2023

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

Summary of Benefits

January 1, 2023 — December 31, 2023

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:

Alcona, Allegan, Alpena, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Luce, Mackinac, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Ilse, Roscommon, Saginaw, Saniliac, Schoolcraft, Shiawassee, St. Clair, St. Joseph, Tuscola, Van Buren, Washtenaw, Wayne, 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 with 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	$0	$0	$78	$177
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren	$0	$0	$110	$240
Region 3 Alcona, Alpena, Arenac, Bay, Charlevoix, Cheboygan, Clare, Crawford, Gladwin, Huron, Iosco, Kalkaska, Luce, Mackinac, Montmorency, Ogemaw, Oscoda, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee and Tuscola	$0	$0	$122	$236
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	$0	$0	$102	$226
Region 5 - Macomb, Oakland, Washtenaw and Wayne	$0	$0	$127	$263
Optional Supplemental Dental and Vision	$20.30			

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Deductible	**In-network:** $0 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 This plan does not have a deductible for Part D prescription drugs.	**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	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 for 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 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service 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	**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	**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	**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: $205 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	**Point-of-service:** $325 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 $0 copay per day for days 7 through 90	**Point-of-service:** $125 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	

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.					
Outpatient Hospital Coverage*	**In-network:** $0 copay for Medicare-covered palliative care. $200 copay for Medicare-covered outpatient hospital surgery. **Point-of-service:** $0 copay for Medicare-covered palliative care. $200 copay for Medicare-covered outpatient hospital surgery.	**In-network:** $0 copay for Medicare-covered palliative care. $275 copay for Medicare-covered outpatient hospital surgery. **Point-of-service:** $0 copay for Medicare-covered palliative care. $275 copay for Medicare-covered outpatient hospital surgery.	**In-network:** $0 copay for Medicare-covered palliative care. $225 copay for Medicare-covered outpatient hospital surgery. **Point-of-service:** $0 copay for Medicare-covered palliative care. $225 copay for Medicare-covered outpatient hospital surgery.	**In-network:** $0 copay for Medicare-covered palliative care. $200 copay for Medicare-covered outpatient hospital surgery. **Point-of-service:** $0 copay for Medicare-covered palliative care. $200 copay for Medicare-covered outpatient hospital surgery.	See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies If you go to out-of-network providers you pay the full cost.

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.					
Ambulatory Surgical Center (ASC) Services*	**In-network:** $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center. $100 copay for Medicare-covered outpatient surgery in an ambulatory surgical center. **Point-of-service:** $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center. $100 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.	**In-network:** $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center. $100 copay for Medicare-covered outpatient surgery in an ambulatory surgical center. **Point-of-service:** $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center. $100 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.	**In-network:** $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center. $95 copay for Medicare-covered outpatient surgery in an ambulatory surgical center. **Point-of-service:** $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center. $95 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.	**In-network:** $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center. $70 copay for Medicare-covered outpatient surgery in an ambulatory surgical center. **Point-of-service:** $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center. $70 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.	See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies If you go to out-of-network providers you pay the full cost.

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.					
Doctor Visits*					See Page 47 for more about your point-of-service travel benefit.
o Primary	**In-network:** $0 copay **Point-of-service:** $35 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 If you go to out-of-network providers you pay the full cost.
o Specialists	**In-network:** $35 copay **Point-of-service:** $35 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	Specialist services may require a referral. Our plan also covers telehealth services for primary care physician services and behavioral health providers.

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.					
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 COVID-19, flu, Hepatitis B, and Pneumococcal vaccines • 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
Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 3.					
Emergency Care	$90 copay	$90 copay	$90 copay	$90 copay	You may go to any emergency room if you reasonably believe you need emergency care. If you are admitted to the hospital within three days, 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 copay for Medicare-covered urgently needed services in a primary care physician's office. $45 copay for Medicare-covered urgently needed services in an urgent care center.	$0 copay for Medicare-covered urgently needed services in a primary care physician's office. $45 copay for Medicare-covered urgently needed services in an urgent care center.	$0 copay for Medicare-covered urgently needed services in a primary care physician's office. $40 copay for Medicare-covered urgently needed services in an urgent care center.	$0 copay for Medicare-covered urgently needed services in a primary care physician's office. $35 copay for Medicare-covered urgently needed services in an urgent care center.	*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
Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 3.					
Diagnostic Services/Labs/ Imaging*					Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information. See Page 47 for more about your point-of-service travel benefit. **All plans:** Lab services must be rendered at a participating Joint Venture Hospital Lab (JVHL). **Elements, Classic and Prestige:** Point-of-service deductible applies
o Diagnostic tests and procedures	**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:** $10 copay **Point-of-service:** $10 copay	
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	
o COVID-19 testing	**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	

