 1-800-877-7195 from 8 a.m. to 11 p.m. Eastern time, Monday through Saturday, hearing impaired users call 711, or visit www.vsp.com.	In-network: The benefit provides a \$250 combined in- and out-of-network maximum once every calendar year and may be used for either (a) elective contact lenses or (b) one frame. Includes lens options: polycarbonate lenses and anti-reflective coating. Out-of-network: The benefit provides a combined in- and out-of-network maximum with 50% of the approved amount up to \$250 every calendar year and may be used for either (a) elective contact lenses or (b) frames. For out-of-network services, you may be required to pay the cost up front and submit for reimbursement. Other limitations apply.
Inpatient Mental Health Care¹ 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: \$295 copay per day, after deductible, for days 1-7, per admission \$0 copay per day, after deductible, days 8 and beyond Out-of-network: 50% of the approved amount
Outpatient Mental Health Care Individual and group therapy	In-network: \$50 copay, after deductible Out-of-network: 50% of the approved amount
Skilled Nursing Facility (SNF)¹ Our plan covers up to 100 days in a SNF. No prior hospital stay is required for a skilled nursing facility stay.	In-network: \$0 copay per day, after deductible, for days 1-20 \$218 copay per day, after deductible, for days 21-100 Out-of-network: 50% of approved amount

Benefits	Medicare Plus Blue Giveback
Outpatient Rehabilitation - Physical therapy and speech therapy - Occupational therapy	In-network: \$55 copay, after deductible Out-of-network: 50% of the approved amount In-network: \$35 copay, after deductible Out-of-network: 50% of the approved amount
Ambulance Services - Ground or air transportation - Ambulance services without transportation	In- and Out-of-network \$360 copay, after deductible In-network: \$90 copay Out-of-network: 50% of the approved amount
Transportation Services	Not offered
Medicare Part B Drugs¹ - Medicare Part B Insulin Drugs (one-month's supply) - Chemotherapy drugs and other Part B drugs	In-network: 0%-20% of approved amount; however, no more than \$35 per month Out-of-network: 0%-50% of approved amount; however, no more than \$35 per month In-network: 0%-20% of approved amount, after deductible Out-of-network: 0%-50% of approved amount
Medical Equipment/Supplies¹ - Durable Medical Equipment - Prosthetics and Orthotics/ Medical supplies - Diabetes supplies	In-network: 0%-20% of the approved amount, after deductible Out-of-network: 0%-50% In-network: 20% of the approved amount, after deductible Out-of-network: 50% of the approved amount In-network: 0%-20% of approved amount, after deductible Out-of-network: 0%-40% of approved amount

Outpatient Prescription Drugs - Giveback

Phase 1: The Deductible Stage

No deductible for Tiers 1 and 2. \$150 total deductible per year for Tiers 3, 4 and 5. Deductible does not apply to insulin.

Phase 2: The Initial Coverage Stage

You pay the amounts listed in the tables below, and on the next page, until your out-of-pocket costs reach \$2,100.

Your share of the cost when you get a *one-month* (31-day) supply of a covered Part D prescription drug:

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	\$5	\$0
Tier 2: Generic	\$12	\$7
Tier 3: Preferred Brand	20%	20%
Tier 4: Non-Preferred Drug	30%	30%
Tier 5: Specialty Tier	31%	31%

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

Your share of the cost when you get a *long-term* (32- to 90-day) supply of a covered Part D prescription drug:

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail cost sharing (in-network)	Preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	\$15	\$0	\$0
Tier 2: Generic	\$36	\$0	\$0
Tier 3: Preferred Brand	20%	20%	20%
Tier 4: Non-Preferred Drug	30%	30%	30%
Tier 5: Specialty Tier	Not offered	Not offered	Not offered

You won't pay more than \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online at www.bcbsm.com/medicare.

Phase 3: The Catastrophic 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 information about your costs in this stage, look at Chapter 6 in the *Evidence of Coverage* online at www.bcbsm.com/medicare.

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website (www.bcbsm.com/pharmaciesmedicare).

You can see the most complete and current information about which drugs are covered on our website (www.bcbsm.com/formularymedicare).

For more information, please call us at the phone number below or visit us at www.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 www.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 BlueSM PPO



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