2027

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.

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

Premium/Cost-sharing Table for BCN Advantage HMO-POS Elements, Classic and Prestige

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 counties	$0	$107	$194
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph, and Van Buren counties	$0	$127	$256
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 counties	$0	$138	$248
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 counties	$0	$117	$241
Region 5 Macomb, Oakland, Washtenaw, and Wayne counties	$0	$158	$282
Optional Supplemental Dental and Vision	$26.60		

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 $0 deductible on Part D prescription drugs in Tiers 1 and 2. $200 total deductible per year for Tiers 3, 4 and 5.	**In-Network** $0 annually **Point-of-service** $200 annually $0 deductible on Part D prescription drugs in Tiers 1 and 2. $100 deductible for Tiers 3, 4 and 5.
Deductible - Optional Supplemental Dental and Vision	There is no deductible.		
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$4,500 annually	$4,800 annually	$4,400 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 a [1] may require prior authorization.			
Inpatient Hospital Coverage[1]	**For Medicare-covered inpatient hospital per admission:** **In-network:** Days 1-7: $250 copayment per day.	**For Medicare-covered inpatient hospital per admission:** **In-network:** Days 1-7: $250 copayment per day.	**For Medicare-covered inpatient hospital per admission:** **In-network:** Days 1-7: $200 copayment per day.

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
	Days 8-90: $0 copayment per day. **Point-of-service:** Days 1-7: $325 copayment after deductible per day, per admission. Days 8-90: $0 copayment per day.	Days 8-90: $0 copayment per day. **Point-of-service:** Days 1-7: $250 copayment after deductible per day, per admission. Days 8-90: $0 copayment per day.	Days 8-90: $0 copayment per day. **Point-of-service:** Days 1-7: $200 copayment after deductible per day, per admission. Days 8-90: $0 copayment per day.
Outpatient Hospital Coverage[1]	**In-network:** $200 copayment for outpatient hospital services **Point-of-service:** $200 copayment, after deductible for outpatient hospital services.	**In-network:** $225 copayment for outpatient hospital services **Point-of-service:** $225 copayment, after deductible for outpatient hospital services.	**In-network:** $200 copayment for outpatient hospital services **Point-of-service:** $200 copayment, after deductible for outpatient hospital services.
Ambulatory Surgical Center (ASC) Services[1]	**In-network:** $0 copayment for Medicare-covered arthroplasty knee and hip services in an ASC **Point-of-service:** $0 copayment after deductible for Medicare-covered arthroplasty knee and hip services in an ASC.	**In-network:** $0 copayment for Medicare-covered arthroplasty knee and hip services in an ASC **Point-of-service:** $0 copayment after deductible for Medicare-covered arthroplasty knee and hip services in an ASC.	**In-network:** $0 copayment for Medicare-covered arthroplasty knee and hip services in an ASC **Point-of-service:** $0 copayment after deductible for Medicare-covered arthroplasty knee and hip services in an ASC.

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
	In-network: $100 copayment for Medicare-covered surgical and non-surgical services. **Point-of-service:** $100 copayment after deductible for Medicare-covered surgical and non-surgical services.	**In-network:** $95 copayment for Medicare-covered surgical and non-surgical services. **Point-of-service:** $95 copayment after deductible for Medicare-covered surgical and non-surgical services.	**In-network:** $70 copayment for Medicare-covered surgical and non-surgical services. **Point-of-service:** $70 copayment after deductible for Medicare-covered surgical and non-surgical services.
Doctor Visits • Primary care provider	**In-network:** $0 copayment **Point-of-service:** $35 copayment after deductible	**In-network:** $0 copayment **Point-of-service:** $30 copayment after deductible	**In-network:** $0 copayment **Point-of-service:** $25 copayment after deductible
• Specialists[1]	**In-network:** $35 copayment **Point-of-service:** $35 copayment after deductible	**In-network:** $30 copayment **Point-of-service:** $30 copayment after deductible	**In-network:** $25 copayment **Point-of-service:** $25 copayment after deductible
• Telehealth	**In-network:** $0 copayment for each telehealth primary care physician medical visit through plan-approved vendor. $0 copayment for each telehealth mental health visit through plan-approved vendor.		

