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BCN AdvantageSM HMO-POS
Community Value

Summary of Benefits

January 1, 2023 — December 31, 2023

This is a summary document, to get a complete list of services we cover, call Customer Service and ask for the *Evidence of Coverage* (phone numbers are printed on the back cover of this booklet).

BCN Advantage is a Health Maintenance Organization with a Point-of-Service (POS) option. To join **BCN Advantage HMO-POS Community Value**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area for **BCN Advantage HMO-POS Community Value** includes these counties in Michigan: Genesee, Livingston, Macomb, Oakland, St. Clair, Washtenaw, and Wayne.

BCN Advantage HMO-POS Community Value has a network of doctors, hospitals, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. For some services you can use providers that are not in our network. You can see our plan's provider directory at our website at www.bcbsm.com/providersmedicare, or call us and we will send you a copy of the provider directory.

Out-of-network/non- contracted providers are under no obligation to treat BCN Advantage members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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

www.bcbsm.com/medicare



Medicare Advantage Plans

Premium/Cost-sharing Table for BCN Advantage HMO-POS Community Value

Premiums vary by county in which you permanently reside (rates are based on the use and cost of health care services in each regional segment). You must continue to pay your Medicare Part B premium.

- 1) Find the county that you live in.
- 2) Look across the plan option column to find your monthly premium rate.

Counties	BCN Advantage HMO-POS Community Value Monthly Premium
Genesee, Livingston and St. Clair	\$17
Macomb, Oakland, Washtenaw and Wayne	\$17
Optional Supplemental Dental and Vision	\$20.30

Deductible and limits on how much you pay for covered services	
Deductible	<p>In-network: \$0 annually</p> <p>Point-of-service: \$250</p> <p>This plan does not have a deductible for Part D prescription drugs.</p>
Deductible – Optional Supplemental Dental and Vision	There is no deductible.

Deductible and limits on how much you pay for covered services

<p>Maximum Out-of-Pocket Responsibility</p> <p><i>(does not include prescription drugs)</i></p>	<p>\$4,300 annually</p>	<p>The most you pay for copays, coinsurance and other costs for medical services for the year.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered for hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>You will still need to pay your monthly plan premiums, Medicare Part B premiums, and cost sharing for your Part D drugs.</p> <p>Point-of-Service: Services received under your point-of-service benefit apply toward your maximum out-of-pocket.</p>
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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	BCN Advantage HMO-POS Community Value	What you should know
<p>Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 2.</p>		
<p>Inpatient Hospital Coverage*</p>	<p>\$300 copay per day for days 1 through 6</p> <p>\$0 copay per day for days 7 through 90</p> <p>\$0 copay per day for days 91 and beyond</p> <p>Point-of-service: 35% coinsurance per day for days 1 through 6.</p> <p>35% coinsurance per day for days 7 through 90</p> <p>35% coinsurance per day for days 91 and beyond</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>The copays are based on benefit periods.</p> <p>A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row.</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <p>Point-of-service deductible applies</p> <p>If you go to out-of-network providers you pay the full cost.</p>
<p>Outpatient Hospital Coverage*</p>	<p>In-network: \$0 copay for Medicare-covered palliative care.</p> <p>\$225 copay for Medicare-covered outpatient hospital surgery.</p> <p>Point-of-service: 35% coinsurance</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p> <p>If you go to out-of-network providers you pay the full cost.</p>
<p>Ambulatory Surgical Center (ASC) Services*</p>	<p>In-network: \$0 copay for Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.</p> <p>\$100 copay for Medicare-covered outpatient surgery in an ambulatory surgical center.</p> <p>Point-of-service: 35% coinsurance</p>	

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<p>Doctor Visits*</p> <ul style="list-style-type: none"> • Primary • Specialists 	<p>In-network: \$0 copay</p> <p>Point-of-service: 35% coinsurance</p> <p>In-network: \$35 copay</p> <p>Point-of-service: 35% coinsurance</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p> <p>If you go to out-of-network providers you pay the full cost.</p> <p>Specialist services may require a referral.</p> <p>Our plan also covers telehealth services for primary care physician services and behavioral health providers.</p>