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.					
o Diagnostic radiology services (e.g., X-rays, 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	**In-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 (e.g., X-rays, 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	**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
Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 3.					
Hearing Services					See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service 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 copay for Medicare-covered hearing services from a primary care provider. $35 copay for Medicare-covered hearing services from a specialist. **Point-of-service:** $35 copay	**In-network:** $0 copay for Medicare-covered hearing services from a primary care provider. $45 copay for Medicare-covered hearing services from a specialist. **Point-of-service:** $45 copay	**In-network:** $0 copay for Medicare-covered hearing services from a primary care provider. $35 copay for Medicare-covered hearing services from a specialist. **Point-of-service:** $35 copay	**In-network:** $0 copay for Medicare-covered hearing services from a primary care provider. $20 copay for Medicare-covered hearing services from a specialist. **Point-of-service:** $20 copay	
o Routine hearing exam (1 per year)	**In-network:** $0 copay for one hearing exam every year from a primary care provider. $35 copay for one hearing exam every year from a specialist. **Point-of-service:** Not covered	**In-network:** $0 copay for one hearing exam every year from a primary care provider. $45 copay for one hearing exam every year from a specialist. **Point-of-service:** Not covered	**In-network:** $0 copay for one hearing exam every year from a primary care provider. $35 copay for one hearing exam every year from a specialist. **Point-of-service:** Not covered	**In-network:** $0 copay for one hearing exam every year from a primary care provider. $20 copay for one hearing exam every year from a specialist. **Point-of-service:** Not covered	
o Hearing aid fitting and evaluation (one every three years)	**In-network:** $0 copay for one hearing aid fitting and evaluation every three years **Point-of-service:** Not covered	**In-network:** $0 copay for one hearing aid fitting and evaluation every three years **Point-of-service:** Not covered	**In-network:** $0 copay for one hearing aid fitting and evaluation every three years **Point-of-service:** Not covered	**In-network:** $0 copay for one hearing aid fitting and 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
Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 3.					
Dental services (Medicare covered)	**In-network:** $0 – $200 copay depending on the Medicare-covered dental service **Point-of-service:** $35 – $200 copay depending on the Medicare-covered dental service	**In-network:** $0 – $275 copay depending on the Medicare-covered dental service **Point-of-service:** $0 – $275 copay depending on the Medicare-covered dental service	**In-network:** $0 – $225 copay depending on the Medicare-covered dental service **Point-of-service:** $35 – $225 copay depending on the Medicare-covered dental service	**In-network:** $0 – $200 copay depending on the Medicare-covered dental service **Point-of-service:** $20 – $200 copay depending on the Medicare-covered dental service	See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies 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 Oral exams (up to 2 every calendar year) o Routine cleanings (up to 2 every calendar year) o Dental X-rays (1 set of up to 4 bitewing X-rays, or 1 set of up to 6 periapical films every 2 calendar years) o Fluoride treatment (1 every calendar year)	This benefit provides a $1,500 annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services. **In-network:** $0 copay **Out-of-network:** You pay 50% of the approved amount				

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.					
Comprehensive dental services In addition to preventive dental, we cover: o Brush biopsies (2 per calendar year) o Resin and amalgam fillings (once per tooth per surface every 48 months) o Crowns for permanent teeth only (once per tooth every 84 months) o Crown repairs (3 per permanent tooth per calendar year) o Root canals (once per tooth per lifetime) o Deep cleaning (once per quadrant per 24 months) o Extractions (one time per tooth per lifetime) o Oral Surgery (two times per tooth per lifetime)	**In-network:** You pay $0 **Out-of-network:** You pay 50% coinsurance.				

