2026

READY TO HELP

BCN Advantage℠ HMO-POS

Elements, Classic, Prestige

Summary of Benefits

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 (HMO) with a Point-of-Service (POS) option. To join BCN Advantage HMO-POS Elements, Classic or Prestige, you must have both Medicare Part A and Medicare Part B, be a United States citizen or lawfully present in the United States and live in our geographic service area. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it. Our service area includes 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, Sanilac, 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.

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. For the Elements plan only, a Medicare Part B premium reduction of $20 is provided.

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	Classic	Prestige
Region 1 Allegan, Barry, Ionia, Kalamazoo, Kent, Mason, Muskegon, Newaygo, Oceana and Ottawa	$0	$93.00	$178.00
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren	$0	$113.60	$240.00
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	$123.60	$231.00
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	$103.00	$225.00
Region 5 - Macomb, Oakland, Washtenaw and Wayne	$0	$145.00	$267.00
Optional Supplemental Dental and Vision	$17.90		

Deductible and limits on how much you pay for covered services	Elements	Classic	Prestige
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:** $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	$0 annually		
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$4,500 annually	$4,400 annually	$4,000 annually
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	Classic	Prestige
Note: Services with * may require prior authorization.			
Inpatient Hospital Coverage* Our plan covers an unlimited number of days for an inpatient stay.	**In-network:** $250 copay per day for days 1 – 7, per admission $0 copay for days 8 and beyond **Point-of-service:** $325 copay after deductible per day for days 1 – 7, per admission	**In-network:** $250 copay per day for days 1 – 7, per admission $0 copay for days 8 and beyond **Point-of-service:** $250 copay after deductible per day for days 1 – 7, per admission	**In-network:** $200 copay per day for days 1 – 7, per admission $0 copay for days 8 and beyond **Point-of-service:** $200 copay after deductible per day for days 1 – 7, per admission
Outpatient Hospital Coverage*	**In-network:** $200 copay for outpatient hospital services. **Point-of-service:** $200 copay after deductible for outpatient hospital services.	**In-network:** $225 copay for outpatient hospital services. **Point-of-service:** $225 copay after deductible for outpatient hospital services.	**In-network:** $200 copay for outpatient hospital services. **Point-of-service:** $200 copay after deductible for outpatient hospital services.

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Ambulatory Surgical Center (ASC) Services*	**In-Network:** $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center. **Point-of-service:** $0 copay after deductible for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.		
	In-network: $100 copay for Medicare-covered surgical and non-surgical services. **Point-of-service:** $100 copay after deductible for Medicare-covered surgical and non-surgical services.	**In-network:** $95 copay for Medicare-covered surgical and non-surgical services. **Point-of-service:** $95 copay after deductible for Medicare-covered surgical and non-surgical services.	**In-network:** $70 copay for Medicare-covered surgical and non-surgical services. **Point-of-service:** $70 copay after deductible for Medicare-covered surgical and non-surgical services.
Doctor Visits			
o Primary care provider	**In-network:** $0 copay **Point-of-service:** $35 copay after deductible	**In-network:** $0 copay **Point-of-service:** $30 copay after deductible	**In-network:** $0 copay **Point-of-service:** $20 copay after deductible
o Specialists*	**In-network:** $35 copay **Point-of-service:** $35 copay after deductible	**In-network:** $30 copay **Point-of-service:** $30 copay after deductible	**In-network:** $25 copay **Point-of-service:** $25 copay after deductible
o Telehealth	**In-network:** $0 copay for each telehealth primary care provider medical visit through Teladoc Health™. $0 copay for each telehealth mental health visit through Teladoc Health™.		

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Preventive Care (Any additional preventive services approved by Medicare during the contract year will be covered.)	In-network: $0 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 • Diabetes self-management training	• 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 • Pre-exposure prophylaxis (PrEP) for HIV prevention • 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)	

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Emergency Care You are covered for emergency medical care worldwide.	$130 copay **Note:** The copay is waived if you are admitted to the hospital within three days for the same condition.		
Urgently Needed Services You are covered for urgently needed services worldwide.	$0 copay for Medicare-covered urgently needed services in a primary care provider's office. $45 copay for Medicare-covered services in an urgent care center.	$0 copay for Medicare-covered urgently needed services in a primary care provider's office. $40 copay for Medicare-covered services in an urgent care center.	$0 copay for Medicare-covered urgently needed services in a primary care provider's office. $35 copay for Medicare-covered services in an urgent care center.