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<p>Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 2.</p>		
<p>Preventive Care</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Flexible sigmoidoscopy, Guaiac-based fecal occult blood test, Fecal immunochemical test, DNA based colorectal screening every 3 years) • Depression screening • Diabetes screenings • Glaucoma screening • HIV screening 	<p>You pay nothing.</p>	<p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>

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<ul style="list-style-type: none"> • Immunizations, including COVID-19, flu, Hepatitis B, Pneumococcal • 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) 		

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<p>Emergency Care</p>	<p>\$90 copay</p>	<p>You may go to any emergency room if you reasonably believe you need emergency care.</p> <p>If you are admitted to the hospital within three days you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.</p> <p>You have coverage for worldwide emergency medical care. There is a combined \$50,000 lifetime plan coverage limit for emergency care, urgent care and transportation services outside the U.S. and its territories.</p>
<p>Urgently Needed Services</p>	<p>\$0 copay for Medicare-covered urgently needed services in a primary care physician’s office.</p> <p>\$45 copay for Medicare-covered urgently needed services in an urgent care center.</p>	<p>You have coverage for worldwide emergency medical care. There is a combined \$50,000 lifetime plan coverage limit for emergency care, urgent care and transportation services outside the U.S. and its territories.</p>

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<p>Diagnostic Services/ Labs/Imaging*</p> <ul style="list-style-type: none"> • Diagnostic tests and procedures • Lab services • COVID-19 testing • Diagnostic radiology service (e.g., X-rays, MRI) • Outpatient X-rays (e.g., X-rays, MRI) • Therapeutic radiology services 	<p>In-network: \$20 copay</p> <p>Point-of-service: 35% coinsurance</p> <p>In-network: \$0 copay</p> <p>Point-of-service: 35% coinsurance</p> <p>In-network: \$0 copay</p> <p>Point-of-service: \$0 copay</p> <p>In-network: \$20 – \$100 copay, depending on the service</p> <p>Point-of-service: 35% coinsurance</p> <p>In-network: \$20 – \$100 copay, depending on the service</p> <p>Point-of-service: 35% coinsurance</p> <p>In-network: 20% coinsurance</p> <p>Point-of-service: 35% coinsurance</p>	<p>Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information.</p> <p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Lab services must be rendered at a participating Joint Venture Hospital Lab (JVHL).</p> <p>Point-of-service deductible applies</p> <p>If you go to out-of-network providers you pay the full cost.</p>

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<p>Hearing Services</p> <ul style="list-style-type: none"> • Hearing exam to diagnose and treat hearing and balance issues • Routine hearing exam (1 per year) • Hearing aid fitting and evaluation (one every three years) • Hearing aids 	<p>In-network: \$0 copay for Medicare-covered hearing services from a primary care provider.</p> <p>\$35 copay for Medicare-covered hearing services from a specialist.</p> <p>Point-of-service: 35% coinsurance</p> <p>In-network: \$0 copay for one hearing exam every year from a primary care provider.</p> <p>\$35 copay for one hearing exam every year from a specialist.</p> <p>Point-of-service: Not covered</p> <p>In-network: \$0 copay for one hearing aid fitting and evaluation every three years</p> <p>Point-of-service: Not covered</p> <p>In-network: Up to a \$1,500 (\$750 per ear) allowance every three years</p> <p>Point-of-service: Not covered</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p> <p>If you go to out-of-network providers you pay the full cost.</p>
<p>Dental Services</p> <p>Dental services (Medicare covered)</p>	<p>In-network: \$0 – \$225 depending on the Medicare-covered dental services</p> <p>Point-of-service: 50% coinsurance for Medicare-covered dental services</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p> <p>If you go to out-of-network providers you pay the full cost.</p>

