2021

BCN Advantage℠ HMO-POS — Elements, Prime Value, Classic, Prestige

Summary of Benefits

January 1, 2021 — December 31, 2021

This is a summary document, 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).

BCN Advantage is a Health Maintenance Organization with a Point-of-Service (POS) option. To join **BCN Advantage HMO-POS Elements, Prime Value, Classic or Prestige**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes these counties in Michigan:

Allegan, Antrim, Barry, Benzie, Berrien, Branch, Calhoun, Clinton, Eaton, Emmet, Genesee, Grand Traverse, Hillsdale, Ingham, Ionia, Isabella, Jackson, Kalamazoo, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Osceola, Otsego, Ottawa, St. Clair, St. Joseph, Van Buren, Washtenaw, Wayne, and Wexford.

BCN Advantage HMO-POS has a network of doctors, hospitals, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. For some services you can use providers that are not in our network. You can see our plan's provider directory at our website at **www.bcbsm.com/providersmedicare**, or call us and we will send you a copy of the provider directory.

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

BCN Advantage is an HMO-POS plan witth a Medicare contract. Enrollment in BCN Advantage depends on contract renewal.

www.bcbsm.com/medicare

Medicare Advantage Plans

Premium/Cost-sharing Table for BCN Advantage HMO-POS

Premiums vary by county in which you permanently reside (rates are based on the use and cost of health care services in each regional segment). You must continue to pay your Medicare Part B premium.

1) Find the county and region that you live in.

2) Look across the plan option columns to find your monthly premium rate.

Regions with counties	BCN Advantage monthly premium			
	Elements	Prime Value	Classic	Prestige
Region 1 Allegan, Barry, Ionia, Kalamazoo, Kent, Mason, Muskegon, Newaygo, Oceana and Ottawa	$8.00	$0	$80	$178.00
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren	$23.20	$0	$112	$249
Region 4 Antrim, Benzie, Clinton, Emmet, Genesee, Grand Traverse, Isabella, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mecosta, Midland, Missaukee, Osceola, Otsego, St. Clair and Wexford	$25.00	$0	$104	$227
Region 5 - Macomb, Oakland, Washtenaw and Wayne	$30.00	$0	$129	$264
Optional Supplemental Dental and Vision Package 1	$20.40	$20.40		
Optional Supplemental Dental and Vision Package 2	$37.40	$32.40		

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Deductible	**In-network:** $160 annually **Point-of-service:** $500 annually This plan does not include Part D prescription drug coverage.	**In-network:** $0 annually **Point-of-service:** $0 annually **Prescription drugs:** $50 annually for Part D prescription drugs in Tiers 3, 4 and 5.	**In-network:** $0 annually **Point-of-service:** $500 annually This plan does not have a deductible for Part D prescription drugs.	**In-network:** $0 annually **Point-of-service:** $200 annually This plan does not have a deductible for Part D prescription drugs.	
Deductible – Optional Supplemental Dental and Vision Package 1	There is no deductible.				
Deductible – Optional Supplemental Dental and Vision Package 2	There is no deductible.				

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$4,500 annually	$4,500 annually	$3,800 annually	$3,400 annually	The most you pay for copays, coinsurance and other costs for medical services for the year. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. **Elements:** Please note that you will still need to pay your monthly premiums. **Prime Value, Classic and Prestige:** Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. **Point-of-Service:** Services received under your point-of-service benefit apply toward your maximum out-of-pocket.
Note: Your primary care provider (PCP) is the best resource for coordinating your care and can help you find an in-network specialist. However, BCN Advantage doesn't require a referral for you to make an appointment with an in-network specialist. Some in-network specialists may still need to confirm with your PCP that you need specialty care.					

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 3.					
Inpatient Hospital Coverage*	The copays are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row. Our plan covers an unlimited number of days for an inpatient hospital stay.				See Page 44 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies If you go to out-of-network providers you pay the full cost.
	In-network: $205 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay per day for days 91 and beyond **Point-of-service:** $205 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	**In-network:** $325 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay per day for days 91 and beyond **Point-of-service:** $325 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	**In-network:** $225 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay per day for days 91 and beyond **Point-of-service:** $225 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	**In-network:** $125 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay per day for days 91 and beyond **Point-of-service:** $125 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	
Outpatient Hospital Coverage*					See Page 44 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies If you go to out-of-network providers you pay the full cost.
o Ambulatory surgical center	**In-network:** $0 – $100 copay **Point-of-service:** $0 – $100 copay	**In-network:** $0 – $100 copay **Point-of-service:** $0 – $100 copay	**In-network:** $0 – $95 copay **Point-of-service:** $0 – $95 copay	**In-network:** $0 – $70 copay **Point-of-service:** $0 – $70 copay	
o Outpatient hospital	**In-network:** $0 – $200 copay **Point-of-service:** $0 – $200 copay	**In-network:** $0 – $250 copay **Point-of-service:** $0 – $250 copay	**In-network:** $0 – $200 copay **Point-of-service:** $0 – $200 copay	**In-network:** $0 – $200 copay **Point-of-service:** $0 – $200 copay	

