2025

READY TO HELP

BCN Advantage℠ HMO-POS

Elements, Prime Value, Classic, Prestige

Summary of Benefits

January 1, 2025 — December 31, 2025

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 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.

www.bcbsm.com/medicare

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. For the Prime Value plan only, a Medicare Part B premium reduction is provided (Region 1 = $7.50, Region 2=$7.00, Region 3 = 7.50, Region 4 = $7.00 and Region 5 = $6.50).

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

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

Regions with counties	BCN Advantage monthly premium			
	Elements	Prime Value	Classic	Prestige
Region 1 Allegan, Barry, Ionia, Kalamazoo, Kent, Mason, Muskegon, Newaygo, Oceana and Ottawa	$0	$0	$75	$174
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren	$0	$0	$106	$237
Region 3 Alcona, Alpena, Arenac, Bay, Charlevoix, Cheboygan, Clare, Crawford, Gladwin, Huron, Iosco, Kalkaska, Luce, Mackinac, Montmorency, Ogemaw, Oscoda, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee and Tuscola	$0	$0	$115	$228
Region 4 Antrim, Benzie, Clinton, Emmet, Genesee, Grand Traverse, Isabella, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mecosta, Midland, Missaukee, Osceola, Otsego, St. Clair and Wexford	$0	$0	$95	$221
Region 5 - Macomb, Oakland, Washtenaw and Wayne	$0	$0	$112	$257
Optional Supplemental Dental and Vision	$20.50			

Benefits	Elements	Prime Value	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:** $0 annually This plan does not have a deductible for Part D prescription drugs.	**In-network:** $0 annually **Point-of-service:** $500 annually This plan does not have a deductible for Part D prescription drugs.	**In-network:** $0 annually **Point-of-service:** $200 annually This plan does not have a deductible for Part D prescription drugs.
Deductible – Optional Supplemental Dental and Vision	There is no deductible.			
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$4,500 annually	$4,200 annually	$3,800 annually	$3,400 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	Prime Value	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:** $205 copay per day for days 1 – 7 $0 copay for days 8 and beyond **Point-of-service:** $205 copay per day after deductible for days 1 – 7 $0 copay for days 8 and beyond	**In-network:** $300 copay per day for days 1 – 7 $0 copay for days 8 and beyond **Point-of-service:** $300 copay per day for days 1 – 7 $0 copay for days 8 and beyond	**In-network:** $225 copay per day for days 1 – 7 $0 copay for days 8 and beyond **Point-of-service:** $225 copay per day after deductible for days 1 – 7 $0 copay for days 8 and beyond	**In-network:** $125 copay per day for days 1 – 7 $0 copay for days 8 and beyond **Point-of-service:** $125 copay per day after deductible for days 1 – 7 $0 copay for days 8 and beyond
Outpatient Hospital Coverage*	**In-network:** $200 copay for Medicare-covered outpatient hospital services. **Point-of-service:** $200 copay after deductible for Medicare-covered outpatient hospital services.	**In-network:** $275 copay for Medicare-covered outpatient hospital services. **Point-of-service:** $275 copay for Medicare-covered outpatient hospital services.	**In-network:** $225 copay for Medicare-covered outpatient hospital services. **Point-of-service:** $225 copay after deductible for Medicare-covered outpatient hospital services.	**In-network:** $200 copay for Medicare-covered outpatient hospital services. **Point-of-service:** $200 copay after deductible for Medicare-covered outpatient hospital services.

Benefits	Elements	Prime Value	Classic	Prestige
Note: Services with * may require prior authorization.				
Ambulatory Surgical Center (ASC) Services*	**In-Network and Point-of-service:** $0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.			
	In-network: $100 copay for Medicare-covered surgical services. **Point-of-service:** $100 copay after deductible for Medicare-covered surgical services.	**In-network:** $240 copay for Medicare-covered surgical services. **Point-of-service:** $240 copay for Medicare-covered surgical services.	**In-network:** $95 copay for Medicare-covered surgical services. **Point-of-service:** $95 copay after deductible for Medicare-covered surgical services.	**In-network:** $70 copay for Medicare-covered surgical services. **Point-of-service:** $70 copay after deductible for Medicare-covered 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:** $0 copay	**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:** $35 copay **Point-of-service:** $35 copay	**In-network:** $30 copay **Point-of-service:** $30 copay after deductible	**In-network:** $20 copay **Point-of-service:** $20 copay after deductible
o Telehealth	$0 copay for each telehealth primary care provider medical visit through plan-approved vendor. $0 copay for each telehealth mental health visit through plan-approved vendor.			