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<p>Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 2.</p>		
<p>Preventive dental services</p> <ul style="list-style-type: none"> • Oral exams (up to 2 every calendar year) • Routine cleanings (up to 2 every calendar year) • Dental X-rays (1 set of up to 4 bitewing X-rays, or 1 set of up to 6 periapical films every 2 calendar years) • Fluoride treatment (1 every calendar year) <p>Comprehensive dental services</p> <p>In addition to preventive dental, we cover:</p> <ul style="list-style-type: none"> • Brush biopsies (2 per calendar year) • Resin and amalgam fillings (once per tooth per surface every 48 months) • Crowns for permanent teeth only (once per tooth every 84 months) • Crown repairs (3 per permanent tooth per calendar year) • Root canals (once per tooth per lifetime) • Deep cleaning (once per quadrant per 24 months) • Extractions (one time per tooth per lifetime) • Oral Surgery (two times per tooth per lifetime) 	<p>This benefit provides a \$1,500 combined annual maximum (combined in- and out-of-network) for preventive and comprehensive dental services.</p> <p>In-network: You pay 0% coinsurance</p> <p>Out-of-network: You pay 50% of the approved amount</p> <p>In-network: You pay 0% coinsurance</p> <p>Out-of-network: You pay 50% of the approved amount</p>	<p>For preventive dental services, you must obtain services from a participating dentist. Please visit www.mibluedentist.com and search for PPO dentists in the BCN Advantage network or contact Customer Service.</p>

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<p>Dental – Optional Supplemental Benefit</p> <p>In addition to the plan-covered dental services, we offer:</p>	<p>Comprehensive Dental: The benefit provides another \$1,500 annual maximum bringing your total annual maximum to \$3,000 (combined in- and out-of-network) for preventive and comprehensive dental services. No waiting period. No Deductible.</p> <p>In-network:</p> <p>25% coinsurance for:</p> <ul style="list-style-type: none"> • Onlays • Periodontics • Bridges • Dentures • Denture adjustments • Denture repairs • Denture relines • Denture rebase • Implants • Implant maintenance and repairs • Anesthesia • Consultation exams 	<p>This optional supplemental benefit is available for an additional premium.</p> <p>For in-network benefits, you must receive dental services from a participating provider.</p> <p>For out-of-network services, if your provider doesn't submit your claim, you may be required to pay costs up front and submit for reimbursement. Out-of-network expenses will be reimbursed at 50% of allowed amounts up to the combined annual maximum.</p> <p>You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.</p> <p>This optional supplemental \$1500 annual maximum applies to all dental services listed in this document. This is in addition to the \$1500 annual maximum for preventive and comprehensive dental services.</p>

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	<p>Out-of-network: 50% coinsurance for:</p> <ul style="list-style-type: none"> • Onlays • Periodontics • Bridges • Dentures • Denture adjustments • Denture repairs • Denture relines • Denture rebase • Implants • Implant maintenance and repairs • Anesthesia • Consultation exams 	
<p>Vision Services</p> <ul style="list-style-type: none"> • Exam to diagnose and treat diseases and conditions of the eye • Eyeglasses or contact lenses after Medicare-covered cataract surgery • Routine eye exam 	<p>In-network: \$0 – \$35 copay, depending on the Medicare-covered service</p> <p>Point-of-service: 35% coinsurance</p> <p>In-network: \$0 copay for eyeglasses or contact lenses after Medicare-covered cataract surgery.</p> <p>Point-of-service: 35% coinsurance</p> <p>In-network: \$0 copay for up to one routine eye exam every 12 months.</p> <p>Point-of-service: Not covered</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies to Medicare-covered services.</p> <p>If you go to out-of-network providers you pay the full cost.</p> <p>Routine vision care must be from a VSP Choice Network provider. To locate a VSP Choice Network provider, call the Customer Service number on the back of this booklet or visit www.vsp.com.</p>

