2027 Medicare Enrolled Health Plan Coverage Comparison Chart

This chart is **not** intended to be a full description of coverage. The complete plan description is contained in the appropriate certificate of coverage or plan document issued by each plan. Every effort has been made to ensure the accuracy of this chart. If statements in this chart differ from applicable plan documents, then the terms and conditions of those documents prevail. This chart assumes all services are provided by a participating medical care provider when required. All benefits are subject to change. Contact the health plan for more detailed information about benefit coverage and medical necessity requirements.

Plan Type	Managed Care Plans	Priority Medicare HMO-POS	Preferred Provider Organization (PPO)
Plan Name	**U-M Premier Care Advantage (BCN)**	**Priority Health Medicare Advantage with Part D**	**Medicare Advantage PPO (BCBSM)**
Deductible	$0	$0	$0
Annual Out-of-pocket Maximum	$3,000 for each individual member.	$3,000 for each individual member	$3,000 for each individual member
Prescription Drug Plan Administrator	Prime Therapeutics	Priority Health	Prime Therapeutics
Important Information About the Terms Used in This Chart	Covered means the plan payment amount for covered charges is 100% unless stated otherwise. Copay means a set dollar amount you pay for a covered service.	Covered means the plan payment amount for covered charges is 100% unless stated otherwise. Copay means a set dollar amount you pay for a covered service.	Covered means the plan payment amount for covered charges is 100% unless stated otherwise. Copay means a set dollar amount you pay for a covered service.
Prior Authorization Required	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.
Preventive Services			
Annual Wellness Visit[2,4]	Covered	Covered	Covered
Annual Physical Exams[3,4]	Covered	Covered	Covered
Breast Cancer Screening	Covered	Covered	Covered
Colorectal Cancer Screening	Covered	Covered	Covered
Lung Cancer Screening	Covered	Covered	Covered
Prostate Cancer Screening	Covered	Covered	Covered
Immunizations – Covered at Provider or Pharmacy[5]	Hepatitis B, Influenza, Pneumonia, COVID-19	Hepatitis B, Influenza, Pneumonia, COVID-19	Hepatitis B, Influenza, Pneumonia, COVID-19
Immunizations – Covered Only at Pharmacy[5]	Shingles, RSV, Tdap, travel, and other CDC-recommended vaccines	Shingles, RSV, Tdap, travel, and other CDC-recommended vaccines	Shingles, RSV, Tdap, travel, and other CDC-recommended vaccines

2 Annual wellness visit or welcome to Medicare. A visit with your health-care provider to develop or update a personalized prevention plan, based on your specific health and risk factors. This is not a physical exam.
3 This is a physical exam that can include checking vital signs, performing screenings, providing immunizations, and ordering tests.
4 A copay may apply if the service is outside the scope of the preventive visit.
5 Medicare Advantage health plans cover COVID-19, pneumonia, flu, and hepatitis B vaccinations at your provider's office. All other vaccinations administered at your provider's office are not covered.

2027 Medicare Enrolled Health Plan Coverage Comparison Chart

Plan Type	Managed Care Plans	Priority Medicare HMO-POS	Preferred Provider Organization (PPO)
Plan Name	**U-M Premier Care Advantage (BCN)**	**Priority Health Medicare Advantage with Part D**	**Medicare Advantage PPO (BCBSM)**
Emergency Care			
In Area	$65 copay for emergency room visits (copay waived if admitted as inpatient)	$65 copay for emergency room visits (copay waived if admitted as inpatient)	$65 copay for emergency room visits (copay waived if admitted as inpatient)
Out of Area	$65 copay for emergency room visits (copay waived if admitted as inpatient)	$65 copay for emergency room visits (copay waived if admitted as inpatient)	$65 copay for emergency room visits (copay waived if admitted as inpatient)
Ambulance	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary
Inpatient Care			
Inpatient Hospital Services	Covered Note: Nonemergency services must be rendered in a participating hospital.	Covered Note: Nonemergency services must be rendered in a participating hospital.	Covered. Note: Nonemergency services must be rendered in a participating hospital.
Days of Care	Unlimited days	Unlimited days	Unlimited days
Room Type	Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary
Surgery	Covered	Covered	Covered
Inpatient Rehabilitation for PT/ST/OT	Covered	Covered	Covered
Skilled Nursing Facility	Covered up to 120 days per calendar year when arranged and authorized by health plan	Covered up to 120 days per calendar year when arranged and authorized by health plan	Covered up to 120 days per calendar year