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Doctor Visits					See Page 44 for more about your point-of-service travel benefit.
o Primary	**In-network:** $0 copay **Point-of-service:** $40 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $35 copay	**In-network:** $0 copay **Point-of-service:** $20 copay	**Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies
o Specialists	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $45 copay **Point-of-service:** $45 copay	**In-network:** $35 copay **Point-of-service:** $35 copay	**In-network:** $20 copay **Point-of-service:** $20 copay	If you go to out-of-network providers you pay the full cost. Specialist services may require a referral.
Preventive Care	In-network: You pay nothing. Our plan covers many preventive services, including:				
	• Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • 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, Flexible sigmoidoscopy, Guaiac-based fecal occult blood test, Fecal immunochemical test, DNA based colorectal screening every 3 years) • Depression screening • Diabetes screenings • Glaucoma screening			• HIV screening • Immunizations, including Flu shots, Hepatitis B shots, Pneumococcal shots • Intensive behavioral therapy for obesity • Medical nutrition therapy services • Medicare Diabetes Prevention Program • Prostate cancer screenings (PSA) • Screening for lung cancer with low dose computed tomography • 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)	
	Any additional preventive services approved by Medicare during the contract year will be covered.				

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Emergency Care	$90 copay	$90 copay	$90 copay	$90 copay	If you are admitted to the hospital within one day, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs. *You have coverage for worldwide emergency medical care. There is a combined $50,000 lifetime plan coverage limit for emergency care, urgent care and transportation services outside the U.S. and its territories.*
Urgently Needed Services	$0 – $45 copay	$0 – $45 copay	$0 – $40 copay	$0 – $35 copay	*You have coverage for worldwide emergency medical care. There is a combined $50,000 lifetime plan coverage limit for emergency care, urgent care and transportation services outside the U.S. and its territories.*

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Diagnostic Services/Labs/ Imaging*					See Page 44 for more about your point-of-service travel benefit.
o Diagnostic tests and procedures	**In-network:** $0 – $20 copay **Point-of-service:** $20 copay	**In-network:** $0 – $20 copay **Point-of-service:** $20 copay	**In-network:** $0 – $20 copay, **Point-of-service:** $20 copay	**In-network:** $0 – $10 copay **Point-of-service:** $10 copay	**Elements, Classic and Prestige:** Point-of-service deductible applies
o Lab services	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**Elements:** Deductible applies
o COVID-19 testing	**In-network:** $0 copay **Point-of-service:** $20 copay	**In-network:** $0 copay **Point-of-service:** $20 copay	**In-network:** $0 copay **Point-of-service:** $20 copay	**In-network:** $0 copay **Point-of-service:** $10 copay	

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
o Diagnostic radiology service (e.g., MRI)	**In-network:** $20 – $100 copay, depending on the service **Point-of-service:** $20 – $100 copay, depending on the service	**In-network:** $20 – $100 copay, depending on the service **Point-of-service:** $20 – $100 copay, depending on the service	**In-network:** $20 – $75 copay, depending on the service **Point-of-service:** $20 – $75 copay, depending on the service	**On-network:** $10 – $50 copay, depending on the service **Point-of-service:** $10 – $50 copay, depending on the service	If you go to out-of-network providers you pay the full cost.
o Outpatient X-rays	**In-network:** $20 – $100 copay, depending on the service **Point-of-service:** $20 – $100 copay, depending on the service	**In-network:** $20 – $100 copay, depending on the service **Point-of-service:** $20 – $100 copay, depending on the service	**In-network:** $20 – $75 copay, depending on the service **Point-of-service:** $20 – $75 copay, depending on the service	**In-network:** $10 – $50 copay, depending on the service **Point-of-service:** $10 – $50 copay, depending on the service	
o Therapeutic radiology services	**In-network:** $25 copay **Point-of-service:** $25 copay	**In-network:** $25 copay **Point-of-service:** $25 copay	**In-network:** $15 copay **Point-of-service:** $15 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Hearing Services					See Page 44 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies If you go to out-of-network providers you pay the full cost.
o Hearing exam to diagnose and treat hearing and balance issues	**In-network:** $0 – $40 copay, depending on the service **Point-of-service:** $40 copay, depending on the service	**In-network:** $0 – $45 copay, depending on the service **Point-of-service:** $45 copay, depending on the service	**In-network:** $0 – $35 copay, depending on the service **Point-of-service:** $35 copay, depending on the service	**In-network:** $0 – $20 copay, depending on the service **Point-of-service:** $20 copay, depending on the service	
o Routine hearing exam (for up to 1 per year)	**In-network:** $0 – $40 copay, depending on the service, for one hearing exam every year **Point-of-service:** Not covered	**In-network:** $0 – $45 copay, depending on the service, for one hearing exam every year **Point-of-service:** Not covered	**In-network:** $0 – $35 copay, depending on the service, for one hearing exam every year **Point-of-service:** Not covered	**In-network:** $0 – $20 copay, depending on the service, for one hearing exam every year **Point-of-service:** Not covered	
o Hearing aid fitting and evaluation (for up to one every three years)	**In-network:** $0 copay for one hearing aid fitting evaluation every three years **Point-of-service:** Not covered	**In-network:** $0 copay for one hearing aid fitting evaluation every three years **Point-of-service:** Not covered	**In-network:** $0 copay for one hearing aid fitting evaluation every three years **Point-of-service:** Not covered	**In-network:** $0 copay for one hearing aid fitting evaluation every three years **Point-of-service:** Not covered	
o Hearing aids	**In-network**: Up to a $1,200 ($600 per ear) allowance every three years **Point-of-service:** Not covered	**In-network:** Up to a $1,200 ($600 per ear) allowance every three years **Point-of-service:** Not covered	**In-network:** Up to a $1,200 ($600 per ear) allowance every three years **Point-of-service:** Not covered	**In-network:** Up to a $1,200 ($600 per ear) allowance every three years **Point-of-service:** Not covered	

