READY TO HELP

Pre-Enrollment Checklist

Before making an enrollment decision, it's important that you fully understand our benefits and rules. If you have any questions, call a Customer Service representative at 1-800-565-1770, from 8 a.m. to 9 p.m. Eastern time, seven days a week, from October 1 through March 31; 8 a.m. to 9 p.m. Eastern time, Monday through Friday, from April 1 through September 30. TTY users, call 711.

If you are not a member of this plan, you can call 1-833-844-3871, from 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31. TTY users should call 711

Understanding the benefits

- ☐ The *Evidence of Coverage* provides a complete list of all coverage and services. It's important to review plan coverage, costs and benefits before you enroll. Visit **bcbsm.com/medicare** or call 1-800-565-1770 (TTY users call 711) to view a copy of the EOC.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding important rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums, copayments and coinsurance may change on January 1, 2027.
- ☐ **Effect on current coverage**. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Prescription Blue℠ PDP 2026 Individual Enrollment Form

Prescription Blue℠ PDP

Blue Cross Blue Shield of Michigan

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Prescription Drug Plan, you must also have either or both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare or 3 months prior
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Prescription Blue PDP
P.O. Box 44828
Detroit, MI 48244-0828

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Prescription Blue at **1-833-844-3871**. TTY users can call **711**.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Prescription Blue al **1-833-844-3871 / 711** o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

S5584_26PDPEnrlForm_C CMS Approved 09032025 R1
OMB No. 0938-1378
Expires: 12/31/2026

DF 21002 SEP 25

Section 1 – All fields in this section are required (unless marked optional)

Select the PDP plan you want to join:

☐ **Select – $78.40 per month** ☐ **Premium – $106.70 per month**

First name	Last name	(Optional) Middle initial
Birth date (mm/dd/yyyy)	Sex ☐ M ☐ F	Phone number

Permanent residence street address (Don't enter a PO Box. **Note:** For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)

City	(Optional) County	State	ZIP code

Mailing address, if different from your permanent address (PO Box allowed)

Street address	City	State	ZIP code

Email address (optional)

Your Medicare information

Medicare number: __ __ __ __ – __ __ __ – __ __ __ __

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Prescription Blue?

☐ Yes ☐ No

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage _____

Special enrollment periods: Please check the box that applies to you.

Typically, you may enroll in a Medicare prescription drug plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the annual enrollment period. **Please read the following statements carefully and check the box if the statement applies to you**. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. (Date of Medicare Entitlement Letter) _____.

☐ I had Medicare prior to now, but I'm now turning 65.

☐ Between 1/1-3/31: I'm in a Medicare Advantage Plan and want to make a change.

☐ Between 4/1-12/31: I'm in a Medicare Advantage Plan and have had Medicare for less than 3 months. I want to make a change.

☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date). _____.

☐ I recently was released from incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I am moving into a long-term care facility, like a nursing home or rehabilitation hospital. I will move into the facility on (insert date) _____.

☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital.

☐ I recently moved out of a long-term care facility, like a nursing home or a rehabilitation hospital. I moved out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

Special enrollment periods *(continued)*

- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ☐ I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan. My plan went into receivership on (insert date) _____.
- ☐ I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.
- ☐ I requested Medicare information in an accessible format. I got less time to make my decision, or I didn't get it in time to make a choice before my enrollment period ended.
- ☐ I lost my Medicare Advantage Plan with drug coverage because I lost Medical (Part B) coverage. I want to join a Medicare drug plan.
- ☐ I dropped my Cost Plan with drug coverage and switched to Original Medicare. I want to join a Medicare drug plan.
- ☐ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1 - March 31 each year). I want to join a Medicare Drug Plan (Part D) or Medicare Advantage Plan with drug coverage.
- ☐ I signed up for a Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare drug plan (Part D).
- ☐ I dropped a Medicare Supplement Insurance (Medigap) policy when I first joined a Medicare Advantage Plan. It's been less than 12 months since I left my Medigap policy. I want to switch to Original Medicare so I can go back to my Medigap policy, and I'm joining a Drug Plan (Part D).
- ☐ I joined a Medicare Advantage Plan with drug coverage when I turned 65. It's been less than 12 months since I joined this plan. I want to switch to Original Medicare, and I'm joining a Drug Plan.
- ☐ I have Medicare and Medicaid, or I get Extra Help paying for Medicare drug costs. I want to switch to a different Medicare drug plan.
- ☐ I have Medicare and Medicaid, or I get Extra Help paying for Medicare drug coverage. I want to drop my Medicare Advantage Plan with drug coverage and return to Original Medicare and join a separate Medicare drug plan.
- ☐ I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ Other

If none of these statements applies to you or you're not sure, please contact Prescription Blue at **1-833-844-3871** (TTY users should call **711**) to see if you are eligible to enroll. We are open from 8 a.m. to 9 p.m. Eastern time Monday through Friday, with weekend hours Oct. 1 through March 31.