Plan Type	Managed Care Plans	Priority Medicare HMO-POS	Preferred Provider Organization (PPO)
Plan Name	**U-M Premier Care Advantage (BCN)**	**Priority Health Medicare Advantage with Part D**	**Medicare Advantage PPO (BCBSM)**
Outpatient Services			
Office Visits	$10 copay per office visit with a PCP $10 copay per office visit with a specialist	$10 copay per office visit with a PCP $10 copay per office visit with a specialist	$10 copay per office visit with a PCP $10 copay per office visit with a specialist
Telehealth, Virtual Care, Online Visits	$10 copay	$10 copay	$10 copay
Outpatient Physical, Occupational and Speech Therapy	$10 copay	$10 copay	$10 copay
Observation Stay	$65 ER copay. All services provided while in observation are covered at the outpatient benefit level.	$65 ER copay. All services provided while in observation are covered at the outpatient benefit level.	$65 ER copay. All services provided while in observation are covered at the outpatient benefit level.
Therapeutic Radiology	Covered	Covered	Covered
Diagnostic Lab, X-ray, EKG	Covered	Covered	Covered
Dialysis	Covered	Covered	Covered
Outpatient Surgery	Covered	Covered	Covered
Allergy Testing	$10 copay	$10 copay	$10 copay
Weight-Loss Surgery	Covered when authorized by health plan	Covered when authorized by health plan	Covered when medically necessary
Acupuncture for Chronic Low-Back Pain	$10 copay; up to 20 annual visits	$10 copay, up to 20 annual visits	$10 copay, up to 20 annual visits
Medical Nutrition Therapy Services	Covered	Covered	Covered
Chiropractic	$10 copay	$10 copay	$10 copay
Gender-Affirming Services	$10 copay	$10 copay	$10 copay
Mental Health Care			
Inpatient Days of Care	Covered	Covered	Covered
Outpatient Individual Therapy	$10 copay	$10 copay	$10 copay
Group Therapy	$10 copay	$10 copay	$10 copay
Psychological Testing	$10 copay	$10 copay	$10 copay
Substance Use Care			
Inpatient Days of Care	Covered	Covered	Covered
Outpatient Individual Therapy	$10 copay	$10 copay	$10 copay
Group Therapy	$10 copay	$10 copay	$10 copay

2027 Medicare Enrolled Health Plan Coverage Comparison Chart

Plan Type	Managed Care Plans	Priority Medicare HMO-POS	Preferred Provider Organization (PPO)
Plan Name	**U-M Premier Care Advantage (BCN)**	**Priority Health Medicare Advantage with Part D**	**Medicare Advantage PPO (BCBSM)**
Hearing Care[6,7]			
Audiometric Exam	Covers one every 36 months	Covers one every 36 months	Covers one every 36 months
Hearing Aid(s)	Covered up to allowed amount; monaural or binaural hearing aid every 36 months; member may be balance-billed for amounts above allowed amount.	Covered up to allowed amount; monaural or binaural hearing aid every 36 months; member may be balance-billed for amounts above allowed amount.	Covered up to allowed amount; monaural or binaural hearing aid every 36 months; member may be balance-billed for amounts above allowed amount.
Hearing Aid Evaluation	Covers one every 36 months	Covers one every 36 months	Covers one every 36 months
Ordering & Fitting Hearing Aid(s)	Covers one every 36 months	Covers one every 36 months	Covers one every 36 months
Hearing Aid Conformity Test	Covers one every 36 months	Covers one every 36 months	Covers one every 36 months
Vision Care			
Eye Examinations	Covered at plan vision providers - one exam per year. Non-plan providers covered up to $40. Dilation not covered.	Covered at plan vision providers - one exam per year. Non-plan providers covered up to $40; dilation not covered.	Covered; one exam per year; dilation not covered
Eyeglasses	Not Covered	Not Covered	Not Covered
Home Health Care			
Visiting Nurse Home Care	Covered	Covered	Covered
Private Duty Nursing	Not Covered	Not Covered	Covered at 70% when medically necessary and approved by the plan[8]
Home Health Aides	Covered	Covered	Covered
Home Infusion Services	Covered	Covered	Covered
Other Services			
Human Organ Transplant	Covered	Covered	Covered
Hospice Care	Covered	Covered	Covered
5th Level Hospice	Covered up to 45 days	Covered up to 45 days	Covered up to 45 days
Durable Medical Equipment, Orthotics, Prosthetic Appliance	Covered	Covered	Covered
Gradient Compression Stockings	Covered	Covered	Covered
Adult Incontinence Products	Covered	Covered	Covered
Wigs (for approved medical conditions)	Covered	Covered	Covered
SilverSneakers Gym Membership	Covered	Covered	Covered

6 Specialist office visit may apply.
7 Covered every 36 months, unless significant change in hearing loss (documentation required).
8 Does not apply to the out-of-pocket maximum.