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Dental Services **Limited dental services** (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	**In-network:** $0 – $200 copay for Medicare-covered services **Point-of-service:** $40 – $200 copay for Medicare-covered services	**In-network:** $0 – $250 copay for Medicare-covered services **Point-of-service:** $45 – $250 copay for Medicare-covered services	**In-network:** $0 – $200 copay for Medicare-covered services **Point-of-service:** $35 – $200 copay for Medicare-covered services	**In-network:** $0 – $200 copay for Medicare-covered services **Point-of-service:** $20 – $200 copay for Medicare-covered services	See Page 44 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies for Medicare-covered services. If you go to out-of-network providers you pay the full cost. For preventive dental services, you must obtain services from a participating dentist. Please visit **www.mibluedentist.com** and search for PPO dentists in the BCN Advantage network or contact Customer Service.
Preventive dental services o Cleaning (up to two every year) o Dental X-rays (one set of up to four bitewing X-rays, or one set of up to six periapical films every two years) o Oral exam (up to two every year)	**In-network:** $0 copay				

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Vision Services					See Page 44 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies to Medicare-covered services. **Elements:** Deductible applies for Medicare-covered services. If you go to out-of-network providers you pay the full cost. Routine vision care must be from a VSP Choice Network provider. To locate a VSP Choice Network provider, call the Customer Service number on the back of this booklet or visit **www.vsp.com**. Services may require prior authorization.
o Exam to diagnose and treat diseases and conditions of the eye	**In-network:** $0 – $40 copay, depending on the service **Point-of-service:** $0 – $40 copay, depending on the service	**In-network:** $0 – $45 copay, depending on the service **Point-of-service:** $0 – $45 copay, depending on the service	**In-network:** $0 – $35 copay, depending on the service **Point-of-service:** $0 – $35 copay, depending on the service	**In-network:** $0 – $20 copay, depending on the service **Point-of-service:** $0 – $20 copay, depending on the service	
o Eyeglasses or contact lenses after Medicare-covered cataract surgery	**In-network:** $0 copay	**In-network:** $0 copay	**In-network:** $0 copay	**In-network:** $0 copay	
o Routine eye exam	**In-network:** $0 copay for up to one routine eye exam every 12 months.	**In-network:** $0 copay for up to one routine eye exam every 12 months.	**In-network:** $0 copay for up to one routine eye exam every 12 months.	**In-network:** $0 copay for up to one routine eye exam every 12 months.	

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Every 12 months, we cover one of the following: o Elective contacts o One pair of lenses o One frame o One complete pair of eyeglasses (lenses and frames) If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit	This is not a covered benefit.	$0 copay The eye wear benefit provides a $100 maximum vision benefit every 12 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are covered in full every 12 months. Benefit must be obtained from an in-network provider.	$0 copay The eye wear benefit provides a $100 maximum vision benefit every 12 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are covered in full every 12 months. Benefit must be obtained from an in-network provider.	$0 copay The eye wear benefit provides a $100 maximum vision benefit every 12 months and may be used for either (a) elective contact lenses or (b) frames. Lenses are covered in full every 12 months. Benefit must be obtained from an in-network provider.	

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Mental Health Services*	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 health services provided in a general hospital. The copays are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.				Services may require prior authorization. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies for Medicare-covered services.
o Inpatient visit	**In-network:** $205 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 **Point-of-service:** $205 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90	**In-network:** $300 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 **Point-of-service:** $300 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90	**In-network:** $225 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 **Point-of-service:** $225 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90	**In-network:** $125 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 **Point-of-service:** $125 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90	
o Outpatient group therapy visit	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $35 copay **Point-of-service:** $35 copay	**In-network:** $20 copay **Point-of-service:** $20 copay	
o Outpatient individual therapy visit	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $35 copay **Point-of-service:** $35 copay	**In-network:** $20 copay **Point-of-service:** $20 copay	

