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BCN AdvantageSM HMO-POS — Elements, Prime Value, Classic, Prestige

Summary of Benefits

January 1, 2022 — December 31, 2022

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, Gratiot, 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 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	\$8	\$0	\$80	\$179
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren	\$16.50	\$0	\$112	\$245
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	\$18.50	\$0	\$104	\$228
Region 5 - Macomb, Oakland, Washtenaw and Wayne	\$30	\$0	\$129	\$265
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	<p>In-network: \$160 annually</p> <p>Point-of-service: \$500 annually</p> <p>This plan does not include Part D prescription drug coverage.</p>	<p>In-network: \$0 annually</p> <p>Point-of-service: \$0 annually</p> <p>Prescription drugs: \$50 annually for Part D prescription drugs in Tiers 3, 4 and 5.</p>	<p>In-network: \$0 annually</p> <p>Point-of-service: \$500 annually</p> <p>This plan does not have a deductible for Part D prescription drugs.</p>	<p>In-network: \$0 annually</p> <p>Point-of-service: \$200 annually</p> <p>This plan does not have a deductible for Part D prescription drugs.</p>	
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
<p>Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i></p>	<p>\$4,500 annually</p>	<p>\$4,500 annually</p>	<p>\$3,800 annually</p>	<p>\$3,400 annually</p>	<p>The most you pay for copays, coinsurance and other costs for medical services for the year.</p> <p>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.</p> <p>Elements: Please note that you will still need to pay your monthly premiums.</p> <p>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.</p> <p>Point-of-Service: Services received under your point-of-service benefit apply toward your maximum out-of-pocket.</p>

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
<p>Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 3.</p>					
<p>Inpatient Hospital Coverage*</p>	<p>The copays are based on benefit periods.</p> <p>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.</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p>				<p>See Page 53 for more about your point-of-service travel benefit.</p>
	<p>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</p> <p>Point-of-service: \$205 copay per day for days 1 through 6 \$0 copay per day for days 7 through 90</p>	<p>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</p> <p>Point-of-service: \$325 copay per day for days 1 through 6 \$0 copay per day for days 7 through 90</p>	<p>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</p> <p>Point-of-service: \$225 copay per day for days 1 through 6 \$0 copay per day for days 7 through 90</p>	<p>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</p> <p>Point-of-service: \$125 copay per day for days 1 through 6 \$0 copay per day for days 7 through 90</p>	<p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-covered services.</p> <p>If you go to out-of-network providers you pay the full cost.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Outpatient Hospital Coverage*</p> <ul style="list-style-type: none"> o Ambulatory surgical center 	<p>In-network: \$0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.</p> <p>\$100 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.</p> <p>Point-of-service: \$0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.</p> <p>\$100 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.</p>	<p>In-network: \$0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.</p> <p>\$100 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.</p> <p>Point-of-service: \$0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.</p> <p>\$100 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.</p>	<p>In-network: \$0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.</p> <p>\$95 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.</p> <p>Point-of-service: \$0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.</p> <p>\$95 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.</p>	<p>In-network: \$0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.</p> <p>\$70 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.</p> <p>Point-of-service: \$0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.</p> <p>\$70 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.</p>	<p>See Page 53 for more about your point-of-service travel benefit.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-covered services.</p> <p>If you go to out-of-network providers you pay the full cost.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<ul style="list-style-type: none"> o Outpatient hospital 	<p>In-network: \$0 copay for Medicare-covered palliative care.</p> <p>\$200 copay for Medicare-covered outpatient hospital surgery.</p> <p>Point-of-service: \$0 copay for Medicare-covered palliative care.</p> <p>\$200 copay for Medicare-covered outpatient hospital surgery.</p>	<p>In-network: \$0 copay for Medicare-covered palliative care.</p> <p>\$275 copay for Medicare-covered outpatient hospital surgery.</p> <p>Point-of-service: \$0 copay for Medicare-covered palliative care.</p> <p>\$275 copay for Medicare-covered outpatient hospital surgery.</p>	<p>In-network: \$0 copay for Medicare-covered palliative care.</p> <p>\$225 copay for Medicare-covered outpatient hospital surgery.</p> <p>Point-of-service: \$0 copay for Medicare-covered palliative care.</p> <p>\$225 copay for Medicare-covered outpatient hospital surgery.</p>	<p>In-network: \$0 copay for Medicare-covered palliative care.</p> <p>\$200 copay for Medicare-covered outpatient hospital surgery.</p> <p>Point-of-service: \$0 copay for Medicare-covered palliative care.</p> <p>\$200 copay for Medicare-covered outpatient hospital surgery.</p>	
<p>Doctor Visits</p> <ul style="list-style-type: none"> o Primary o Specialists 	<p>In-network: \$0 copay</p> <p>Point-of-service: \$40 copay</p> <p>In-network: \$40 copay</p> <p>Point-of-service: \$40 copay</p>	<p>In-network: \$0 copay</p> <p>Point-of-service: \$0 copay</p> <p>In-network: \$45 copay</p> <p>Point-of-service: \$45 copay</p>	<p>In-network: \$0 copay</p> <p>Point-of-service: \$35 copay</p> <p>In-network: \$35 copay</p> <p>Point-of-service: \$35 copay</p>	<p>In-network: \$0 copay</p> <p>Point-of-service: \$20 copay</p> <p>In-network: \$20 copay</p> <p>Point-of-service: \$20 copay</p>	<p>See Page 53 for more about your point-of-service travel benefit.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-covered services.</p> <p>If you go to out-of-network providers you pay the full cost.</p> <p>Specialist services may require a referral.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Preventive Care	<p style="text-align: center;">In-network: You pay nothing. Our plan covers many Medicare-covered preventive services, including:</p>				
	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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) 			
	<p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>				