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.					
Dental – Optional Supplemental Benefit In addition to the plan-covered dental services, we offer:	**Comprehensive Dental:** The benefit provides another $1,500 annual maximum bringing your total annual maximum to $3,000 (combined in- and out-of-network) for preventive and comprehensive dental services. No waiting period. No Deductible. **In-network:** **25% coinsurance for:** o Onlays o Periodontics o Bridges o Dentures o Denture adjustments o Denture repairs o Denture relines o Denture rebase o Implants o Implant maintenance and repairs o Anesthesia o Consultation exams **Out-of-network:** **50% coinsurance for:** o Onlays o Periodontics o Bridges o Dentures o Denture adjustments o Denture repairs o Denture relines o Denture rebase o Implants o Implant maintenance and repairs o Anesthesia o Consultation exams				This optional supplemental benefit is available for an additional premium. For in-network benefits, you must receive dental 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 annual maximum. You may pay higher out-of-pocket amounts if you receive services from out-of-network providers. This optional supplemental $1500 annual maximum applies to all dental services listed in this document. This is in addition to the $1500 annual maximum for preventive and comprehensive dental services.

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.					
Vision Services					See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies to 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**.
o Exam to diagnose and treat diseases and conditions of the eye	**In-network:** $0 – $35 copay, depending on the Medicare-covered service **Point-of-service:** $0 – $35 copay, depending on the Medicare-covered service	**In-network:** $0 – $45 copay, depending on the Medicare-covered service **Point-of-service:** $0 – $45 copay, depending on the Medicare-covered service	**In-network:** $0 – $35 copay, depending on the Medicare-covered service **Point-of-service:** $0 – $35 copay, depending on the Medicare-covered service	**In-network:** $0 – $20 copay, depending on the Medicare-covered service **Point-of-service:** $0 – $20 copay, depending on the Medicare-covered service	
o Eyeglasses or contact lenses after Medicare-covered cataract surgery	**In-network:** $0 copay for eyeglasses or contact lenses after Medicare-covered cataract surgery. **Point-of-service:** $0 copay	**In-network:** $0 copay for eyeglasses or contact lenses after Medicare-covered cataract surgery. **Point-of-service:** $0 copay	**In-network:** $0 copay for eyeglasses or contact lenses after Medicare-covered cataract surgery. **Point-of-service:** $0 copay	**In-network:** $0 copay for eyeglasses or contact lenses after Medicare-covered cataract surgery. **Point-of-service:** $0 copay	
o Routine eye exam	**In-network:** $0 copay for up to one routine eye exam every 12 months. **Point-of-service:** Not covered	**In-network:** $0 copay for up to one routine eye exam every 12 months. **Point-of-service:** Not covered	**In-network:** $0 copay for up to one routine eye exam every 12 months. **Point-of-service:** Not covered	**In-network:** $0 copay for up to one routine eye exam every 12 months. **Point-of-service:** Not covered	

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.					
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.	$0 copay The eyewear benefit provides a $150 maximum vision benefit every 12 months and may be used for either (a) elective contact lenses or (b) one frame. Standard eyeglass 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
Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 3.					
Vision – Optional Supplemental Benefit In addition to the plan-covered vision services, 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. If standard eyeglass lenses or one complete pair of eyeglasses are chosen, lenses have the options of polycarbonate lenses and anti-reflective coating.	The optional eyewear benefit provides a $250 (in addition to the Enhanced Vision benefit) combined in and out-of-network benefit maximum every 12 months and may be used for either (a) elective contact lenses or (b) one frame. Standard eyeglass lenses are covered in full every 12 months as part of the Enhanced Vision benefit.				The optional supplemental benefit is available for an additional premium. Supplemental vision benefits are provided in conjunction with Enhanced Vision benefit. Frequency limits apply. 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 annual maximum. You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.

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.					
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 for hospital benefits 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. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. 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.				Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies
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 or individual therapy visit	**In-network:** $20 copay **Point-of-service:** $35 copay	**In-network:** $20 copay **Point-of-service:** $40 copay	**In-network:** $20 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
Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 3.					
Skilled Nursing Facility (SNF)*	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $188 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $188 copay per day	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $188 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $188 copay per day	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $188 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $188 copay per day	**In-network:** Days 1 – 20: $0 copay Days 21 – 100: $188 copay per day **Point-of-service:** Days 1 – 20: $0 copay Days 21 – 100: $188 copay per day	Our plan covers up to 100 days in a SNF. No prior hospital stay is required. **Elements, Classic and Prestige:** Point-of-service deductible applies See Page 47 for more about your point-of-service travel benefit.
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	See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies

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.					
Ambulance o Ground or Air	**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	**In-network:** $250 copay **Point-of-service:** $250 copay	See Page 47 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