Benefits	Elements	Prime Value	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 • 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)			
Emergency Care	**In- and Out-of-network**: $125 copay **Note:** The copay is waived if you are admitted to the hospital within three days for the same condition. You are covered for emergency medical care worldwide.			
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. $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	Prime Value	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	**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	**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	**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 – $100 copay **Point-of-service:** $20 – $100 copay	**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:** $25 copay **Point-of-service:** $25 copay	**In-network:** $15 copay **Point-of-service:** $15 copay after deductible	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible

Benefits	Elements	Prime Value	Classic	Prestige
Note: Services with * may require prior authorization.				
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 from a specialist after deductible	**In-network:** $0 – $35 copay **Point-of-service:** $0 – $35 copay	**In-network:** $0 – $30 copay **Point-of-service:** $30 copay from a specialist after deductible	**In-network:** $0 – $20 copay **Point-of-service:** $20 copay from a specialist after deductible
o Routine hearing exam (1 per year)	**In-network:** $0 – $35 copay **Point-of-service:** Not covered	**In-network:** $0 – $35 copay **Point-of-service:** Not covered	**In-network:** $0 – $30 copay **Point-of-service:** Not covered	**In-network:** $0 – $20 copay **Point-of-service:** Not covered
o Hearing aid fitting and evaluation (one every three years)	**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	**In-network:** $0 copay **Point-of-service:** Not covered
o Hearing aids	**In-network**: Up to a $1,200 ($600 per ear) allowance every 3 years **Point-of-service:** Not covered	**In-network:** Up to a $1,200 ($600 per ear) allowance every 3 years **Point-of-service:** Not covered	**In-network:** Up to a $1,200 ($600 per ear) allowance every 3 years **Point-of-service:** Not covered	**In-network:** Up to a $1,200 ($600 per ear) allowance every 3 years **Point-of-service:** Not covered

Benefits	Elements	Prime Value	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 – $275 copay **Point-of-service:** $0 – $275 copay	**In-network:** $0 – $225 copay **Point-of-service:** $30 – $225 copay after deductible	**In-network:** $0 – $200 copay **Point-of-service:** $20 – $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. **In-network:** $0 copay **Out-of-network:** 50% of the approved amount			
Dental – Optional Supplemental Benefit **(available at additional monthly premium)** Includes, but not limited to, dentures, bridges, onlays and implants	The benefit provides another $1,500 annual maximum bringing your total annual maximum to $3,000 (combined in- and out-of-network) for preventive and comprehensive dental services. No Deductible. **In-network:** 25% coinsurance **Out-of-network:** 50% of the approved amount			

Benefits	Elements	Prime Value	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 – $35 copay **Point-of-service:** $0 – $35 copay	**In-network:** $0 – $30 copay **Point-of-service:** $0 – $30 copay after deductible	**In-network:** $0 – $20 copay **Point-of-service:** $0 – $20 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	**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:** Not covered	**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

Benefits	Elements	Prime Value	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.			
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	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.			
For a complete pair of eyeglasses, the allowance can be used for the frame only.				

Benefits	Elements	Prime Value	Classic	Prestige
Note: Services with * may require prior authorization.				
Optional Supplemental Vision (available for 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 combined in and out-of-network benefit maximum (in addition to the enhanced vision benefit for a total of $400) once every calendar year and may be used for either (a) elective contact lenses or (b) 1 frame. **Out-of-network** The optional eyewear benefit provides (in addition to the Enhanced vision benefit) a combined in- and out-of-network benefit maximum with 50% coinsurance up to $250 every calendar year and may be used for either (a) elective contact lenses or (b) 1 frame.			

Benefits	Elements	Prime Value	Classic	Prestige
Note: Services with * may require prior authorization.				
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:** $205 copay per day for days 1 – 7 $0 copay per day for days 8 – 90 **Point-of-service:** $205 copay per day for days 1 – 7, after deductible $0 copay per day for days 8 – 90, after deductible	**In-network:** $300 copay per day for days 1 – 7 $0 copay per day for days 8 – 90 **Point-of-service:** $300 copay per day for days 1 – 7 $0 copay per day for days 8 – 90	**In-network:** $225 copay per day for days 1 – 7 $0 copay per day for days 8 – 90 **Point-of-service:** $225 copay per day for days 1 – 7, after deductible $0 copay per day for days 8 – 90, after deductible	**In-network:** $125 copay per day for days 1 – 7 $0 copay per day for days 8 – 90 **Point-of-service:** $125 copay per day for days 1 – 7, after deductible $0 copay per day for days 8 – 90, 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:** $40 copay	**In-network:** $20 copay **Point-of-service:** $35 copay after deductible	**In-network:** $20 copay **Point-of-service:** $20 copay after deductible
Skilled Nursing Facility (SNF)* Our plan covers up to 100 days in a SNF. No prior hospital stay is required.	**In-network:** $0 copay per day for days 1 – 20 $214 copay per day for days 21 – 100 **Point-of-service:** $0 copay per day for days 1 – 20, after deductible $214 copay per day for days 21 – 100, after deductible	**In-network:** $0 copay per day for days 1 – 20 $214 copay per day for days 21 – 100 **Point-of-service:** $0 copay per day for days 1 – 20 $214 copay per day for days 21 – 100	**In-network:** $0 copay per day for days 1 – 20 $214 copay per day for days 21 – 100 **Point-of-service:** $0 copay per day for days 1 – 20, after deductible $214 copay per day for days 21 – 100, after deductible	**In-network:** $0 copay per day for days 1 – 20 $214 copay per day for days 21 – 100 **Point-of-service:** $0 copay per day for days 1 – 20, after deductible $214 copay per day for days 21 – 100, after deductible