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Emergency Care	\$90 copay	\$90 copay	\$90 copay	\$90 copay	<p>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.</p> <p><i>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.</i></p>
Urgently Needed Services	<p>\$0 copay for Medicare-covered urgently needed services in a primary care physician’s office.</p> <p>\$45 copay for Medicare-covered urgently needed services in an urgent care center.</p>	<p>\$0 copay for Medicare-covered urgently needed services in a primary care physician’s office.</p> <p>\$45 copay for Medicare-covered urgently needed services in an urgent care center.</p>	<p>\$0 copay for Medicare-covered urgently needed services in a primary care physician’s office.</p> <p>\$40 copay for Medicare-covered urgently needed services in an urgent care center.</p>	<p>\$0 copay for Medicare-covered urgently needed services in a primary care physician’s office.</p> <p>\$35 copay for Medicare-covered urgently needed services in an urgent care center.</p>	<p><i>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.</i></p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Diagnostic Services/Labs/Imaging* <ul style="list-style-type: none"> <li data-bbox="121 297 373 362">o Diagnostic tests and procedures <li data-bbox="121 508 327 540">o Lab services <li data-bbox="121 719 394 751">o COVID-19 testing 	<p data-bbox="447 297 615 362">In-network: \$20 copay</p> <p data-bbox="447 402 688 467">Point-of-service: \$20 copay</p> <p data-bbox="447 508 615 573">In-network: \$0 copay</p> <p data-bbox="447 613 688 678">Point-of-service: \$0 copay</p> <p data-bbox="447 719 615 784">In-network: \$0 copay</p> <p data-bbox="447 824 688 889">Point-of-service: \$0 copay</p>	<p data-bbox="758 297 926 362">In-network: \$20 copay</p> <p data-bbox="758 402 999 467">Point-of-service: \$20 copay</p> <p data-bbox="758 508 926 573">In-network: \$0 copay</p> <p data-bbox="758 613 999 678">Point-of-service: \$0 copay</p> <p data-bbox="758 719 926 784">In-network: \$0 copay</p> <p data-bbox="758 824 999 889">Point-of-service: \$0 copay</p>	<p data-bbox="1068 297 1236 362">In-network: \$20 copay</p> <p data-bbox="1068 402 1310 467">Point-of-service: \$20 copay</p> <p data-bbox="1068 508 1236 573">In-network: \$0 copay</p> <p data-bbox="1068 613 1310 678">Point-of-service: \$0 copay</p> <p data-bbox="1068 719 1236 784">In-network: \$0 copay</p> <p data-bbox="1068 824 1310 889">Point-of-service: \$0 copay</p>	<p data-bbox="1379 297 1547 362">In-network: \$10 copay</p> <p data-bbox="1379 402 1621 467">Point-of-service: \$10 copay</p> <p data-bbox="1379 508 1547 573">In-network: \$0 copay</p> <p data-bbox="1379 613 1621 678">Point-of-service: \$0 copay</p> <p data-bbox="1379 719 1547 784">In-network: \$0 copay</p> <p data-bbox="1379 824 1621 889">Point-of-service: \$0 copay</p>	<p data-bbox="1690 172 1980 302">See Page 53 for more about your point-of-service travel benefit.</p> <p data-bbox="1690 334 1980 537">All plans: Lab services must be rendered at a participating Joint Venture Hospital Lab (JVHL).</p> <p data-bbox="1690 570 1980 699">Elements, Classic and Prestige: Point-of-service deductible applies</p> <p data-bbox="1690 716 1980 854">Elements: Deductible applies for Medicare-covered services.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<ul style="list-style-type: none"> o Diagnostic radiology service (e.g., X-rays, MRI) o Outpatient X-rays (e.g., X-rays, MRI) o Therapeutic radiology services 	<p>In-network: \$20 – \$100 copay, depending on the service</p> <p>Point-of-service: \$20 – \$100 copay, depending on the service</p> <p>In-network: \$20 – \$100 copay, depending on the service</p> <p>Point-of-service: \$20 – \$100 copay, depending on the service</p> <p>In-network: \$25 copay</p> <p>Point-of-service: \$25 copay</p>	<p>In-network: \$20 – \$100 copay, depending on the service</p> <p>Point-of-service: \$20 – \$100 copay, depending on the service</p> <p>In-network: \$20 – \$100 copay, depending on the service</p> <p>Point-of-service: \$20 – \$100 copay, depending on the service</p> <p>In-network: \$25 copay</p> <p>Point-of-service: \$25 copay</p>	<p>In-network: \$20 – \$75 copay, depending on the service</p> <p>Point-of-service: \$20 – \$75 copay, depending on the service</p> <p>In-network: \$20 – \$75 copay, depending on the service</p> <p>Point-of-service: \$20 – \$75 copay, depending on the service</p> <p>In-network: \$15 copay</p> <p>Point-of-service: \$15 copay</p>	<p>On-network: \$10 – \$50 copay, depending on the service</p> <p>Point-of-service: \$10 – \$50 copay, depending on the service</p> <p>In-network: \$10 – \$50 copay, depending on the service</p> <p>Point-of-service: \$10 – \$50 copay, depending on the service</p> <p>In-network: \$0 copay</p> <p>Point-of-service: \$0 copay</p>	<p>If you go to out-of-network providers you pay the full cost.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Hearing Services</p> <ul style="list-style-type: none"> o Hearing exam to diagnose and treat hearing and balance issues o Routine hearing exam (for up to 1 per year) o Hearing aid fitting and evaluation (for one every three years) o Hearing aids 	<p>In-network: \$0 copay for Medicare-covered hearing services from a primary care provider. \$40 copay for Medicare-covered hearing services from a specialist.</p> <p>Point-of-service: \$40 copay</p> <p>In-network: \$0 copay for one hearing exam every year from a primary care provider. \$40 copay for one hearing exam every year from a specialist.</p> <p>Point-of-service: Not covered</p> <p>In-network: \$0 copay for one hearing aid fitting and evaluation every three years</p> <p>Point-of-service: Not covered</p> <p>In-network: Up to a \$1,200 (\$600 per ear) allowance every three years</p> <p>Point-of-service: Not covered</p>	<p>In-network: \$0 copay for Medicare-covered hearing services from a primary care provider. \$45 copay for Medicare-covered hearing services from a specialist.</p> <p>Point-of-service: \$45 copay</p> <p>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.</p> <p>Point-of-service: Not covered</p> <p>In-network: \$0 copay for one hearing aid fitting and evaluation every three years</p> <p>Point-of-service: Not covered</p> <p>In-network: Up to a \$1,200 (\$600 per ear) allowance every three years</p> <p>Point-of-service: Not covered</p>	<p>In-network: \$0 copay for Medicare-covered hearing services from a primary care provider. \$35 copay for Medicare-covered hearing services from a specialist.</p> <p>Point-of-service: \$35 copay</p> <p>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.</p> <p>Point-of-service: Not covered</p> <p>In-network: \$0 copay for one hearing aid fitting and evaluation every three years</p> <p>Point-of-service: Not covered</p> <p>In-network: Up to a \$1,200 (\$600 per ear) allowance every three years</p> <p>Point-of-service: Not covered</p>	<p>In-network: \$0 copay for Medicare-covered hearing services from a primary care provider. \$20 copay for Medicare-covered hearing services from a specialist.</p> <p>Point-of-service: \$20 copay</p> <p>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.</p> <p>Point-of-service: Not covered</p> <p>In-network: \$0 copay for one hearing aid fitting and evaluation every three years</p> <p>Point-of-service: Not covered</p> <p>In-network: Up to a \$1,200 (\$600 per ear) allowance every three years</p> <p>Point-of-service: Not covered</p>	<p>See Page 53 for more about your point-of-service travel benefit.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-covered services.</p> <p>If you go to out-of-network providers you pay the full cost.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Dental Services</p> <p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)</p> <p>Preventive dental services</p> <ul style="list-style-type: none"> 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) 	<p>In-network: \$0 – \$200 copay depending on the Medicare-covered dental service</p> <p>Point-of-service: \$40 – \$200 copay depending on the Medicare-covered dental service</p>	<p>In-network: \$0 – \$275 copay depending on the Medicare-covered dental service</p> <p>Point-of-service: \$0 – \$275 copay depending on the Medicare-covered dental service</p>	<p>In-network: \$0 – \$225 copay depending on the Medicare-covered dental service</p> <p>Point-of-service: \$35 – \$225 copay depending on the Medicare-covered dental service</p>	<p>In-network: \$0 – \$200 copay depending on the Medicare-covered dental service</p> <p>Point-of-service: \$20 – \$200 copay depending on the Medicare-covered dental service</p>	<p>See Page 53 for more about your point-of-service travel benefit.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-covered services.</p> <p>If you go to out-of-network providers you pay the full cost.</p> <p>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.</p>
<p>In-network: \$0 copay</p>					