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Diagnostic Services/Labs/Imaging*			
o Diagnostic tests and procedures	**In-network:** $20 copay **Point-of-service:** $20 copay after deductible	**In-network:** $20 copay **Point-of-service:** $20 copay after deductible	**In-network:** $10 copay **Point-of-service:** $10 copay after deductible
o Lab services When rendered at a participating Joint Venture Hospital Lab (JVHL).	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible
o COVID-19 testing	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible
o Diagnostic radiology services (e.g., X-rays, MRI)	**In-network:** $20 – $100 copay **Point-of-service:** $20 – $100 copay after deductible	**In-network:** $20 – $75 copay **Point-of-service:** $20 – $75 copay after deductible	**In-network:** $10 – $50 copay **Point-of-service:** $10 – $50 copay after deductible
o Therapeutic radiology services	**In-network:** $25 copay **Point-of-service:** $25 copay after deductible	**In-network:** $15 copay **Point-of-service:** $15 copay after deductible	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Hearing Services			
Medicare-covered hearing services			
o Medicare-covered hearing exam to diagnose and treat hearing and balance issues	**In-network:** $0 – $35 copay **Point-of-service:** $35 copay after deductible	**In-network:** $0 – $30 copay **Point-of-service:** $30 copay after deductible	**In-network:** $0 – $25 copay **Point-of-service:** $25 copay after deductible
Non-Medicare-covered hearing services Must be received from a TruHearing® provider.			
o Routine hearing exam (1 per year)	**In-network:** $0 copay **Point-of-service:** Not covered	**In-network:** $0 copay **Point-of-service:** Not covered	**In-network:** $0 copay **Point-of-service:** Not covered
o Hearing aid fitting and evaluation	**In-network:** $0 copay **Point-of-service:** Not covered	**In-network:** $0 copay **Point-of-service:** Not covered	**In-network:** $0 copay **Point-of-service:** Not covered
o Hearing aids	**In-network:** $495 copay per aid for Basic Aids, per ear per year $895 copay per aid for Standard Aids, per ear per year $1,295 copay per aid for Advanced Aids, per ear per year $1,695 copay per aid for Premium Aids, per ear per year **Point-of-service:** Not covered 		

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Dental services (Medicare covered)	**In-network:** $0 – $200 copay **Point-of-service:** $35 – $200 copay after deductible	**In-network:** $0 – $225 copay **Point-of-service:** $30 – $225 copay after deductible	**In-network:** $0 – $200 copay **Point-of-service:** $25 – $200 copay after deductible
Enhanced dental services (Preventive and Comprehensive) o Preventive services include oral exams, routine cleanings, certain dental X-rays and fluoride treatment o Comprehensive services include brush biopsies, resin and amalgam fillings, crowns for permanent teeth only, crown repairs, root canals, deep cleaning, simple extractions and oral surgery	This benefit provides a $1,500 annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services. No deductible. **In-network:** $0 copay **Out-of-network:** 50% of the approved amount		
Dental – Optional Supplemental Benefit **(available at an additional monthly premium)** Includes, but not limited to, dentures, bridges, onlays and implants	The benefit provides a $1,500 annual maximum (in addition to the enhanced dental annual maximum for combined in- and out-of-network) for comprehensive dental services. No deductible. **In-network:** 25% coinsurance **Out-of-network:** 50% of the approved amount		