Benefits	Elements	Prime Value	Classic	Prestige
Note: Services with * may require prior authorization.				
Outpatient Rehabilitation*				
Physical/Speech/ Occupational therapy	**In-network:** $30 copay **Point-of-service:** $30 copay after deductible	**In-network:** $30 copay **Point-of-service:** $30 copay	**In-network:** $30 copay **Point-of-service:** $30 copay after deductible	**In-network:** $15 copay **Point-of-service:** $15 copay after deductible
Ambulance				
o Ground or air transportation	**In-network:** $300 copay **Point-of-service:** $300 copay after deductible	**In-network:** $310 copay **Point-of-service:** $310 copay	**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	**In-network:** $90 copay **Point-of-service:** $90 copay after deductible	**In-network:** $90 copay **Point-of-service:** $90 copay after deductible
Transportation services All members are eligible for 1 round trip per calendar year to an annual physical exam within the state of Michigan	$0 copay for transportation for one round trip to an annual physical exam per calendar year within the state of Michigan; no referral needed. $0 copay for qualified members who live in Wayne, Oakland, Macomb and Washtenaw counties, non-emergency medical transportation is covered for up to 28 days after a hospital discharge.			

Benefits	Elements	Prime Value	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 for Elements, Classic, and Prestige (there is no deductible for Prime Value)			
Cardiac and Pulmonary rehabilitation services	**In-network:** $0 copay **Point-of-service:** $0 copay after deductible for Elements, Classic, and Prestige $0 copay for Prime Value			
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	**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	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance
Health fitness program (SilverSneakers)	$0 for the health fitness program. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved.			

Benefits	Elements	Prime Value	Classic	Prestige
Note: Services with * 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 $60 per quarter for members living in Allegan, Barry, Ionia, Kalamazoo, Kent, Macomb, Mason, Muskegon, Newaygo, Oakland, Oceana, Ottawa, Washtenaw and Wayne counties. You receive $95 per quarter for members living in all other covered counties.	You receive $65 per quarter	You receive $90 per quarter
	An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will not carry over into the next quarter or the next calendar year. The final day to spend allowance dollars is December 31, 2025 and any unspent allowance will not carry over to 2026. **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 available.	Not available.	$0 copay for qualifying members.	

Benefits	Elements	Prime Value	Classic	Prestige
Note: Services with * may require prior authorization.				
Special Supplemental Benefits for the Chronically Ill Food and Produce Allowance Members with certain health conditions can use their quarterly over-the-counter Advantage Dollars allowance to buy approved foods. The benefits described are Special Supplemental Benefits for the Chronically Ill. Qualifying chronic conditions include hypertension, diabetes, chronic cardiovascular disorders, chronic lung disorders, and chronic heart failure. Other qualifying conditions may apply. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. Your plan will notify you when you're eligible. For details, please contact us.	You receive $50 per quarter.	You receive $60 per quarter for members living in Allegan, Barry, Ionia, Kalamazoo, Kent, Macomb, Mason, Muskegon, Newaygo, Oakland, Oceana, Ottawa, Washtenaw and Wayne counties. You receive $95 per quarter for members living in all other covered counties.	You receive $65 per quarter.	You receive $90 per quarter.
	Your Advantage Dollars account will be loaded automatically with the appropriate allowance amount on January 1, April 1, July 1, and October 1. Unused amounts will not carry over into the next quarter or the next calendar year. The final day to spend allowance dollars is December 31, 2025 and any unspent allowance will not carry over to 2026. **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.			

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

Prime Value

Phase 1: The Deductible Stage

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

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 $2,000.

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
Tier 4: Non-Preferred Drug	50%	50%
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 cost sharing (in-network)	Preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$15	$0	$0
Tier 2: Generic	$60	$0	$0
Tier 3: Preferred Brand	$141	$126	$84
Tier 4: Non-Preferred Drug	50%	50%	50%
Tier 5: Specialty Tier	Not Covered	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**).

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 $2,000.

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
Tier 4: Non-Preferred Drug	50%	50%
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 cost sharing (in-network)	Preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	$15	$0	$0
Tier 2: Generic	$36	$0	$0
Tier 3: Preferred Brand	$129	$114	$76
Tier 4: Non-Preferred Drug	50%	50%	50%
Tier 5: Specialty Tier	Not Covered	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

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What does “point-of-service” mean?

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

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

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

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