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Vision Services</p> <ul style="list-style-type: none"> o Exam to diagnose and treat diseases and conditions of the eye o Eyeglasses or contact lenses after Medicare-covered cataract surgery o Routine eye exam 	<p>In-network: \$0 – \$40 copay, depending on the Medicare-covered service</p> <p>Point-of-service: \$0 – \$40 copay, depending on the Medicare-covered service</p> <p>In-network: \$0 copay for eyeglasses or contact lenses after Medicare-covered cataract surgery.</p> <p>Point-of-service: \$0 copay</p> <p>In-network: \$0 copay for up to one routine eye exam every 12 months.</p> <p>Point-of-service: Not covered</p>	<p>In-network: \$0 – \$45 copay, depending on the Medicare-covered service</p> <p>Point-of-service: \$0 – \$45 copay, depending on the Medicare-covered service</p> <p>In-network: \$0 copay for eyeglasses or contact lenses after Medicare-covered cataract surgery.</p> <p>Point-of-service: \$0 copay</p> <p>In-network: \$0 copay for up to one routine eye exam every 12 months.</p> <p>Point-of-service: Not covered</p>	<p>In-network: \$0 – \$35 copay, depending on the Medicare-covered service</p> <p>Point-of-service: \$0 – \$35 copay, depending on the Medicare-covered service</p> <p>In-network: \$0 copay for eyeglasses or contact lenses after Medicare-covered cataract surgery.</p> <p>Point-of-service: \$0 copay</p> <p>In-network: \$0 copay for up to one routine eye exam every 12 months.</p> <p>Point-of-service: Not covered</p>	<p>In-network: \$0 – \$20 copay, depending on the Medicare-covered service</p> <p>Point-of-service: \$0 – \$20 copay, depending on the Medicare-covered service</p> <p>In-network: \$0 copay for eyeglasses or contact lenses after Medicare-covered cataract surgery.</p> <p>Point-of-service: \$0 copay</p> <p>In-network: \$0 copay for up to one routine eye exam every 12 months.</p> <p>Point-of-service: Not covered</p>	<p>See Page 53 for more about your point-of-service travel benefit.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies to Medicare-covered services.</p> <p>Elements: Deductible applies for Medicare-covered services.</p> <p>If you go to out-of-network providers you pay the full cost.</p> <p>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.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Every 12 months, we cover one of the following:</p> <ul style="list-style-type: none"> o Elective contacts o One pair of lenses o One frame o One complete pair of eyeglasses (lenses and frames) <p>If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit.</p>	<p>This is not a covered benefit.</p>	<p>\$0 copay</p> <p>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) one frame.</p> <p>Lenses are covered in full every 12 months.</p> <p>Benefit must be obtained from an in-network provider.</p>	<p>\$0 copay</p> <p>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) one frame.</p> <p>Lenses are covered in full every 12 months.</p> <p>Benefit must be obtained from an in-network provider.</p>	<p>\$0 copay</p> <p>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) one frame.</p> <p>Lenses are covered in full every 12 months.</p> <p>Benefit must be obtained from an in-network provider.</p>	