Preventive Care (Any additional preventive services approved by Medicare during the contract year will be covered.)	**In-network:** $0 copayment 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 • 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 screening 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)

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
	• "Welcome to Medicare" preventive visit (one-time)		
Emergency Care You are covered for emergency medical care worldwide.	$130 copayment **Note**: The copayment 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 copayment for Medicare-covered urgently needed services in a primary care provider's office. $45 copayment for Medicare-covered services in an urgent care center.	$0 copayment for Medicare-covered urgently needed services in a primary care provider's office. $40 copayment for Medicare-covered services in an urgent care center.	$0 copayment for Medicare-covered urgently needed services in a primary care provider's office. $35 copayment for Medicare-covered services in an urgent care center.
Diagnostic Services/Labs/ Imaging[1] - Medicare-covered • Diagnostic tests and procedures	**In-network:** $20 copayment **Point-of-service:** $20 copayment after deductible		**In-network:** $10 copayment **Point-of-service:** $10 copayment after deductible
• Lab services When rendered at a participating Joint Venture Hospital Lab (JVHL).	**In-network:** $0 copayment **Point-of-service:** $0 copayment after deductible		

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
• COVID-19 testing	**In-network:** $0 copayment **Point-of-service:** $0 copayment after deductible		
• Diagnostic radiology services (e.g., X-rays, MRI)	**In-network:** $20-$100 copayment **Point-of-service:** $20-$100 copayment after deductible	**In-network:** $20-$75 copayment **Point-of-service:** $20-$75 copayment after deductible	**In-network:** $10-$50 copayment **Point-of-service:** $10-$50 copayment after deductible
• Therapeutic radiology services	**In-network:** $25 copayment **Point-of-service:** $25 copayment after deductible	**In-network:** $15 copayment **Point-of-service:** $15 copayment after deductible	**In-network:** $0 copayment **Point-of-service:** $0 copayment after deductible
Hearing Services **Medicare-covered hearing services** • Medicare-covered hearing exam to diagnose and treat hearing and balance issues	**In-network:** $0-$35 copayment **Point-of-service:** $35 copayment after deductible	**In-network:** $0-$30 copayment **Point-of-service:** $30 copayment after deductible	**In-network:** $0-$25 copayment **Point-of-service:** $25 copayment after deductible

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
Non-Medicare-covered hearing services Must be received from a TruHearing® provider. • Routine hearing exam – 1 per year. • Fitting and evaluation for hearing aids. Each hearing aid purchase includes one year of follow-up provider visits for fitting and adjustments. These visits are available for 12 months following hearing aid purchase and only with the purchase of a hearing aid.	**In-network:** $0 copayment for routine hearing exam once per year **In-network:** $0 copayment for hearing aid fitting/evaluation once per year		
• One hearing aid per ear once a year. Up to two hearing aids, (limit one hearing aid per ear per year) from the applicable TruHearing catalog. All content © 2026 TruHearing, Inc. All Rights Reserved. TruHearing® is a registered trademark of TruHearing, Inc.	**In-network:** Hearing aids (one hearing aid per ear once a year): $495 copayment per aid for Basic Aids $895 copayment per aid for Standard Aids $1,295 copayment per aid for Advanced Aids $1,695 copayment per aid for Premium Aids **Point-of-service:** Not offered		
Dental Services (Medicare-covered)	**In-network:** $0-$200 copayment **Point-of-service:** $35-$200 copayment after deductible	**In-network:** $0-$225 copayment **Point-of-service:** $30-$225 copayment after deductible	**In-network:** $0-$200 copayment **Point-of-service:** $25-$200 copayment after deductible

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
Enhanced Dental Services (Preventive and Comprehensive) • Preventive services include oral exams, routine cleanings, certain dental X-rays and fluoride treatment • 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. **In-network:** $0 copayment **Out-of-network:** 50% of the allowed 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 dental services per calendar year. **In-network:** 25% coinsurance **Out-of-network:** 50% coinsurance		
Vision Services (Medicare-covered) • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	**In-network:** $0-$35 copayment **Point-of-service:** $0-$35 copayment after deductible	**In-network:** $0-$30 copayment **Point-of-service:** $0-$30 copayment after deductible	**In-network:** $0-$25 copayment **Point-of-service:** $0-$25 copayment after deductible
• Eyeglasses or contact lenses after Medicare-covered cataract surgery	**In-network:** $0 copayment		

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
	Point-of-service: $0 copayment after deductible		
• Screening for diabetic retinopathy is covered once per year for those at risk.	**In-network:** $0 copayment **Point-of-service:** $0 copayment after deductible		
Enhanced Vision Services Routine eye exam through VSP Choice Network, one per calendar year	$0 copayment for up to one routine eye exam once every calendar year.		
Eligible for one each calendar year: • Elective contacts, OR • One pair standard lenses, OR • One frame	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.
Optional Supplemental Vision (available for additional monthly premium)	**In-network:** $0 copayment for routine eye exam once every calendar year		