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Skilled Nursing Facility (SNF)*	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $178 copay per day	Our plan covers up to 100 days in a SNF. **Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies for Medicare-Covered services. See Page 44 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.
Physical Therapy o Physical therapy, occupational therapy, and speech and language therapy visit	**In-network:** $30 copay **Point-of-service:** $30 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	**In-network:** $30 copay **Point-of-service:** $30 copay	**In-network:** $15 copay **Point-of-service:** $15 copay	**Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies for Medicare-covered services.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Ambulance	**In-network:** $250 copay **Point-of-service:** $250 copay	**In-network:** $275 copay **Point-of-service:** $275 copay	**In-network:** $250 copay **Point-of-service:** $250 copay		See Page 44 for more about your point-of-service travel benefit. Copay is for each one-way trip for Medicare-covered services. **Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies for Medicare-covered services. If you go to out-of-network providers you pay the full cost.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Transportation	Qualified members pay $0.	Qualified members pay $0.	Qualified members pay $0.	Qualified members pay $0.	Qualified members who have been selected to be a part of Blue Cross Coordinated Care, our care management program for members with special health needs may be eligible for non-emergency medical transportation provided by a plan-approved transportation provider, to medical appointments, physical therapy, a pharmacy or other plan-approved locations. For members who reside in Wayne, Oakland, Macomb and Washtenaw counties, non-emergency, medical transportation is covered for up to 28 days after each acute care hospital discharge.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
					For members who reside in Allegan, Barry, Ionia, Kalamazoo, Kent, Mason, Muskegon, Newago, Oceana and Ottawa counties only, transportation is limited to 2 trips per month and each trip is limited to up to 100 miles round trip. Your Care Manager must arrange your transportation with the plan-approved transportation provider. Members residing in all other counties do not have coverage for transportation services.
Medicare Part B Drugs* o Part B drugs such as chemotherapy/ radiation drugs o Other Part B drugs o Home infusion drugs	**In-network:** 0% – 20% of the cost depending on the drug **Point-of-service:** 0% – 20% of the cost depending on the drug	**In-network:** 0% – 20% of the cost depending on the drug **Point-of-service:** 0% – 20% of the cost depending on the drug	**In-network:** 0% – 20% of the cost depending on the drug **Point-of-service:** 0% – 20% of the cost depending on the drug	**In-network:** 0% – 20% of the cost depending on the drug. **Point-of-service:** 0% – 20% of the cost depending on the drug	Services may require prior authorization and/or step therapy may apply. **Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies for Medicare-covered services.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Chiropractic Care*					**Elements, Classic and Prestige:** Point-of-service deductible applies
o Manipulation of the spine to correct a subluxation (when one or more bones in your spine moves out of position)	**In-network:** $20 copay **Point-of-service:** $20 copay	**In-network:** $20 copay **Point-of-service:** $20 copay	**In-network:** $20 copay **Point-of-service:** $20 copay	**In-network:** $20 copay. **Point-of-service:** $20 copay	**Elements:** Deductible may apply for Medicare-covered services.
o Routine care/other Routine chiropractic visits give members coverage for one set of X-rays (up to three views) per year performed by a chiropractor. Cost share is the same as diagnostic X-rays.	**In-network:** $20 – $40 copay depending on the service **Point-of-service:** $20 – $40 copay, depending on the service.	**In-network:** $20 – $45 copay depending on the service **Point-of-service:** $20 – $45 copay, depending on the service.	**In-network:** $20 – $35 copay depending on the service **Point-of-service:** $20 – $35 copay, depending on the service.	**In-network:** $10 – $20 copay depending on the service **Point-of-service:** $10 – $20 copay depending on the service.	See Page 44 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.
Durable Medical Equipment/Supplies*					Services may require prior authorization.
o Durable Medical Equipment (e.g., wheelchairs, oxygen)	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	See Page 44 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible may apply for Medicare-covered services. If you go to out-of-network providers you pay the full cost.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
o Prosthetics (e.g., braces, artificial limbs)	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	**In-network:** 20% coinsurance of the cost for Medicare-covered items. **Point-of-service:** 20% coinsurance of the cost for Medicare-covered items.	Member must obtain diabetic supplies (except diabetic shoes) from BCN's supplier, J&B Medical Supply Company at 1-888-896-6233 from 8 a.m. to 5 p.m. Monday through Friday, Eastern time. TTY users call 711.
o Diabetes supplies (e.g., monitoring, shoes or inserts)	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	Member must obtain diabetic shoes and inserts from BCN's DME supplier, Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m. Monday through Friday, Eastern time. TTY users call 711. When outside of the plan's service area, members must contact the appropriate vendor listed above. Prosthetics must be obtained from a preferred vendor. Contact us for a list of preferred vendors.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Health Fitness Program	All members can join the SilverSneakers® Fitness program at no additional cost. SilverSneakers® is a leading fitness program for people with Medicare. • Locations nationwide • Low-impact classes to improve strength and balance • Health education events • Live and on-demand online classes, online tools, and basic fitness equipment to use in your home. You must use network facilities to obtain this benefit. You can find locations and more information at **www.silversneakers.com**. Tivity Health® is an independent corporation retained by Blue Care Network to provide health and fitness services to its BCN Advantage members. Tivity Health and SilverSneakers® are registered trademarks or trademarks of Tivity Health, Inc. and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2017 Tivity Health, Inc. All rights reserved.				
Home Health Care*	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	**In-network:** $0 copay **Point-of-service:** $0 copay	Includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc. Custodial care is not a benefit. Services may require prior authorization.
Hospice	$0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details (phone numbers are on the back of this booklet).				