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Mental Health Services*</p> <p>o Inpatient visit</p> <p>o Outpatient group or individual therapy visit</p>	<p>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.</p> <p>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.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>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.</p>				<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>See Page 53 for more about your point-of-service travel benefit.</p>
	<p>In-network: \$205 copay per day for days 1 through 6</p> <p>\$0 copay per day for days 7 through 90</p> <p>Point-of-service: \$205 copay per day for days 1 through 6</p> <p>You pay nothing per day for days 7 through 90</p>	<p>In-network: \$300 copay per day for days 1 through 6</p> <p>\$0 copay per day for days 7 through 90</p> <p>Point-of-service: \$300 copay per day for days 1 through 6</p> <p>You pay nothing per day for days 7 through 90</p>	<p>In-network: \$225 copay per day for days 1 through 6</p> <p>\$0 copay per day for days 7 through 90</p> <p>Point-of-service: \$225 copay per day for days 1 through 6</p> <p>You pay nothing per day for days 7 through 90</p>	<p>In-network: \$125 copay per day for days 1 through 6</p> <p>\$0 copay per day for days 7 through 90</p> <p>Point-of-service: \$125 copay per day for days 1 through 6</p> <p>You pay nothing per day for days 7 through 90</p>	<p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-covered services.</p>
<p>In-network: \$40 copay</p> <p>Point-of-service: \$40 copay</p>	<p>In-network: \$40 copay</p> <p>Point-of-service: \$40 copay</p>	<p>In-network: \$35 copay</p> <p>Point-of-service: \$35 copay</p>	<p>In-network: \$20 copay</p> <p>Point-of-service: \$20 copay</p>		