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
Standard eyeglass lenses are covered in full once every calendar year. You are eligible for ONE of the following, every calendar year: • Elective contacts, OR • One frame Lens options for eyeglasses include polycarbonate lenses and/or anti-reflective coating.	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. **Point-of-service:** Not covered		
Inpatient Mental Health Care[1] - Medicare-covered	**In-network:** Days 1-7: $250 copayment per day, per admission. Days 8-90: $0 copayment per day. **Point-of-service:** Days 1-7: $325 copayment after deductible per day, per admission. Days 8-90: $0 copayment per day.	**In-network:** Days 1-7: $250 copayment per day, per admission. Days 8-90: $0 copayment per day. **Point-of-service:** Days 1-7: $250 copayment after deductible per day, per admission. Days 8-90: $0 copayment per day.	**In-network:** Days 1-7: $200 copayment per day, per admission. Days 8-90: $0 copayment per day. **Point-of-service:** Days 1-7: $200 copayment after deductible per day, per admission. Days 8-90: $0 copayment per day.
Outpatient Mental Health Care Individual and group therapy	**In-network:** $20 copayment **Point-of-service:** $35 copayment after deductible		**In-network:** $20 copayment **Point-of-service:** $20 copayment after deductible

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
Skilled Nursing Facility (SNF)[1] - Medicare-covered Our plan covers up to 100 days in a SNF. No prior hospital stay is required for a skilled nursing facility stay.	**In-network:** Days 1-20: $0 copayment per day. Days 21-100: $221 copayment per day. **Point-of-service:** Days 1-20: $0 copayment after deductible per day. Days 21-100: $221 copayment after deductible per day.		
Outpatient Rehabilitation[1] Physical/Speech/Occupational therapy	**In-network:** $35 copayment **Point-of-service:** $35 copayment after deductible		**In-network:** $25 copayment **Point-of-service:** $25 copayment after deductible
Ambulance Services • Medicare-covered ground or air transportation	**In-network:** $300 copayment **Point-of-service:** $300 copayment after deductible	**In-network:** $250 copayment **Point-of-service:** $250 copayment after deductible	
• Ambulance services without transportation	**In-network:** $90 copayment **Point-of-service:** $90 copayment after deductible		
Transportation Services	Not covered		

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
Medicare Part B Drugs[1] • 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		
• 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[1] • Durable Medical Equipment and Prosthetics and Orthotic Devices	**In-network:** 20% coinsurance **Point-of-service:** 20% coinsurance after deductible		
• Diabetes supplies Diabetes supplies are items such as continuous glucose monitors and blood glucose testing supplies	**In-network:** 0%-20% coinsurance **Point-of-service:** 0%-40% coinsurance		
Health fitness program (SilverSneakers®)	$0 copayment for the health fitness program. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved.		

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
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.	You receive $30 per quarter.	You receive $50 per quarter.
	An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will not carry over quarter to quarter or year to year. **Note**: All purchases must be made through plan-approved retailers.		
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 copayment for qualifying members.	
Special supplemental benefits for the chronically ill **Food and Produce Allowance** This benefit will be available to plan-identified members with a history of one or more specified chronic conditions: • **Autoimmune disorders** including polyarteritis nodosa, polymyalgia rheumatica, polymyositis, dermatomyositis, rheumatoid arthritis, systemic lupus erythematosus, psoriatic arthritis and scleroderma • **Cancer** • **Cardiovascular disorders** including cardiac arrhythmias, coronary artery disease,	You receive $50 per quarter.	You receive $30 per quarter.	You receive $50 per quarter.
	Note: Your OTC account will be loaded automatically with the above amount on January 1, April 1, July 1 and October 1. Unused amounts will not carry over quarter to quarter or year to year.		

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
peripheral vascular disease and valvular heart disease • **Chronic alcohol use disorder and other substance use disorders (**SUDs) • **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 • **Chronic gastrointestinal disease** including chronic liver disease, non-alcoholic fatty liver disease (NAFLD), hepatitis B, hepatitis C, pancreatitis, irritable bowel syndrome, inflammatory bowel disease • **Chronic heart failure** • **Chronic hypertension** • **Chronic kidney disease** (CKD) including CKD requiring dialysis/End-stage renal disease (ESRD) and CKD not requiring dialysis • **Chronic lung disorders** including cystic fibrosis, emphysema, pulmonary fibrosis, pulmonary hypertension and chronic obstructive pulmonary disease (COPD)			