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
In-Home Support Services Eligible members will have access to in-home help provided by a non-clinical care team. Care team staff will help eligible members with daily living activities such transportation, light household help and meal preparation, technology education and support, grocery shopping, companionship and more. Members can verify their eligibility for this benefit by calling our vendor partner Papa, at 1-888-597-6294, Monday-Friday 8 a.m. – 11 p.m. Eastern time and Saturday and Sunday 8 a.m. – 8 p.m. Eastern time.	Not covered.	$0 for up to 8 hours of time with a Papa Pal each month for qualified members.	Not covered.	Not covered.	To qualify for this benefit, you must meet the following requirements: 1) Live alone, and 2) Require help with activities related to living independently, such as transportation, light housework, meal preparation, etc. An over-the-phone eligibility assessment with Blue Care Network's approved vendor, Papa, is required to determine if members qualify.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Meal Benefit	$0 copay for qualified members for 28 meals over 14 days from plan-approved meal provider. Twenty-eight (28) meals will be delivered to your home in a refrigerated cooler pack in two shipments (14 meals per shipment). Meals can be tailored to meet certain dietary needs.				Members who have been selected to be a part of our Blue Cross care management program for members with special health needs and have been discharged from a hospital may be eligible for a two-week (14 day) meal benefit. Members are eligible for this benefit during the 30-day period after they return home from the hospital. An assessment with your Blue Cross nurse care manager is required to determine eligibility for the meal benefit. If you qualify for this benefit your Blue Cross Care Manager will make a referral to the plan-approved meal provider.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Online Visits o Remote access technologies give you the opportunity to meet with a health care provider through electronic forms of communication (such as online). o This does not replace an in-person visit, but allows you to meet with a health care provider when it is not possible for you to meet with your doctor in the office.	**Medical:** $0 copay **Mental Health:** $0 copay	**Medical:** $0 copay **Mental Health:** $0 copay	**Medical:** $0 copay **Mental Health:** $0 copay	**Medical:** $0 copay **Mental Health:** $0 copay	**Elements:** Deductible may apply for Medicare-covered services.
Outpatient Substance Abuse* o Individual or Group therapy visit	**In-network:** $40 copay **Point-of-service:** $40 copay	**In-network:** $45 copay **Point-of-service:** $45 copay	**In-network:** $35 copay **Point-of-service:** $35 copay	**In-network:** $20 copay **Point-of-service:** $20 copay	Services may require prior authorization. **Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies for Medicare-covered services.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Over-the-counter items (from authorized vendor only)* Over-the-Counter (OTC) items are drugs and health related products that do not need a prescription. Covered items include but are not limited to antacids, cough drops, denture adhesive, eye drops, ibuprofen, toothpaste and first aid items. Food items are covered for members with certain conditions. There are four ways to use your benefit: 1) **In-store:** You will receive an allowance card in the mail. You can use this card to purchase many common items at	Members receive a $25 per quarter benefit, no rollover.	For members residing in Antrim, Benzie, Clinton, Emmet, Genesee, Grand Traverse, Isabella, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mecosta, Midland, Missaukee, Osceola, Otsego, St. Clair, Wexford, you receive a $25 per quarter benefit, no rollover. For all other members, you receive a $75 per quarter benefit, no rollover.	Members receive a $25 per quarter benefit, no rollover.		This benefit covers certain approved non-prescription over-the-counter drugs and health-related items. You will receive one OTC card which can be used for purchasing approved non-prescription, over-the-counter drugs and health-related items at participating retail locations. The dollar benefit amount will be automatically reloaded each quarter. For online and mail orders, only one order can be placed per quarter. Benefits are available each quarter (January, April, July, October). In addition to the over-the-counter benefit, plan-identified members

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
local retailers. You can find a complete list of participating retailers online at **bcbsm.com/medicareotc**. 2) **Online.** Go to **bcbsm.com/medicareotc** and follow the prompts to place an order using the online catalog. 3) **Mail.** You may request a printed catalog by calling 1-866-637-6863, Monday - Friday, 8 a.m. - 8 p.m. Eastern time (TTY: 711). Complete and mail the order form included with the requested catalog that you will receive in the mail. 4) **Telephone.** Select items using the requested physical or online catalog and call 866-637-6863, Monday - Friday, 8 a.m. - 8 p.m. Eastern time (TTY: 711), to place an order. Items will be mailed to you.					diagnosed with certain health conditions can use their quarterly allowance to buy approved foods. The food benefit will be available to plan-identified members who have been diagnosed with: diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), stroke, hypertension, coronary artery disease (CAD), and/or rheumatoid arthritis or have known risk factors associated with exposure to COVID-19. See Special supplemental benefits for the chronically ill below. Note: All purchases must be made through the plan's approved vendor or purchased at participating retail

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
					locations. Items cannot be obtained from any other vendor or retailer. Note: Amounts left on the account at the end of each quarter do not roll over into the next quarter, so be sure to use this benefit regularly.
Renal dialysis	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance	**Elements, Classic and Prestige:** Point-of-service deductible applies **Elements:** Deductible applies for Medicare-covered services.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Special Supplemental Benefits for the Chronically Ill Plan-identified members with certain health conditions can use their quarterly over-the-counter allowance to buy approved foods. This benefit will be available only to plan-identified members who have been diagnosed with: o Diabetes o Chronic obstructive pulmonary disease (COPD) o Congestive Heart Failure (CHF) o Stroke o Hypertension o Coronary Artery Disease (CAD) o Rheumatoid arthritis o Have known risk factors associated with exposure to COVID-19	$25 per quarter benefit, no rollover	For members with Prime Value residing in Antrim, Benzie, Clinton, Emmet, Genesee, Grand Traverse, Isabella, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mecosta, Midland, Missaukee, Osceola, Otsego, St. Clair, Wexford, you receive a $25 per quarter benefit, no rollover. For all other Prime Value members, you receive a $75 per quarter benefit, no rollover.	$25 per quarter benefit, no rollover	$25 per quarter benefit, no rollover	See above for more information on the over-the-counter items benefit.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Support for Caregivers of Enrollees Eligible members who have a non-professional caregiver (e.g. a family member who cares for them) may be eligible for access to an online Caregiver Support tool. The tool provides training, coaching and support to family members who care for our high-risk Medicare Advantage members. Caregivers will have access to online coaching, education and support where they can learn: o How to manage stress and social isolation o How to access available resources such as transportation and home health assistance o Home safety improvements o How to prevent falls o About advanced care planning	Not covered.	$0 copay	Not covered.	Not covered.	An eligibility assessment with a nurse care manager is required to determine if members qualify. Qualifying members will be referred to this program by their Care Manager. For a caregiver to qualify for this benefit, the member must meet the following requirements: 1. Have been selected to be a part of a Blue Cross care management program for members with special health needs 2. Be cared for at home by a family member or other person who would benefit from the support, training and coaching this program provides.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Worldwide Coverage Worldwide coverage consists of:					If you need care when you're outside of the United States, you have coverage for emergency and urgently needed services only. You have coverage for worldwide emergency medical care. You have coverage for worldwide emergency transportation. There is a combined $50,000 lifetime plan coverage limit for emergency care, urgent care, and transportation services outside the U.S. and its territories.
o Worldwide emergency coverage	$90 copay for worldwide emergency care services.	$90 copay for worldwide emergency care services.	$90 copay for worldwide emergency care services.	$90 copay for worldwide emergency care services.	
o Worldwide urgent coverage	$45 copay for worldwide urgent care services.	$45 copay for worldwide urgent care services.	$40 copay for worldwide urgent care services.	$35 copay for worldwide urgent care services.	
o Worldwide emergency transportation	$250 copay for each one-way trip for worldwide emergency transportation.	$275 copay for each one-way trip for worldwide emergency transportation.	$250 copay for each one-way trip for worldwide emergency transportation.	$250 copay for each one-way trip for worldwide emergency transportation.	