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Skilled Nursing Facility (SNF)*	<p>In-network: Days 1 – 20: \$0 copay</p> <p>Days 21 – 100: \$188 copay per day</p> <p>Point-of-service: Days 1 – 20: \$0 copay</p> <p>Days 21 – 100: \$188 copay per day</p>	<p>In-network: Days 1 – 20: \$0 copay</p> <p>Days 21 – 100: \$188 copay per day</p> <p>Point-of-service: Days 1 – 20: \$0 copay</p> <p>Days 21 – 100: \$188 copay per day</p>	<p>In-network: Days 1 – 20: \$0 copay</p> <p>Days 21 – 100: \$188 copay per day</p> <p>Point-of-service: Days 1 – 20: \$0 copay</p> <p>Days 21 – 100: \$188 copay per day</p>	<p>In-network: Days 1 – 20: \$0 copay</p> <p>Days 21 – 100: \$188 copay per day</p> <p>Point-of-service: Days 1 – 20: \$0 copay</p> <p>Days 21 – 100: \$188 copay per day</p>	<p>Our plan covers up to 100 days in a SNF.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-Covered services.</p> <p>See Page 53 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.</p>
<p>Physical Therapy*</p> <ul style="list-style-type: none"> o Physical therapy, occupational therapy, and speech and language therapy visit 	<p>In-network: \$30 copay</p> <p>Point-of-service: \$30 copay</p>	<p>In-network: \$30 copay</p> <p>Point-of-service: \$30 copay</p>	<p>In-network: \$30 copay</p> <p>Point-of-service: \$30 copay</p>	<p>In-network: \$15 copay</p> <p>Point-of-service: \$15 copay</p>	<p>See Page 53 for more about your point-of-service travel benefit.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-covered services.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
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 53 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
<p>Transportation</p> <p>Qualified members who have been selected to be a part of Blue Cross Coordinated Care CoreSM, 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.</p>	<p>Qualified members pay \$0 for transportation.</p> <p>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.</p> <p>For qualified BCN Advantage members who reside in Allegan, Barry, Ionia, Kalamazoo, Kent, Mason, Muskegon, Newaygo, Ottawa, and Oceana counties, non-emergency medical transportation is covered for 2 trips per member per month when no other resources are available.</p>				<p>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.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Medicare Part B Drugs*</p> <ul style="list-style-type: none"> o Part B drugs such as chemotherapy/radiation drugs o Other Part B drugs 	<p>In-network: 20% coinsurance</p> <p>Point-of-service: 20% coinsurance</p>	<p>In-network: 20% coinsurance</p> <p>Point-of-service: 20% coinsurance</p>	<p>In-network: 20% coinsurance</p> <p>Point-of-service: 20% coinsurance</p>	<p>In-network: 20% coinsurance</p> <p>Point-of-service: 20% coinsurance</p>	<p>Services may require prior authorization and/or step therapy may apply.</p> <p>See Page 53 for more about your point-of-service travel benefit.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-covered services.</p>
<p>Bathroom Safety</p> <p>Eligible members who receive a physician order may use the annual plan benefit maximum towards supplemental bathroom safety items such as:</p> <ul style="list-style-type: none"> • Shower/bathtub grab bar • Tub stool or transfer bench • Commode rails • Elevated toilet seats 	<p>\$0 copay Covered in full up to \$100 annual plan benefit maximum.</p>				<p>Physician order is required.</p> <p><i>Installation and in-home assessment are not covered.</i></p> <p>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.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Blue Cross Online Visits Medical</p> <p>Members can get 24 hours a day, 7 days a week online health care for minor illnesses and symptoms through Blue Cross Online VisitsSM or from their in-network provider.</p> <p>Examples of symptoms that can be addressed in an online visit:</p> <ul style="list-style-type: none"> • Respiratory and sinus infections • Colds, flu and seasonal allergies • Eye irritation or redness • Strains and sprains <p>Behavioral Health</p> <p>Members can get 24 hours a day, 7 days a week online health care for mental health through Blue Cross Online VisitsSM or from an in-network behavioral health provider who offers online visits.</p>	<p>\$0 copay for telehealth services provided by a primary care physician or mental health provider.</p>				<p>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.</p> <p>You can also use Blue Cross Online Visits to access telehealth services. Visit bcbsmonlinevisits.com for more information.</p> <p>Please note: You must have video capability for visits through smartphone or computer. If your camera isn't working, please call 1-844-606-1608 to speak with a service rep.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Cardiac rehabilitation services*</p> <p>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.</p> <p>The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>In-network: \$0 copay for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services.</p> <p>Point-of-service: \$0 copay for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services.</p>				<p>See Page 53 for more about your point-of-service travel benefit.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible may apply for Medicare-covered services.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Chiropractic Care*</p> <ul style="list-style-type: none"> o Manipulation of the spine to correct a subluxation (when one or more bones in your spine moves out of position) o Routine care/other 	<p>In-network: \$20 copay</p> <p>Point-of-service: \$20 copay</p> <p>In-network: \$20 – \$40 copay, depending on the service.</p> <p>Point-of-service: \$20 – \$40 copay, depending on the service.</p>	<p>In-network: \$20 copay</p> <p>Point-of-service: \$20 copay</p> <p>In-network: \$20 – \$45 copay, depending on the service.</p> <p>Point-of-service: \$20 – \$45 copay, depending on the service.</p>	<p>In-network: \$20 copay</p> <p>Point-of-service: \$20 copay</p> <p>In-network: \$20 – \$35 copay, depending on the service.</p> <p>Point-of-service: \$20 – \$35 copay, depending on the service.</p>	<p>In-network: \$20 copay.</p> <p>Point-of-service: \$20 copay</p> <p>In-network: \$10 – \$20 copay, depending on the service.</p> <p>Point-of-service: \$10 – \$20 copay, depending on the service.</p>	<p>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.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-covered services.</p> <p>See Page 53 for more about your point-of-service travel benefit. If you go to out-of-network providers you pay the full cost.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Durable Medical Equipment/Supplies*</p> <ul style="list-style-type: none"> o Durable Medical Equipment (e.g., wheelchairs, oxygen) 	<p>In-network: 20% coinsurance of the cost for Medicare-covered items.</p> <p>Point-of-service: 20% coinsurance of the cost for Medicare-covered items.</p>	<p>In-network: 20% coinsurance of the cost for Medicare-covered items.</p> <p>Point-of-service: 20% coinsurance of the cost for Medicare-covered items.</p>	<p>In-network: 20% coinsurance of the cost for Medicare-covered items.</p> <p>Point-of-service: 20% coinsurance of the cost for Medicare-covered items.</p>	<p>In-network: 20% coinsurance of the cost for Medicare-covered items.</p> <p>Point-of-service: 20% coinsurance of the cost for Medicare-covered items.</p>	<p>See Page 53 for more about your point-of-service travel benefit.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible may apply for Medicare-covered services.</p> <p>If you go to out-of-network providers you pay the full cost.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<ul style="list-style-type: none"> o Prosthetics (e.g., braces, artificial limbs) o Diabetes supplies (e.g., monitoring, shoes or inserts) 	<p>In-network: 20% coinsurance of the cost for Medicare-covered items.</p> <p>Point-of-service: 20% coinsurance of the cost for Medicare-covered items.</p> <p>In-network: \$0 copay</p> <p>Point-of-service: \$0 copay</p>	<p>In-network: 20% coinsurance of the cost for Medicare-covered items.</p> <p>Point-of-service: 20% coinsurance of the cost for Medicare-covered items.</p> <p>In-network: \$0 copay</p> <p>Point-of-service: \$0 copay</p>	<p>In-network: 20% coinsurance of the cost for Medicare-covered items.</p> <p>Point-of-service: 20% coinsurance of the cost for Medicare-covered items.</p> <p>In-network: \$0 copay</p> <p>Point-of-service: \$0 copay</p>	<p>In-network: 20% coinsurance of the cost for Medicare-covered items.</p> <p>Point-of-service: 20% coinsurance of the cost for Medicare-covered items.</p> <p>In-network: \$0 copay</p> <p>Point-of-service: \$0 copay</p>	<p>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 6 p.m. Monday through Friday, Eastern time. TTY users call 711.</p> <p>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.</p> <p>When outside of the plan's service area, members must contact the appropriate vendor listed above.</p> <p>Prosthetics must be obtained from a preferred vendor. Contact us for a list of preferred vendors.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Health Fitness Program</p> <p>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.</p> <p>Benefits include:</p> <ul style="list-style-type: none"> • At participating locations nationwide, you can take classes plus use exercise equipment and other amenities • SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls, and parks) 	<p>You Pay \$0 for health fitness program.</p> <p>SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers LIVE and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved.</p>				