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
• **Conditions with functional challenges** including spinal cord injuries, paralysis, limb loss, stroke and arthritis • **Dementia** • **Diabetes Mellitus** • **HIV/AIDS** • **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 • **Pre-diabetes** • **Severe hematologic disorders** including aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease (excluding sickle-cell trait) and chronic venous thromboembolic disorder **Note:** This benefit works with the over-the-counter (OTC) Advantage Dollars allowance and is limited to the maximum OTC allowance amount. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must			

Benefits	Elements	Classic	Prestige
Note: Services with a [1] may require prior authorization.			
be met before the benefit is provided. For details, please contact us. See Chapter 4, Section 2 Over-the-Counter Allowance (OTC): Advantage Dollars for more information.			

Elements

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

Classic

Medicare Part D: Prescription Drugs

Costs may differ based on pharmacy type (standard, preferred or mail-order).
Your provider may need to obtain prior authorization

Stage 1: Deductible Stage

$0 deductible on Part D prescription drugs in Tiers 1 and 2. $200 total deductible per year for Tiers 3, 4 and 5. Deductible does not apply to insulins.

Stage 2: Initial Coverage Stage

You pay the amounts listed in the table below until your out-of-pocket costs reach $2,400.

	Standard retail and standard mail-order cost sharing (in-network) 31-day supply	**Preferred retail and preferred mail-order cost sharing (in-network) 31-day supply**	**Standard retail and standard mail-order cost sharing(in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)**	**Preferred retail and preferred mail-order cost sharing (in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)**
Tier 1: Preferred Generic	$5	$0	$15	$0
Tier 2: Generic	$12	$7	$36	$0
Tier 3: Preferred Brand	24%	20%	24%	20%
Tier 4: Non-Preferred	30%	30%	30%	30%
Tier 5: Specialty	31%	31%	Not Offered	Not Offered

*Tier 1 drugs allow for a 100-day supply at the same cost share as a 90-day supply. If you are taking Tier 1 drug, talk to your doctor about whether it's appropriate to get a new prescription for a 100-day supply.

You won't pay more than $35 for a 31-day supply and no more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

Stage 3: Catastrophic Coverage Stage	You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your *Evidence of Coverage*. You can also see our plan's pharmacy directory at our website **bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit **bcbsm.com/formularymedicare**.

*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 (**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 (**bcbsm.com/pharmaciesmedicare**).

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 **bcbsm.com/medicare-evidence-of-coverage**.

Prestige

Medicare Part D: Prescription Drugs

Costs may differ based on pharmacy type (standard, preferred or mail-order).
Your provider may need to obtain prior authorization

Stage 1: Deductible Stage

$0 deductible on Part D prescription drugs in Tiers 1 and 2. $100 total deductible for Tiers 3, 4 and 5. Deductible does not apply to insulins.

Stage 2: Initial Coverage Stage

You pay the amounts listed in the table below until your out-of-pocket costs reach $2,400.

	Standard retail and standard mail-order cost sharing (in-network) 31-day supply	**Preferred retail and preferred mail-order cost sharing (in-network) 31-day supply**	**Standard retail and standard mail-order cost sharing(in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)**	**Preferred retail and preferred mail-order cost sharing (in-network) 32- to 90-day supply (Tiers 2-5) 32- to 100-day supply (Tier 1*)**
Tier 1: Preferred Generic	$5	$0	$15	$0
Tier 2: Generic	$12	$5	$36	$0
Tier 3: Preferred Brand	24%	20%	24%	20%
Tier 4: Non-Preferred	30%	30%	30%	30%
Tier 5: Specialty	32%	32%	Not Offered	Not Offered

*Tier 1 drugs allow for a 100-day supply at the same cost share as a 90-day supply. If you are taking Tier 1 drug, talk to your doctor about whether it's appropriate to get a new prescription for a 100-day supply.

You won't pay more than $35 for a 31-day supply and no more than $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

Stage 3: Catastrophic Coverage Stage	You have coverage for generic and brand-name drugs in the Catastrophic Coverage stage. During this stage, you will pay $0. Most members do not reach this stage. For detailed cost information, look at Chapter 6 in your *Evidence of Coverage*. You can also see our plan's pharmacy directory at our website **bcbsm.com/pharmaciesmedicare**. For the most current information about covered drugs visit **bcbsm.com/formularymedicare**.

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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 (**bcbsm.com/pharmaciesmedicare**).

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 **bcbsm.com/medicare-evidence-of-coverage**.

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 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 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 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

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.