Outpatient Prescription Drugs
This plan does not cover Part D prescription drugs.

Prime Value

Phase 1: The Deductible Stage

You pay $0 for Tiers 1, 2 and 6. You pay $50 per year for Tiers 3, 4 and 5.

As part of the Senior Savings Model, there is no deductible for select insulins. You pay no more than $35 for a 30-day supply for select insulins.

Phase 2: The Initial Coverage Stage

After you pay your deductible, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $4,130.

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	$9	$3
Tier 2: Generic	$20	$11
Tier 3: Preferred Brand	$47	$42
Select preferred insulin (Senior Savings Model 30-day supply)	$35	$35
Tier 4: Non-Preferred Drug	50%	50%
Tier 5: Specialty Tier	32%	32%
Tier 6: Select Care Drugs	$5	$0

Your share of the cost when you get a *long-term* (90-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	$27	$0
Tier 2: Generic	$60	$0
Tier 3: Preferred Brand	$141	$126
Select preferred insulin (Senior Savings Model 30-day supply)	$105	$105
Tier 4: Non-Preferred Drug	50%	50%
Tier 5: Specialty Tier	Not Covered	Not Covered
Tier 6: Select Care Drugs	$15	$0

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.**

Phase 3 & 4: The Coverage Gap & The Catastrophic Stages

You have additional coverage in the Coverage Gap stage for Tier 6 drugs. You pay a $0 copayment for Tier 6 drugs at a preferred pharmacy. You pay 25% of the cost for all other generic drugs. For brand-name drugs, you pay 25% of the price (plus a portion of the dispensing fee). You have additional coverage in the Coverage Gap stage for select insulins. You pay no more than $35 for a 30-day supply. Most members do not reach the Coverage Gap stage or the Catastrophic Coverage stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* online at **www.bcbsm.com/medicare-evidence-of-coverage.**

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

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**).

Classic

Phase 1: The Deductible Stage

Because there is no deductible for the plan, this stage does not apply to you.

As part of the Senior Savings Model, you pay no more than $35.00 for a 30-day supply on select insulins.

Phase 2: The Initial Coverage Stage

You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $4,130.

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	$6	$1
Tier 2: Generic	$12	$7
Tier 3: Preferred Brand	$43	$38
Select preferred insulin (Senior Savings Model 30-day supply)	$35	$35
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty Tier	33%	33%
Tier 6: Select Care Drugs	$5	$0

Your share of the cost when you get a *long-term* (90-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	$18	$0
Tier 2: Generic	$36	$0
Tier 3: Preferred Brand	$129	$114
Select preferred insulin (Senior Savings Model 30-day supply)	$105	$105
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty Tier	Not Covered	Not Covered
Tier 6: Select Care Drugs	$15	$0

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**.

Phase 3 & 4: The Coverage Gap & The Catastrophic Stages

You have additional coverage in the Coverage Gap stage for Tier 6 drugs. You pay a $0 copayment for Tier 6 drugs at a preferred pharmacy. You pay 25% of the cost for all other generic drugs. For brand-name drugs, you pay 25% of the price (plus a portion of the dispensing fee). You have additional coverage in the Coverage Gap stage for select insulins. You pay no more than $35 for a 30-day supply. Most members do not reach the Coverage Gap stage or the Catastrophic Coverage stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* online at **www.bcbsm.com/medicare-evidence-of-coverage**.

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

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**).

Prestige

Phase 1: The Deductible Stage

Because there is no deductible for the plan, this stage does not apply to you.

As part of the Senior Savings Model, you pay no more than $35 for a 30-day supply on select insulins.

Phase 2: The Initial Coverage Stage

You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $4,130.

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	$6	$1
Tier 2: Generic	$12	$7
Tier 3: Preferred Brand	$43	$38
Select preferred insulin (Senior Savings Model 30-day supply)	$35	$35
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty Tier	33%	33%
Tier 6: Select Care Drugs	$5	$0

Your share of the cost when you get a *long-term* (90-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	$18	$0
Tier 2: Generic	$36	$0
Tier 3: Preferred Brand	$129	$114
Select preferred insulin (Senior Savings Model 30-day supply)	$105	$105
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty Tier	Not Covered	Not Covered
Tier 6: Select Care Drugs	$15	$0

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**.