IMPORTANT: Read and sign below

- I must keep Hospital (Part A) or Medical (Part B) to stay in Prescription Blue.
- By joining this Medicare Prescription Drug Plan, I acknowledge that Prescription Blue will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

  1) This person is authorized under state law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature	**Today's date**

If you're the authorized representative, sign above and fill out these fields:

Name	Address
Phone number	Relationship to enrollee

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

☐ English (default) ☐ Spanish ☐ Other (language other than English)

Select one if you want us to send you information in an accessible format.

☐ Large print ☐ Audio CD ☐ Data CD

Please call Prescription Blue PDP at **1-800-565-1770** (TTY users, call **711**) if you need information in an accessible format or language other than what's listed above. Our office hours are from 8 a.m. to 9 p.m. Monday through Friday, with weekend hours from October 1 through March 31.

Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic or health center:

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or automatic withdrawal from your bank account each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month**.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare or the RRB. DON'T pay Prescription Blue PDP the Part D-IRMAA.

Please select a premium payment option:

☐ Get a bill each month.

You may choose from the following payment methods:

- **Pay online:** To learn how to pay your premium online, go to **bcbsm.com/paymedicare**. Members can make one-time payments or set up automatic withdrawals from a bank account or credit/debit card.
- **Pay by phone:** To make a one-time payment or set up an automatic withdrawal from a bank account or credit/debit card, call Customer Service at **1-800-565-1770**, from 8 a.m. to 9 p.m. Eastern time Monday through Friday, with weekend hours from October 1 through March 31. TTY users call **711**.
- **Pay by mail:** Mail your check, cashier's check or money order made payable to:
  Blue Cross Blue Shield of Michigan
  P.O. Box 553912
  Detroit, Michigan 48255-3912

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or the RRB approves the deduction. Please pay any premium bills prior to your Social Security/Railroad Retirement Board deduction effective date. If Social Security/the RRB doesn't approve your request for automatic deduction, we'll send you a paper bill for your monthly premiums.)

For individuals helping enrollee with completing this form only	
Complete this section if you're an individual (i.e. agent, broker, SHIP counselor, family member or other third party) helping an enrollee fill out this form.	
Name	Relationship to enrollee
Signature	National Producer Number (Agents/Brokers only)

AGENT/OFFICE USE ONLY (Applicants do not complete this section)

Note to producing agents: Paper enrollment forms must be keyed in by logging into the BCBSM Agent Portal at **bcbsm.com/agents/** or submitted to the general agent within 24 hours of accepting the paper enrollment form.

Date producing agent accepted paper enrollment from Medicare eligible: _____

Date managing or general agent or association received paper enrollment form from producing agent: _____

Name of managing/general agent or association: _____

Name of producing agent (print first/last names): _____

First name *Last name*

Signature of producing agent: _____

Email of producing agent: _____

2-digit managing or general agent or association code: ___/___/

5-digit producing agent code: ___/___/___/___/___

I helped the applicant by partially or completely filling out the paper enrollment form on behalf of the applicant: ☐ Yes ☐ No

Name of person entering enrollment information online (print first/last names):

_____

First name *Last name*

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Prescription Blue℠ PDP

Select and Premium

Summary of Benefits

January 1, 2026 – December 31, 2026

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 Prescription Blue PDP, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, be a United States citizen or lawfully present in the United States and live in our 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 the state of Michigan.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **www.bcbsm.com/formularymedicare**.

Outpatient Prescription Drugs

Monthly Premium Amount

In addition to the amounts listed below, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party)

Prescription Blue Select	Prescription Blue Premium
$78.40	$106.70

Phase 1: The Deductible Stage

Prescription Blue Select:

You pay $615 per year for your Part D prescription drugs.

Prescription Blue Premium:

Because this plan has no deductible, this payment stage does not apply to you.

Phase 2: The Initial Coverage Stage

Prescription Blue Select:

After you pay your yearly deductible, you pay the amounts listed in the tables on the next page until your total out of pocket costs reach $2,100.

Prescription Blue Premium:

You pay the amounts listed in the tables on the next page until your total yearly drug 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, standard mail-order and long-term care (LTC) cost sharing (in-network)		Preferred retail and preferred mail-order cost sharing (in-network)	
	Select	**Premium**	**Select**	**Premium**
Tier 1: Preferred Generic	$6	$6	$1	$1
Tier 2: Generic	$10	$10	$5	$5
Tier 3: Preferred Brand	20%	24%	20%	24%
Tier 4: Non-Preferred Drug	25%	27%	25%	27%
Tier 5: Specialty Tier	25%	33%	25%	33%

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost sharing tier (Select plan only: even if you haven't paid your deductible).