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<ul style="list-style-type: none"> • SilverSneakers LIVE™ classes and workshops taught by instructors trained in senior fitness • 200+ workout videos in the SilverSneakers On-Demand™ online library • SilverSneakers GO™ mobile app with digital workout programs • Thousands of locations • Online fitness and nutrition tips • Social connections through events such as shared meals, holiday celebrations, and class socials <p>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.</p>					

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
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 53 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 53 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.
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
<p>In-Home Support Services</p> <p>Eligible members will have access to in-home and virtual 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.</p> <p>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.</p>	<p>Not covered.</p>	<p>\$0 for up to 8 hours with a Papa Pal each month for qualified members.</p>	<p>Not covered.</p>	<p>Not covered.</p>	<p>To qualify for this benefit, members must meet the following requirements:</p> <ol style="list-style-type: none"> 1) Live alone, and 2) Require help with activities related to living independently, such as transportation, light housework, meal preparation, etc. <p>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.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Meal Benefit</p> <p>Qualified members who have been selected to be a part of Blue Cross Coordinated Care CoreSM, our 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.</p>	<p>\$0 copay for qualified members.</p>				<p>Qualified members will receive up to 28 meals over 14 days from a 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.</p> <p>There is no annual limit to the number of occurrences. Members can receive up to 28 meals following each hospital discharge.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
Outpatient Substance Abuse* <ul style="list-style-type: none"> 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	See Page 53 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.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Over-the-Counter (OTC) Allowance: Advantage Dollars (from authorized vendor only)</p> <p>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.</p> <p>Food items are covered for members with certain conditions.</p> <p>There are four ways to use your benefit:</p> <p>1) In-store: You will receive an allowance card in the mail. You can use this card to purchase many common items at local retailers. You can find a complete list of participating retailers online at bcbsm.com/medicareotc.</p>	<p>Members receive a \$25 per quarter allowance, no rollover.</p>	<p>Members receive a \$75 per quarter allowance, no rollover.</p> <p><u>Exceptions:</u></p> <p>\$25 per quarter allowance, no rollover for members who reside in one of the following counties: Antrim, Benzie, Clinton, Emmet, Genesee, Grand Traverse, Isabella, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mecosta, Midland, Missaukee, Osceola, Otsego, St. Clair, and Wexford.</p>	<p>Members receive a \$25 per quarter allowance, no rollover.</p>	<p>Members receive a \$25 per quarter allowance, no rollover.</p>	<p>You will receive one OTC card which can be used for purchasing approved nonprescription, over-the-counter drugs and health-related items at participating retail locations. The dollar benefit amount will be automatically reloaded each quarter (January 1, April 1, July 1, October 1). Unspent allowance dollars will not carry forward into the next quarter or the next calendar year.</p> <p>In addition to the over-the-counter benefit, plan identified members 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,</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>2) Online. Go to bcbsm.com/medicareotc and follow the prompts to place an order using the online catalog.</p> <p>3) Mail. You may request a printed catalog by calling 1-855-856-7878, from 8 a.m. – 11 p.m. Eastern time, Monday through Friday (TTY: 711). Complete and mail the order form included with the catalog.</p> <p>4) Telephone. Select items using the requested printed or online catalog and call 1-855-856-7878, from 8 a.m. – 11 p.m. Eastern time, Monday through Friday (TTY: 711), to place an order. Items will be mailed to you.</p>					<p>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.</p> <p>Note: All purchases must be made through the plan's approved vendor or purchased at participating retail locations.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
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 53 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.
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 53 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.