Phase 3 & 4: The Coverage Gap & The Catastrophic Stages

You have additional coverage in the Coverage Gap stage for Tier 6 drugs. You pay a $0 copayment for Tier 6 drugs at a preferred pharmacy. You pay 25% of the cost for all other generic drugs. For brand-name drugs, you pay 25% of the price (plus a portion of the dispensing fee). You have additional coverage in the Coverage Gap stage for select insulins. You pay no more than $35 for a 30-day supply. Most members do not reach the Coverage Gap stage or the Catastrophic Coverage stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* online at **www.bcbsm.com/medicare-evidence-of-coverage**.

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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**).

Optional Supplemental Benefits

(You must pay an extra premium each month for these benefits)

Package 1: Supplemental Dental and Vision

Benefit	BCN Advantage Elements	BCN Advantage Prime Value	BCN Advantage Classic	BCN Advantage Prestige
Benefits include:	o Comprehensive Dental o Eyewear			
How much is the monthly premium?	Additional $20.40 per month. You must keep paying your Medicare Part B premium and your $8 – $30 monthly plan premium.	Additional $20.40 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	Additional $20.40 per month. You must keep paying your Medicare Part B premium and your $79.39 – $128.30 monthly plan premium.	Additional $20.40 per month. You must keep paying your Medicare Part B premium and your $178 – $263.00 monthly plan premium.
How much is the deductible?	This package does not have a deductible.			
Is there a limit on how much the plan will pay?	***Each benefit has its own dollar maximum and cannot be combined with another benefit.*** ***Comprehensive Dental:*** *$1,500 every year* ***Comprehensive Vision:*** *$200 every 12 months*			

Benefit	BCN Advantage Elements	BCN Advantage Prime Value	BCN Advantage Classic	BCN Advantage Prestige
Dental – Optional Supplemental Benefit – Package 1 In addition to preventive dental, we cover:	$1,500 combined annual maximum for in-network and out-of-network services. **In Network** $0 cost-share for fluoride treatments and brush biopsies **50% coinsurance for:** o Resin and amalgam fillings o Crowns o Crown repairs o Adjunct Crown Services o Root canals o Simple extractions **Out-of-network** **50% coinsurance of the allowed amount:** o Up to two periodic oral exams per calendar year (includes emergency exams). *Emergency exams are subject to the two oral exams per year limit.* o Up to two routine cleanings per calendar year (includes periodontal maintenance). o X-rays every two calendar years. Either one set of bitewings (up to four) **OR** one set of periapical films (up to six). o Fluoride treatments o Brush biopsies o Resin and amalgam fillings o Crowns o Crown repairs o Adjunct Crown Services o Root canals o Simple extractions For in-network benefits, you must receive services from a participating provider. For out-of-network services, if your provider doesn't submit your claim, you may be required to pay costs up front and submit for reimbursement. Out-of-network expenses will be reimbursed at 50% of allowed amounts up to the combined benefit maximum. You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.			

<table>
<tr><th>Benefit</th><th>BCN Advantage Elements</th><th>BCN Advantage Prime Value</th><th>BCN Advantage Classic</th><th>BCN Advantage Prestige</th></tr>
<tr><td rowspan="8">Vision – Optional Supplemental Benefit – Package 1
Every 12 months, we cover <u>one</u> of the following:
o Elective contacts
o One pair of lenses
o One frame
o One complete pair of eyeglasses (lenses and frames)
If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit.</td><td colspan="4">In-network Eyewear</td></tr>
<tr><td>The optional eye wear benefit provides a $200 combined in and out-of-network maximum vision benefit every 12 months and may be used for either (a) elective contact lenses or (b) frames.</td><td colspan="3">The optional eye wear benefit provides a $200 (in addition to the enhanced vision benefit) combined in and out-of-network maximum vision allowance every 12 months and may be used for either (a) elective contact lenses or (b) frames.</td></tr>
<tr><td>Standard eyeglass lenses are covered in full every 12 months.</td><td colspan="3">Standard eyeglass lenses are covered in full every 12 months.</td></tr>
<tr><td colspan="4">Supplemental vision benefits are provided in conjunction with standard vision benefit. Frequency limits apply.
You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.</td></tr>
<tr><td colspan="4">Out-of-network Eyewear</td></tr>
<tr><td>The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit with 50% coinsurance up to $200 every 12 months and may be used for either (a) elective contact lenses or (b) frames.</td><td colspan="3">The optional eye wear benefit provides a combined in and out-of-network maximum vision allowance with 50% coinsurance up to $200 (in addition to the enhanced vision benefit) every 12 months and may be used for either (a) elective contact lenses or (b) frames.</td></tr>
<tr><td>Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts.</td><td colspan="3">Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts.</td></tr>
<tr><td>Exams are reimbursed at 50% coinsurance up to allowed amounts.</td><td colspan="3">Exams are reimbursed at 50% coinsurance up to allowed amounts.</td></tr>
</table>

Optional Supplemental Benefits

(You must pay an extra premium each month for these benefits)

Package 2: Supplemental Dental and Vision

Benefit	BCN Advantage Elements	BCN Advantage Prime Value	BCN Advantage Classic	BCN Advantage Prestige
Benefits include:	o Comprehensive Dental o Eyewear			
How much is the monthly premium?	Additional $37.40 per month. You must keep paying your Medicare Part B premium and your $8 – $30 monthly plan premium.	Additional $32.40 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	Additional $32.40 per month. You must keep paying your Medicare Part B premium and your $79.39 – $128.30 monthly plan premium.	Additional $32.40 per month. You must keep paying your Medicare Part B premium and your $178 – $263.00 monthly plan premium.
How much is the deductible?	This package does not have a deductible.			
Is there a limit on how much the plan will pay?	***Each benefit has its own dollar maximum and cannot be combined with another benefit.*** ***Comprehensive Dental:*** *$2,500 annual maximum for combined in-network and out-of-network services.* ***Eyewear:*** *$300 combined in-network and out-of-network maximum vision allowance every 12 months.*			