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Vision Services (Medicare-covered)			
o Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	**In-network:** $0 – $35 copay **Point-of-service:** $0 – $35 copay after deductible	**In-network:** $0 – $30 copay **Point-of-service:** $0 – $30 copay after deductible	**In-network:** $0 – $25 copay **Point-of-service:** $0 – $25 copay after deductible
o Eyeglasses or contact lenses after Medicare-covered cataract surgery	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible
o Screening for diabetic retinopathy is covered once per year for those at risk.	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Enhanced Vision Services			
Routine eye exam through the VSP Choice Network	$0 copay for up to 1 routine eye exam once every calendar year.	$0 copay for up to 1 routine eye exam once every calendar year.	$0 copay for up to 1 routine eye exam once every calendar year.
Eligible for one each calendar year: o Elective contacts, OR o One pair standard lenses, OR o One frame OR o One complete pair of eyeglasses For a complete pair of eyeglasses, the allowance can be used for the frame only.	The eyewear benefit provides a $100 maximum vision benefit every calendar year and may be used for either (a) elective contact lenses or (b) 1 frame. Standard eyeglass lenses are covered in full every calendar year. Benefit must be obtained from an in-network provider.	The eyewear benefit provides a $100 maximum vision benefit every calendar year and may be used for either (a) elective contact lenses or (b) 1 frame. Standard eyeglass lenses are covered in full every calendar year. Benefit must be obtained from an in-network provider.	The eyewear benefit provides a $150 maximum vision benefit every calendar year and may be used for either (a) elective contact lenses or (b) 1 frame. Standard eyeglass lenses are covered in full every calendar year. Benefit must be obtained from an in-network provider.

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Optional Supplemental Vision (available for an additional monthly premium) Every calendar year, 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) For a complete pair of eyeglasses, the allowance can be used for the frame only.	**In-network:** $0 copay The benefit provides an extra $250 benefit maximum once every calendar year and may be used for either (a) elective contact lenses or (b) 1 frame.		
Inpatient Mental Health Care* Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**In-network:** $250 copay per day for days 1 – 7, per admission **Point-of-service:** $325 copay per day for days 1 – 7, per admission, after deductible	**In-network:** $250 copay per day for days 1 – 7, per admission **Point-of-service:** $250 copay per day for days 1 – 7, per admission, after deductible	**In-network:** $200 copay per day for days 1 – 7, per admission **Point-of-service:** $200 copay per day for days 1 – 7, per admission, after deductible
Outpatient Mental Health Care Individual and group therapy	**In-network:** $20 copay **Point-of-service:** $35 copay after deductible	**In-network:** $20 copay **Point-of-service:** $35 copay after deductible	**In-network:** $20 copay **Point-of-service:** $20 copay after deductible

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Skilled Nursing Facility (SNF)* Our plan covers up to 100 days in a SNF. No prior hospital stay is required for a skilled nursing facility stay.	**In-network:** $0 copay per day for days 1 – 20 $218 copay per day for days 21 – 100 **Point-of-service:** $0 copay per day for days 1 – 20, after deductible $218 copay per day for days 21 – 100, after deductible	**In-network:** $0 copay per day for days 1 – 20 $218 copay per day for days 21 – 100 **Point-of-service:** $0 copay per day for days 1 – 20, after deductible $218 copay per day for days 21 – 100, after deductible	**In-network:** $0 copay per day for days 1 – 20 $218 copay per day for days 21 – 100 **Point-of-service:** $0 copay per day for days 1 – 20, after deductible $218 copay per day for days 21 – 100, after deductible
Outpatient Rehabilitation* Physical/Speech/Occupational therapy	**In-network:** $35 copay **Point-of-service:** $35 copay after deductible	**In-network:** $35 copay **Point-of-service:** $35 copay after deductible	**In-network:** $25 copay **Point-of-service:** $25 copay after deductible
Ambulance services o Medicare-covered ground or air transportation	**In-network:** $300 copay **Point-of-service:** $300 copay after deductible	**In-network:** $250 copay **Point-of-service:** $250 copay after deductible	**In-network:** $250 copay **Point-of-service:** $250 copay after deductible
o Ambulance services without transportation	**In-network:** $90 copay **Point-of-service:** $90 copay after deductible	**In-network:** $90 copay **Point-of-service:** $90 copay after deductible	**In-network:** $90 copay **Point-of-service:** $90 copay after deductible
Transportation services	Not covered		

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Medicare Part B Drugs*			
o Medicare Part B Insulin Drugs (one month's supply)	**In-Network and Point-of-Service:** Up to 20% coinsurance; however, not more than $35 per month		
o Drugs such as chemotherapy drugs and other Part B Drugs	**In-network:** 0% – 20% coinsurance **Point-of-service:** 0% – 20% coinsurance after deductible		
Medical Equipment/Supplies*			
o Durable Medical Equipment and Prosthetics and Orthotic Devices	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance after deductible	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance after deductible	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance after deductible
o Diabetes supplies	**In-network:** 0%-20% coinsurance **Point-of-service:** 0%-40% coinsurance	**In-network:** 0%-20% coinsurance **Point-of-service:** 0%-40% coinsurance	**In-network:** 0%-20% coinsurance **Point-of-service:** 0%-40% coinsurance
Health fitness program (SilverSneakers)	$0 for the health fitness program. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved.		
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.	You receive $50 per quarter, no rollover. **Note:** All purchases must be made through plan-approved retailers.		