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.					
Transportation All members are eligible for 1 round trip per calendar year to an annual wellness visit within the state of Michigan, no referral needed. Mileage limits may apply. To arrange transportation, call 1-888-617-0468 from 6 a.m. to 6 p.m. Eastern time, Monday through Saturday. TTY users call 711. Members should call 48 hours in advance to schedule transportation.	$0 copay for transportation to an Annual Wellness Visit				No referral is needed for round trip to Annual Wellness Visit.
Qualified members selected for Blue Cross Coordinated Care Core℠, our care management program for members with special health needs, may be eligible for non-emergency medical transportation (NEMT) by a plan-approved transportation provider, to medical appointments, physical therapy, a pharmacy, or other plan-approved locations.	$0 copay for qualified 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.				Your Care Manager must arrange your transportation with the plan-approved transportation provider.

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.					
Medicare Part B Drugs* o Part B drugs such as chemotherapy/ radiation drugs o Other Part B Drugs	**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	Services may require prior authorization and/or step therapy may apply. See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies
Bathroom Safety Eligible members who receive a physician order may use the annual plan benefit maximum towards supplemental bathroom safety items such as: • Shower/bathtub grab bar • Tub stool or transfer bench • Commode rails • Elevated toilet seats	$0 copay Covered in full up to $100 annual plan benefit maximum.				Physician order is required. *Installation and in-home assessment are not covered.* Member must obtain medical equipment through BCN's DME Supplier, Northwood, at 1-800-667-8496, 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY users call 711. When outside of the plan's service area, members must contact Northwood.

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.					
Blue Cross Online Visits **Medical** Members can get 24 hours a day, 7 days a week online health care for minor illnesses and symptoms through Blue Cross Online Visits℠ or from their in-network provider. Examples of symptoms that can be addressed in an online visit: • Respiratory and sinus infections • Colds, flu and seasonal allergies • Eye irritation or redness • Strains and sprains **Behavioral Health** Members can get 24 hours a day, 7 days a week online health care for mental health through Blue Cross Online Visits℠ or from an in-network behavioral health provider who offers online visits.	$0 copay for telehealth services provided by a primary care physician or mental health provider.				Members have the option of getting primary care and behavioral health services either through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, then you must use a network provider who offers the service by telehealth. You can also use Blue Cross Online Visits to access telehealth services. Visit **bcbsmonlinevisits.com** for more information. Please note: You must have video capability for visits through smartphone or computer.

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.					
Cardiac rehabilitation services Comprehensive cardiac rehabilitation programs and services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-network:** $0 copay for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services. **Point-of-service:** $0 copay for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services.				See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies

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.					
Chiropractic Care*					One routine office visit per year.
o Manipulation of the spine to correct a subluxation (when one or more bones in your spine moves out of position)	**In-network:** $15 copay **Point-of-service:** $15 copay	**In-network:** $15 copay **Point-of-service:** $15 copay	**In-network:** $15 copay **Point-of-service:** $15 copay	**In-network:** $15 copay **Point-of-service:** $15 copay	Routine chiropractic visits give members coverage for one set of X-rays (up to three views) per year performed by a chiropractor.
o Routine care	**In-network:** $35 copay **Point-of-service:** $35 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	**Elements, Classic and Prestige:** Point-of-service deductible applies
o Chiropractic X-rays (one set per year)	**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:** $10 copay **Point-of-service:** $10 copay	See Page 47 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*					See Page 47 for more about your point-of-service travel benefit.
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.	**Elements, Classic and Prestige:** Point-of-service deductible applies If you go to out-of-network providers you pay the full cost.

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.					
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 may 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 6 p.m. Monday through Friday, Eastern time. TTY users call 711. Member may 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. Select continuous glucose monitors and other diabetic supplies (except diabetic shoes) may be obtained from any in-network pharmacy. When outside of the plan's service area, members can contact the appropriate vendor listed above. Prosthetics must be obtained from a preferred vendor. Contact us for a list of preferred vendors.
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	