Benefit	BCN Advantage Elements	BCN Advantage Prime Value	BCN Advantage Classic	BCN Advantage Prestige
Dental – Optional Supplemental Benefit – Package 2 In addition to preventive dental, we cover:	$2,500 combined annual maximum for in-network and out-of-network services. **In Network** $0 cost-share for fluoride treatments and brush biopsies **25% coinsurance for:** o Resin and amalgam fillings o Crowns o Crown repairs o Adjunct Crown Services o Root canals o Simple extractions o Dentures o Bridges o Onlays o Endodontics and periodontics o Oral surgery o Consultation exams o Anesthesia			

Benefit	BCN Advantage Elements	BCN Advantage Prime Value	BCN Advantage Classic	BCN Advantage Prestige
	Out-of-network **50% coinsurance of the allowed amount:** o Up to two periodic oral exams per calendar year (includes emergency exams). *Emergency exams are subject to the two oral exams per year limit.* o Up to two routine cleanings per calendar year (includes periodontal maintenance). o X-rays every two calendar years. Either one set of bitewings (up to four) **OR** one set of periapical films (up to six). o Fluoride treatments o Brush biopsies o Resin and amalgam fillings o Crowns o Crown repairs o Adjunct Crown Services o Root canals o Simple extractions o Dentures o Bridges o Onlays o Endodontics and periodontics o Oral surgery o Consultation exams o Anesthesia For in-network benefits, you must receive services from a participating provider. For out-of-network services, if your provider doesn't submit your claim, you may be required to pay costs up front and submit for reimbursement. Out-of-network expenses will be reimbursed at 50% of allowed amounts up to the combined benefit maximum. You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.			

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<tr><th>Benefit</th><th>BCN Advantage Elements</th><th>BCN Advantage Prime Value</th><th>BCN Advantage Classic</th><th>BCN Advantage Prestige</th></tr>
<tr><td rowspan="6">Vision – Optional Supplemental Benefit – Package 2

Every 12 months, we cover <u>one</u> of the following:
o Elective contacts
o One pair of lenses
o One frame
o One complete pair of eyeglasses (lenses and frames)

If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit.</td><td colspan="4">In-network Eyewear</td></tr>
<tr><td>The optional eye wear benefit provides a $300 combined in and out-of-network maximum vision benefit every 12 months and may be used for either (a) elective contact lenses or (b) frames.</td><td colspan="3">The optional eye wear benefit provides a $300 (in addition to the enhanced vision benefit) combined in and out-of-network maximum vision allowance every 12 months and may be used for either (a) elective contact lenses or (b) frames.</td></tr>
<tr><td>Standard eyeglass lenses are covered in full every 12 months.</td><td colspan="3">Standard eyeglass lenses are covered in the standard benefit.</td></tr>
<tr><td colspan="4">Supplemental vision benefits are provided in conjunction with standard vision benefit. Frequency limits apply.
You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.</td></tr>
<tr><td colspan="4">Out-of-network Eyewear</td></tr>
<tr><td>The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit with 50% coinsurance up to $300 every 12 months and may be used for either (a) elective contact lenses or (b) frames.</td><td colspan="3">The optional eye wear benefit provides a combined in and out-of-network maximum vision allowance with 50% coinsurance up to $300 (in addition to the enhanced vision benefit) every 12 months and may be used for either (a) elective contact lenses or (b) frames.</td></tr>
<tr><td>Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts.</td><td colspan="3">Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts.</td></tr>
<tr><td>Exams are reimbursed at 50% coinsurance up to allowed amounts.</td><td colspan="3">Exams are reimbursed at 50% coinsurance up to allowed amounts.</td></tr>
</table>

What does “point-of-service” mean?

This is an HMO-POS plan. HMO means Health Maintenance Organization; POS means Point-of-Service. You can use certain providers outside the BCN Advantage network when traveling, often for your in-network cost-sharing amount.

When you’re **out of Michigan**, our POS benefit (offered through BlueCard® via the Blue Cross and Blue Shield Association) lets you get care from providers who participate with Blues plans. **In Michigan**, except for emergency or urgent care, if you go to an out-of-network doctor, you must pay for this care yourself.

Note: POS is not the same as out-of-network; you pay all costs for POS services from out-of-network providers.

Note: Services received under your point-of-service benefit apply toward your maximum out-of-pocket.

For more information

A complete list of services is found in the *Evidence of Coverage*. For a copy of the *Evidence of Coverage*, go to **www.bcbsm.com/medicare-evidence-of-coverage**, or contact Customer Service at 1-800-450-3680 from 8 a.m. to 8 p.m., Eastern time, seven days a week from October 1 through March 31; 8 a.m. to 8 p.m., Eastern time, Monday through Friday from April 1 through September 30, for more information. TTY users call 711.

You can order a copy of the “Medicare & You” handbook at **www.medicare.gov**, or you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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.
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 are a member of this plan, call toll-free 1-800-450-3680. TTY users should call 711.
From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Eastern time. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 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. For additional information, call us at 1-800-450-3680. TTY users should call 711.

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BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

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