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, standard mail-order and long-term care (LTC) cost sharing (in-network)		Preferred retail and preferred mail-order cost sharing (in-network)	
	Select	**Premium**	**Select**	**Premium**
Tier 1: Preferred Generic	$18	$18	$3	$2
Tier 2: Generic	$30	$30	$15	$10
Tier 3: Preferred Brand	20%	24%	20%	24%
Tier 4: Non-Preferred Drug	25%	27%	25%	27%
Tier 5: Specialty Tier	Not Offered	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 (Select plan only: even if you haven't paid your deductible).

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-evidence-of-coverage.**

Phases 3: Catastrophic Stage

Prescription Blue Select & Premium:

You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0 for the cost of the drug.

Most members do not reach the Catastrophic Coverage stage. For information about your costs in these stages, look at Chapter 4, Sections 6 and 7, in the *Evidence of Coverage* online at **www.bcbsm.com/medicare-evidence-of-coverage**.

Formulary (Drug List)

To view the formularies listed below and see if your drugs are included in the plan you are considering, visit our website at **www.bcbsm.com/formularymedicare**.

Prescription Blue Select:

2026 Core Comprehensive Formulary

Prescription Blue Premium:

2026 Core Comprehensive Formulary

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.

We have a network of pharmacies and you must generally use these 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**.

Or, call us and we will send you a copy of the pharmacy directory. Phone numbers for Customer Service are on the back cover of this booklet.

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 1-800-565-1770. 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.

Prescription Blue℠ PDP

Blue Cross Blue Shield of Michigan

Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face or telephone sales meeting to ensure understanding of what will be discussed between the agent and the Medicare member (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his or her authorized representative.

Please initial beside the products you want the agent to discuss.
(Refer to the following page for product descriptions.)

Stand-alone Medicare prescription drug plans (Part D)

Medicare Advantage plans (Part C)

Dental/vision/hearing products

Ancillary products (not Medicare-affiliated)

Medicare supplement (Medigap) products

By signing the form, you agree to meet with a sales agent to discuss the products you initialed above. The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work for the federal government. This individual may also be paid based on your enrollment in a plan. **Signing this form doesn't obligate you to enroll in a plan, affect your current or future enrollment status, or automatically enroll you in a Medicare plan.**

Member or authorized representative signature and signature date	
Signature	Signature date
If you are the authorized representative, please sign above and print below	
Representative name	Your relationship to the member
To be completed by agent	
Agent name	Agent phone
Member name	Member phone
Member address	
Initial method of contact (indicate here if member was a walk-in)	
Agent signature	
Plans represented by agent during meeting	Date appointment completed

Scope of Appointment documentation is subject to CMS record retention requirements.

Stand-alone Medicare prescription drug plans (Part D)
Medicare Prescription Drug Plan (PDP) – A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare cost plans, some Medicare private fee-for-service plans and Medicare medical savings account plans.
Medicare Advantage plans (Part C)
Medicare health maintenance organization (HMO) – A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare preferred provider organization (PPO) plan – A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare private fee-for-service (PFFS) plan – A Medicare Advantage plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare special needs plan (SNP) – A Medicare Advantage plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who live in nursing homes, and people who have certain chronic medical conditions.
Dental/vision/hearing products
Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.
Ancillary products
Critical illness and accident insurance – Plans offering coverage for consumers who have been diagnosed with a specific illness on a predetermined list. These plans are not affiliated or connected to Medicare. **Hospital indemnity insurance** – Plans that offer coverage each day you are hospitalized, up to a designated number of days. These plans are not affiliated with or connected to Medicare. **Travel insurance** – Plans offering additional benefits for consumers who travel outside the United States. These plans are not affiliated or connected to Medicare.
Medicare supplement (Medigap) products
Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

Out-of-network/non-contracted providers are under no obligation to treat Plan 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.

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S. Government Medicare Information

Blue Cross Blue Shield of Michigan - S5584

For 2025, Blue Cross Blue Shield of Michigan - S5584 received the following Star Ratings from Medicare:

Prescription Blue℠ PDP

Overall Star Rating:	★★★★☆
Health Services Rating:	Service not offered
Drug Services Rating:	★★★★☆

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at Medicare.gov/plan-compare.

Questions about this plan?

Contact Blue Cross Blue Shield of Michigan 7 days a week from 8:00 a.m. to 9:00 p.m. Eastern time at 888-563-3307 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time. Current members please call 800-565-1770 (toll-free) or 711 (TTY).

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

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

Notice of Availability

English: Call the phone number on the back of your member ID card to reach a complimentary interpreter who speaks English or to receive additional support you may need.