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.					
Health Fitness Program Members are covered for a fitness benefit through SilverSneakers®. SilverSneakers is a comprehensive program that can improve overall well-being and social connections. Designed for all levels and abilities, SilverSneakers provides convenient access to a nationwide fitness network, a variety of programming options and activities beyond the gym that incorporate physical well-being and social interaction.	You Pay $0 for the health fitness program. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers GO, SilverSneakers On-Demand and SilverSneakers LIVE are trademarks of Tivity Health, Inc. © 2022 Tivity Health, Inc. All rights reserved.				Benefits include: • Use of exercise equipment, classes, and other amenities at thousands of participating locations • SilverSneakers LIVE™ online classes and workshops taught by instructors trained in senior fitness • SilverSneakers On-Demand™ online library with hundreds of workout videos • SilverSneakers GO™ mobile app with on-demand videos and live classes • SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls, and parks)

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.					
					• Online fitness tips and healthy eating information • Social connections through events such as shared meals, holiday celebrations, and class socials • GetSetUp virtual enrichment program with classes on topics ranging from healthy eating to aging in place Go to **www.silversneakers.com** to learn more or call 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call 711.

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.					
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. See Page 47 for more about your point-of-service travel benefit.
Home Infusion Therapy* Intravenous or subcutaneous administration of drugs or biologicals to an individual at home.	**In-network:** 0% coinsurance for Medicare-covered home infusion therapy services. **Point-of-service:** 0% coinsurance for Medicare-covered home infusion therapy services.				See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies
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
Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 3.					
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 as transportation, light household help, meal preparation, basic technology support, and grocery shopping. Members can verify their eligibility for this benefit by calling our vendor partner Papa, at 1-888-597-6294, 8 a.m. – 11 p.m. Eastern time, Monday – Friday, and 8 a.m. – 8 p.m. Eastern time, Saturday and Sunday.	Not covered.	$0 copay for up to 8 hours with a Papa Pal each month for qualified members.	Not covered.	Not covered.	To qualify for this benefit, members 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. Members must use a plan contracted vendor.

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.					
Meal Benefit Qualified members who have been selected to be a part of our Blue Cross Coordinated Care Core℠ 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 nurse care manager will make a referral to the plan-approved meal provider.	$0 copay for qualified members.				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. There is no annual limit to the number of occurrences.

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.					
Outpatient Substance Abuse Individual or Group therapy visit	**In-network:** $35 copay **Point-of-service:** $35 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	See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies

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.					
Over-the-Counter (OTC) Allowance: Advantage Dollars Over-the-Counter (OTC) items are drugs and health related products that do not need a prescription. This benefit covers certain approved non-prescription over-the-counter drugs and health-related items. Covered items include but are not limited to antacids, cough drops, denture adhesive, eye drops, pain medications, 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 Advantage Dollars card in the mail. You can use this card to purchase many common items at local retailers. You can find a complete list of	You receive $50 per quarter.	You receive $85 per quarter.	You receive $25 per quarter.		You will receive one card for purchasing approved non-prescription, over-the-counter drugs, health-related items and if you qualify, healthy food at participating retail locations. See *Special supplemental benefits for the chronically ill Food Allowance* for more information.
	An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will carry forward into the next quarter but not into the next calendar year. The final day to spend allowance dollars is December 31, 2023. Any unspent allowance will not carry over to 2024. Note: All purchases must be made through plan-approved retailers.				

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.					
plan-approved retailers online at **www.bcbsm.com/medicareotc.** 2) **Online.** Go to **www.bcbsm.com/medicareotc** and follow the prompts to place the order using the online catalog. Items will be mailed to you. 3) **Mail.** You may request a printed catalog and order form by calling 1-855-856-7878 from 8 a.m. – 11 p.m. Eastern time (TTY: 711), Monday – Friday. Complete and return the order form. Items will be mailed to you. 4) **Telephone.** Select items using the printed or online catalog and call 1-855-856-7878 from 8 a.m. – 11 p.m. Eastern time (TTY: 711), Monday – Friday. Items will be mailed to you.					

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.					
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In-network:** $0 copay for each Medicare-covered pulmonary rehabilitation service rendered in an office setting. **Point-of-service:** $0 copay for each Medicare-covered pulmonary rehabilitation service rendered in an office setting.				See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies
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	See Page 47 for more about your point-of-service travel benefit. **Elements, Classic and Prestige:** Point-of-service deductible applies

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.					
Special Supplemental Benefits for the Chronically Ill **Food Allowance** Members with certain health conditions can use their quarterly over-the-counter Advantage Dollars allowance to buy approved foods. This benefit will be available only 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) • Rheumatoid arthritis	You receive $50 per quarter.	You receive $85 per quarter.	You receive $25 per quarter.		Note: This benefit works in conjunction with the **Over-the-Counter (OTC) Allowance: Advantage Dollars** benefit and is limited to the maximum OTC allowance. See **Over-the-Counter (OTC) Allowance: Advantage Dollars** benefit for more information on the over-the-counter items benefit.
	Your Advantage Dollars account will be loaded automatically with the appropriate allowance amount on January 1, April 1, July 1, and October 1. Unused amounts will carry forward into the next quarter but not into the next calendar year. The final day to spend allowance dollars is December 31, 2023. Any unspent allowance will not carry over to 2024. Note: All purchases must be made through plan-approved retailers.				