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Special Supplemental Benefits for the Chronically Ill Food Benefit</p> <p>Members with certain health conditions can use their quarterly Over-the-Counter Allowance (OTC): Advantage Dollars to buy approved foods.</p> <ul style="list-style-type: none"> • 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 • Have known risk factors associated with exposure to COVID-19 	<p>Members receive a \$25 per quarter OTC allowance, no rollover.</p>	<p>Members receive a \$75 per quarter OTC allowance, no rollover.</p> <p><u>Exceptions:</u></p> <p>\$25 per quarter OTC allowance, no rollover for members who reside in one of the following counties: Antrim, Benzie, Clinton, Emmet, Genesee, Grand Traverse, Isabella, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mecosta, Midland, Missaukee, Osceola, Otsego, St. Clair, and Wexford.</p>	<p>Members receive a \$25 per quarter OTC allowance, no rollover.</p>	<p>Members receive a \$25 per quarter OTC allowance, no rollover.</p>	<p>Your Advantage Dollars account will be loaded automatically with the appropriate allowance amount on January 1, April 1, July 1, and October 1.</p> <p>Please note this benefit works in conjunction with the Over-the-Counter (OTC) Allowance: Advantage Dollars benefit and is limited to the maximum OTC allowance.</p> <p>See Over-the-Counter (OTC) Allowance: Advantage Dollars benefit for more information on the over-the-counter items benefit.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Supervised Exercise Therapy (SET)*</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for SET from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office 	<p>In-network: \$0 copay for Medicare-covered supervised exercise therapy visits.</p> <p>Point-of-service: \$0 copay for Medicare-covered supervised exercise therapy visits.</p>				<p>See Page 53 for more about your point-of-service travel benefit.</p> <p>Elements, Classic and Prestige: Point-of-service deductible applies</p> <p>Elements: Deductible applies for Medicare-covered services.</p>

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<ul style="list-style-type: none"> • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/ clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. 					

Benefits	Elements	Prime Value	Classic	Prestige	What you should know
<p>Support for Caregivers of Enrollees</p> <p>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 member with dementia and other high-risk Medicare Advantage members.</p> <p>Caregivers will have access to online coaching, education, and support where they can learn:</p> <ul style="list-style-type: none"> • How to manage stress and social isolation • How to access available resources such as transportation and home health assistance • Home safety improvements • How to prevent falls • About advanced care planning 	<p>Not covered.</p>	<p>\$0 copay for support for caregivers of enrollees.</p>	<p>Not covered.</p>	<p>Not covered.</p>	<p>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:</p> <ol style="list-style-type: none"> 1. Have been selected to be a part of Blue Cross Coordinated Care CoreSM, our care management program for members with special 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
<p>Worldwide Coverage</p> <p>Worldwide coverage consists of:</p> <ul style="list-style-type: none"> o Worldwide emergency coverage o Worldwide urgent coverage o Worldwide emergency transportation 	<p>\$90 copay for worldwide emergency care services.</p> <p>\$45 copay for worldwide urgent care services.</p> <p>\$250 copay for each one-way trip for worldwide emergency transportation.</p>	<p>\$90 copay for worldwide emergency care services.</p> <p>\$45 copay for worldwide urgent care services.</p> <p>\$275 copay for each one-way trip for worldwide emergency transportation.</p>	<p>\$90 copay for worldwide emergency care services.</p> <p>\$40 copay for worldwide urgent care services.</p> <p>\$250 copay for each one-way trip for worldwide emergency transportation.</p>	<p>\$90 copay for worldwide emergency care services.</p> <p>\$35 copay for worldwide urgent care services.</p> <p>\$250 copay for each one-way trip for worldwide emergency transportation.</p>	<p>If you need care when you're outside of the United States, you have coverage for emergency and urgently needed services only.</p> <p>You have coverage for worldwide emergency medical care.</p> <p>You have coverage for worldwide emergency transportation.</p> <p>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.</p>

Elements

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 and 2. 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 \$4,430.

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 preferred insulin (Senior Savings Model)	\$35	\$35
Tier 4: Non-Preferred Drug	50%	50%
Tier 5: Specialty Tier	32%	32%

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 and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	\$15	\$0
Tier 2: Generic	\$60	\$0
Tier 3: Preferred Brand	\$141	\$126
Select preferred insulin (Senior Savings Model)	\$105	\$105
Tier 4: Non-Preferred Drug	50%	50%
Tier 5: Specialty Tier	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. You also 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 for a 30-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 \$4,430.

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 preferred insulin (Senior Savings Model)	\$35	\$35
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty Tier	33%	33%

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 and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	\$15	\$0
Tier 2: Generic	\$36	\$0
Tier 3: Preferred Brand	\$129	\$114
Select preferred insulin (Senior Savings Model)	\$105	\$105
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty Tier	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.

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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. You also 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).

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 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 \$4,430.

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 preferred insulin (Senior Savings Model)	\$35	\$35
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty Tier	33%	33%

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 and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	\$15	\$0
Tier 2: Generic	\$36	\$0
Tier 3: Preferred Brand	\$129	\$114
Select preferred insulin (Senior Savings Model)	\$105	\$105
Tier 4: Non-Preferred Drug	45%	45%
Tier 5: Specialty Tier	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. You also have additional coverage in the Coverage Gap stage for select insulins. You pay no more than \$35 for a 30-day supply.

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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).