Spanish: Llame al número de teléfono que aparece en el reverso de su tarjeta de identificación de miembro para comunicarse de forma gratuita con un intérprete que hable español o para recibir apoyo adicional que pueda necesitar.

Arabic: اتصل برقم الهاتف الموجود على ظهر بطاقة هوية عضويتك للوصول إلى مترجم مجاني يتحدث باللغة العربية أو لتلقي المزيد من الدعم الذي قد تحتاجه.

Chinese Mandarin: 拨打您的会员 ID 卡背面的电话号码，即可联系一位会说普通话的免费翻译，或获取您可能需要的其他支持。

Albanian: Telefononi në numrin e telefonit që gjendet në anën e pasme të kartës suaj të anëtarësisë për t'u lidhur me një interpret pa pagesë që flet shqip ose për të marrë mbështetje shtesë që mund t'ju nevojitet.

German: Rufen Sie die Telefonnummer auf der Rückseite Ihres Mitgliedsausweises an, um einen kostenlosen Dolmetscher zu finden, der Deutsch spricht, oder um weitere Unterstützung zu erhalten.

Amharic: አማርኛ ከሚናገር ነጻ ተርጓሚ ጋር ለመገናኘት ወይም ሊያስፈልግዎ የሚችል ተጨማሪ ድጋፍ ለማግኘት ከአባል መታወቂያ ካርድዎ ጀርባ ያለው ስልክ ቁጥር ላይ ይደውሉ።

Bengali: বিনামূল্যে বাংলা ভাষায় কথা বলতে পারেন এমন একজন সহায়ক দোভাষীর সাথে যোগাযোগ করতে অথবা আপনার প্রয়োজনীয় অতিরিক্ত সহায়তা পেতে আপনার মেম্বারশিপ ID কার্ডের পিছনে দেওয়া ফোন নম্বরে কল করুন।

French: Appelez le numéro de téléphone figurant au dos de votre carte d'adhérent pour joindre un interprète gratuit qui parle français ou pour bénéficier d'un soutien supplémentaire dont vous pourriez avoir besoin.

Hindi: किसी ऐसे मानार्थ (कंप्लीमेंटरी) दुभाषिए से संपर्क करने के लिए जो हिंदी बोलता हो या ऐसी अतिरिक्त सहायता प्राप्त करने के लिए जिसकी आपको आवश्यकता हो सकती है, आपके सदस्य ID कार्ड के पीछे दिए गए फ़ोन नंबर पर कॉल करें।

Korean: 가입자 ID 카드 뒷면의 전화번호로 전화를 주시면 한국어 무료 통역사와 연결하시거나 필요한 추가 지원을 받으실 수 있습니다.

Polish: Zadzwoń pod numer telefonu znajdujący się z tyłu karty członkowskiej, aby skontaktować się z nieodpłatnym tłumaczem posługującym się językiem polskim lub aby – w razie potrzeby – uzyskać dodatkową pomoc.

Telugu: తెలుగు మాట్లాడే ఉచిత ఇంటర్‌ప్రెటీటర్‌తో కనెక్ట్ కావడానికి లేదా మీకు అవసరం కాగల అదనపు మద్దతును పొందడానికి మీ మెంబర్ ID కార్డు వెనుక ఉండే ఫోన్ నెంబర్‌కు కాల్ చేయండి.

Vietnamese: Xin gọi số điện thoại ghi ở mặt sau thẻ ID thành viên của quý vị để kết nối với một thông dịch viên tiếng Việt miễn phí hoặc để được hỗ trợ thêm nếu quý vị cần

Pennsylvania Dutch: Call der Number as uff die hinnerscht Seit vun dei Member ID Card is fer schwetze mit en Interpreter as Deitsch schwetzt odder fer ennichi Hilf griege as du brauchscht. Des zellt dich nix koschde.

Tagalog: Tumawag sa numero ng telepono sa likod ng member ID card mo para makipag-ugnayan sa isang walang bayad na interpreter na nagsasalita ng Tagalog o para makatanggap ng karagdagang suporta na maaaring kailanganin mo.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Discrimination is against the law

Blue Cross Blue Shield of Michigan, Blue Care Network and our vendors comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan, Blue Care Network and our vendors do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan, Blue Care Network and our vendors:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 1-877-469-2583 or, if you're 65 or older, call 1-888-563-3307, TTY: 711.

Here's how you can file a civil rights complaint

If you believe that Blue Cross Blue Shield of Michigan, Blue Care Network or our vendors have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd., MC 1302
Detroit, MI 48226
Phone: 1-888-605-6461, TTY: 711
Fax: 1-866-559-0578
Email: CivilRights@bcbsm.com

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal website at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, SW, Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, TDD: 1-800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website: https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/.