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.					
Support for Caregivers of Enrollees Eligible members who have a non-professional caregiver (e.g., a family member or other person 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 or other person who care for members who care for members with dementia and other high-risk conditions. Caregivers will have access to online coaching, education, and support where they can learn: • How to manage stress and social isolation • How to access available resources such as transportation and home health assistance	$0 copay for support for caregivers of enrollees. 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 Coordinated Care Core℠ 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
Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 3.					
• Home safety improvements • How to prevent falls • About advanced care planning					
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

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 31-day supply of 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 $4,660.

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

	Standard retail and standard mail-order cost sharing (in-network)	**Preferred retail and preferred mail-order cost sharing (in-network)**
Tier 1: Preferred Generic	$5	$0
Tier 2: Generic	$20	$11
Tier 3: Preferred Brand	$47	$42
Select Insulin (Senior Savings Model)	$35	$35
Tier 4: Non-Preferred Drug	50%	50%
Tier 5: Specialty Tier	33%	33%

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

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

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail cost sharing (in-network)	Preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$15	$0	$0
Tier 2: Generic	$60	$0	$0
Tier 3: Preferred Brand	$141	$126	$116
Select Insulin (Senior Savings Model)	$105	$105	$105
Tier 4: Non-Preferred Drug	50%	50%	50%
Tier 5: Specialty Tier	Not Covered	Not Covered	Not Covered

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 coverage for some Tier 1 generics during the Coverage Gap stage. During this stage, you will pay either $0 at a Preferred pharmacy or $5 at a Standard pharmacy for a 31-day supply of these medications. For other drugs you pay 25% for generic and brand name drugs. You also have additional coverage in the Coverage Gap stage for Select Insulins. You pay no more than $35 for a 31-day supply for these Select Insulins. You have coverage during the Catastrophic Coverage stage. During this stage you will pay either a coinsurance of 5% of the cost of the drug, or $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs, whichever is the larger amount.

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 for a 31-day supply of 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 $4,660.

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

	Standard retail and standard mail-order cost sharing (in-network)	**Preferred retail and preferred mail-order cost sharing (in-network)**
Tier 1: Preferred Generic	$5	$0
Tier 2: Generic	$12	$7
Tier 3: Preferred Brand	$43	$38
Select Insulin (Senior Savings Model)	$35	$35
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty Tier	33%	33%

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

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

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail cost sharing (in-network)	Preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$15	$0	$0
Tier 2: Generic	$36	$0	$0
Tier 3: Preferred Brand	$129	$114	$105
Select Insulin (Senior Savings Model)	$105	$105	$105
Tier 4: Non-Preferred Drug	45%	45%	45%
Tier 5: Specialty Tier	Not Covered	Not Covered	Not Covered

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 coverage for some Tier 1 generics during the Coverage Gap stage. During this stage, you will pay either $0 at a Preferred pharmacy or $5 at a Standard pharmacy for a 31-day supply of these medications. For other drugs you pay 25% for generic and brand name drugs. You also have additional coverage in the Coverage Gap stage for Select Insulins. You pay no more than $35 for a 31-day supply for these Select Insulins. You have coverage during the Catastrophic Coverage stage. During this stage you will pay either a coinsurance of 5% of the cost of the drug, or $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs, whichever is the larger amount.

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 31-day supply of 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 $4,660.

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

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$5	$0
Tier 2: Generic	$12	$7
Tier 3: Preferred Brand	$43	$38
Select Insulin (Senior Savings Model)	$35	$35
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty Tier	33%	33%

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

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

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail cost sharing (in-network)	Preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$15	$0	$0
Tier 2: Generic	$36	$0	$0
Tier 3: Preferred Brand	$129	$114	$105
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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 the nationwide network of Blue Plan Providers 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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