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:	<ul style="list-style-type: none"> • Comprehensive Dental • 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 \$80 – \$129 monthly plan premium.	Additional \$20.40 per month. You must keep paying your Medicare Part B premium and your \$178 – \$264 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?	<p><i>Each benefit has its own dollar maximum and cannot be combined with another benefit.</i></p> <p><i>Comprehensive Dental: \$1,500 annual maximum for combined in-network and out-of-network services every year.</i></p> <p><i>Eyewear: \$200 maximum vision allowance every 12 months</i></p>			

Benefit	BCN Advantage Elements	BCN Advantage Prime Value	BCN Advantage Classic	BCN Advantage Prestige
<p>Dental – Optional Supplemental Benefit – Package 1</p> <p>In addition to preventive dental, we cover:</p>	<p>\$1,500 combined annual maximum for in-network and out-of-network services.</p>			
	<p>In Network</p>			
	<p>\$0 cost-share for fluoride treatments and brush biopsies</p>			
	<p>50% coinsurance for:</p>			
	<ul style="list-style-type: none"> o Resin and amalgam fillings o Crowns o Crown repairs o Adjunct crown services o Root canals o Simple extractions 			
	<p>Out-of-network</p>			
	<p>50% coinsurance of the allowed amount:</p>			
	<ul style="list-style-type: none"> o Up to two periodic oral exams per calendar year (includes emergency exams). <i>Emergency exams are subject to the two oral exams per year limit.</i> 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 			
	<p>For in-network benefits, you must receive services from a participating provider.</p>			
	<p>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.</p>			
	<p>Out-of-network expenses will be reimbursed at 50% of allowed amounts up to the combined benefit maximum.</p>			
	<p>You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.</p>			

Benefit	BCN Advantage Elements	BCN Advantage Prime Value	BCN Advantage Classic	BCN Advantage Prestige
<p>Vision – Optional Supplemental Benefit – Package 1</p> <p>Every 12 months, we cover one of the following:</p> <ul style="list-style-type: none"> o Elective contacts o One pair of lenses o One frame o One complete pair of eyeglasses (lenses and frames) <p>If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit.</p>	In-network Eyewear			
	<p>The optional eye wear benefit provides a \$200 combined in- and out-of-network maximum vision allowance every 12 months and may be used for either (a) elective contact lenses or (b) one frame.</p> <p>Standard eyeglass lenses are covered in full every 12 months.</p>	<p>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) one frame.</p> <p>Standard eyeglass lenses are covered in full every 12 months.</p>		
	<p>Supplemental vision benefits are provided in conjunction with standard vision benefit. Frequency limits apply.</p> <p>You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.</p>			
	Out-of-network Eyewear			
<p>The optional eye wear benefit provides a combined in- and out-of-network maximum vision allowance with 50% coinsurance up to \$200 every 12 months and may be used for either (a) elective contact lenses or (b) one frame.</p> <p>Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts.</p> <p>Exams are reimbursed at 50% coinsurance up to allowed amounts.</p>	<p>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) one frame.</p> <p>Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts.</p> <p>Exams are reimbursed at 50% coinsurance up to allowed amounts.</p>			

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:	<ul style="list-style-type: none"> • Comprehensive Dental • 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 \$80 – \$129 monthly plan premium.	Additional \$32.40 per month. You must keep paying your Medicare Part B premium and your \$178 – \$264 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?	<p><i>Each benefit has its own dollar maximum and cannot be combined with another benefit.</i></p> <p><i>Comprehensive Dental: \$2,500 annual maximum for combined in-network and out-of-network services every year.</i></p> <p><i>Eyewear: \$300 combined in-network and out-of-network maximum vision allowance every 12 months.</i></p>			

Benefit	BCN Advantage Elements	BCN Advantage Prime Value	BCN Advantage Classic	BCN Advantage Prestige
<p>Dental – Optional Supplemental Benefit – Package 2</p> <p>In addition to preventive dental, we cover:</p>	<p>\$2,500 combined annual maximum for in-network and out-of-network services.</p> <p>In Network</p> <p>\$0 cost-share for fluoride treatments and brush biopsies</p> <p>25% coinsurance for:</p> <ul style="list-style-type: none"> 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
	<p>Out-of-network</p> <p>50% coinsurance of the allowed amount:</p> <ul style="list-style-type: none"> o Up to two periodic oral exams per calendar year (includes emergency exams). <i>Emergency exams are subject to the two oral exams per year limit.</i> 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 <p>For in-network benefits, you must receive services from a participating provider.</p> <p>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.</p> <p>Out-of-network expenses will be reimbursed at 50% of allowed amounts up to the combined benefit maximum.</p> <p>You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.</p>			

Benefit	BCN Advantage Elements	BCN Advantage Prime Value	BCN Advantage Classic	BCN Advantage Prestige
<p>Vision – Optional Supplemental Benefit – Package 2</p> <p>Every 12 months, we cover one of the following:</p> <ul style="list-style-type: none"> o Elective contacts o One pair of lenses o One frame o One complete pair of eyeglasses (lenses and frames) <p>If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit.</p>	In-network Eyewear			
	<p>The optional eye wear benefit provides a \$300 combined in- and out-of-network maximum vision allowance every 12 months and may be used for either (a) elective contact lenses or (b) one frame.</p> <p>Standard eyeglass lenses are covered in full every 12 months.</p>	<p>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) one frame.</p> <p>Standard eyeglass lenses are covered in the standard benefit.</p>		
	<p>Supplemental vision benefits are provided in conjunction with standard vision benefit. Frequency limits apply.</p> <p>You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.</p>			
	Out-of-network Eyewear			
<p>The optional eye wear benefit provides a combined in- and out-of-network maximum vision allowance with 50% coinsurance up to \$300 every 12 months and may be used for either (a) elective contact lenses or (b) one frame.</p> <p>Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts.</p> <p>Exams are reimbursed at 50% coinsurance up to allowed amounts.</p>	<p>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) one frame.</p> <p>Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts.</p> <p>Exams are reimbursed at 50% coinsurance up to allowed amounts.</p>			

Additional Information about BCN Advantage HMO-POS

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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Medicare and more

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.