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Personal Emergency Response System The Personal Emergency Response System (PERS) comprehensive system can be catered to individual care plans, includes activity, vital signs, fall, sleep and environment tracking, and can serve as an engagement tool.	Not offered.	$0 copay for qualifying members.	
Special supplemental benefits for the chronically ill **Food and Produce Allowance** The benefits described are Special Supplemental Benefits for the Chronically Ill. 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: o **Autoimmune disorders** including polyarteritis nodosa, polymyalgia rheumatica, polymyositis, dermatomyositis, rheumatoid arthritis, systemic lupus erythematosus, psoriatic arthritis and scleroderma o **Cancer** o **Cardiovascular disorders** including cardiac arrhythmias, coronary artery disease, peripheral vascular disease and valvular heart disease o **Chronic alcohol use disorder and other substance use disorders** (SUDs) o **Chronic and disabling mental health conditions** including bipolar disorders, major depressive disorders, paranoid disorder, schizophrenia, schizoaffective disorder, post-traumatic stress disorder (PTSD), eating disorders and anxiety disorders	You receive $50 per quarter. **Note:** This benefit works with the over-the-counter (OTC) Advantage Dollars allowance and is limited to the maximum OTC allowance amount. All purchases must be made through plan-approved retailers.		

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Special supplemental benefits for the chronically ill (continued) o **Chronic gastrointestinal disease** including Chronic Liver disease, (Non-alcoholic fatty liver disease (NAFLD), Hepatitis B, Hepatitis C, Pancreatitis, Irritable bowel syndrome, Inflammatory bowel disease o **Chronic heart failure** o **Chronic hypertension** o **Chronic kidney disease** (CKD) including CKD requiring dialysis/End-stage renal disease (ESRD) and CKD not requiring dialysis o **Chronic lung disorders** including cystic fibrosis, emphysema, pulmonary fibrosis, pulmonary hypertension and chronic obstructive pulmonary disease (COPD) o **Conditions with functional challenges** including spinal cord injuries, paralysis, limb loss, stroke and arthritis o **Dementia** o **Diabetes Mellitus** o **HIV/AIDS** o **Neurologic disorders** including amyotrophic lateral sclerosis (ALS), epilepsy, extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington's disease, multiple sclerosis, Parkinson's disease, polyneuropathy, fibromyalgia, chronic fatigue syndrome, spinal cord injuries, spinal stenosis and stroke-related neurologic deficit			

Benefits	Elements	Classic	Prestige
Note: Services with * may require prior authorization.			
Special supplemental benefits for the chronically ill (continued) o **Pre-diabetes** o **Severe hematologic disorders** including aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease (excluding sickle-cell trait) and chronic venous thromboembolic disorder. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.			

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

Classic

Phase 1: The Deductible Stage

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

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 out-of-pocket costs (your payments) total $2,100.

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

	Standard retail 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	20%	20%
Tier 4: Non-Preferred Drug	25%	25%
Tier 5: Specialty Tier	33%	33%

You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

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	20%	20%
Tier 4: Non-Preferred Drug	25%	25%
Tier 5: Specialty Tier	Not Covered	Not Covered

You won't pay more than $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

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: The Catastrophic Stage

You have coverage during the Catastrophic Coverage stage. During this stage, you will pay $0.

Most members do not reach the Catastrophic Coverage stage. For information about your costs in this stage, look at Chapter 6, Section 6, 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.

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 out-of-pocket costs (your payments) total $2,100.

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

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
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You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

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	20%	20%
Tier 4: Non-Preferred Drug	25%	25%
Tier 5: Specialty Tier	Not Covered	Not Covered

You won't pay more than $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

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 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**).

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 amount.

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.

BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more