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<p>Every 12 months, we cover one of the following:</p> <ul style="list-style-type: none"> • Elective contacts • One pair of lenses • One frame • One complete pair of eyeglasses (lenses and frames) <p>If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit.</p>	<p>In-network: \$0 copay</p> <p>The eyewear benefit provides a \$150 maximum vision benefit every 12 months and may be used for either (a) elective contact lenses or (b) one frame.</p> <p>Standard eyeglass lenses are covered in full every 12 months.</p> <p>Benefit must be obtained from an in-network provider.</p>	
<p>Vision – Optional Supplemental Benefit</p> <p>In addition to the plan-covered vision services, every 12 months, we cover one of the following:</p> <ul style="list-style-type: none"> • Elective contacts • One pair of lenses • One frame • One complete pair of eyeglasses (lenses and frames) <p>If elective contact lenses are chosen, they are unlimited up to the maximum vision benefit.</p> <p>If standard eyeglass lenses or one complete pair of eyeglasses are chosen, lenses have the options of polycarbonate lenses and anti-reflective coating.</p>	<p>The optional eyewear benefit provides a \$250 (in addition to the Enhanced Vision benefit) combined in and out-of-network benefit maximum every 12 months and may be used for either (a) elective contact lenses or (b) one frame.</p> <p>Standard eyeglass lenses are covered in full every 12 months as part of the Enhanced Vision benefit.</p>	<p>The optional supplemental benefit is available for an additional premium.</p> <p>Supplemental vision benefits are provided in conjunction with Enhanced Vision benefit. Frequency limits apply.</p> <p>For out-of-network services, if your provider doesn't submit your claim, you may be required to pay costs up front and submit for reimbursement. Out-of-network expenses will be reimbursed at 50% of allowed amounts up to the combined annual maximum.</p> <p>You may pay higher out-of-pocket amounts if you receive services from out-of-network providers.</p>

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<p>Mental Health Services*</p> <ul style="list-style-type: none"> • Inpatient visit • Outpatient group or individual therapy visit 	<p>In-network: \$300 copay per day for days 1 through 6</p> <p>\$0 copay per day for days 7 through 90</p> <p>Point-of-service: 35% coinsurance per day</p> <p>In-network: \$20 copay for outpatient group or individual therapy visit</p> <p>Point-of-service: 35% coinsurance for outpatient group/individual therapy visit</p>	<p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.</p> <p>The copays for hospital benefits are based on benefit periods. A benefit period begins the day you’re admitted as an inpatient and ends when you haven’t received any inpatient care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There’s no limit to the number of benefit periods.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

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<p>Skilled Nursing Facility* (SNF)</p>	<p>In-network: \$0 copay per day for days 1 through 20</p> <p>\$188 copay per day for days 21 through 100</p> <p>Point-of-service: 35% coinsurance per day</p>	<p>Our plan covers up to 100 days in a SNF. No prior hospital stay is required.</p> <p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p>
<p>Physical Therapy*</p> <ul style="list-style-type: none"> Physical therapy, occupational therapy, and speech and language therapy visit 	<p>In-network: \$30 copay</p> <p>Point-of-service: 35% coinsurance</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p>
<p>Ambulance</p> <ul style="list-style-type: none"> Ground or Air 	<p>In-network: \$250 copay</p> <p>Point-of-service: \$250 copay</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Copay is for each one-way trip for Medicare-covered services.</p> <p>Point-of-service deductible applies</p>

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<p>Medicare Part B Drugs*</p> <ul style="list-style-type: none"> • Part B drugs such as chemotherapy/ radiation drugs • Other Part B drugs 	<p>In-network: 20% coinsurance</p> <p>Point-of-service: 20% coinsurance</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p> <p>Services may require prior authorization and/or step therapy.</p>
<p>Blue Cross Online Visits</p> <p>Medical</p> <p>Members can get 24 hours a day, 7 days a week online health care for minor illnesses and symptoms through Blue Cross Online VisitsSM or from their in-network provider.</p> <p>Examples of symptoms that can be addressed in an online visit:</p> <ul style="list-style-type: none"> • Respiratory and sinus infections • Colds, flu and seasonal allergies • Eye irritation or redness • Strains and sprains <p>Behavioral Health</p> <p>Members can get 24 hours a day, 7 days a week online health care for mental health through Blue Cross Online VisitsSM or from an in-network behavioral health provider who offers online visits.</p>	<p>\$0 copay for telehealth services provided by a primary care physician or mental health provider</p>	<p>Members have the option of getting primary care and behavioral health care either through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, then you must use a network provider who offers the service by telehealth.</p> <p>You can also use Blue Cross Online Visits to access telehealth services. Visit bcbsmonlinevisits.com for more information.</p> <p>Please note: You must have video capability for visits through smartphone or computer.</p>

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<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order.</p> <p>The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>In-network: \$0 copay for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services.</p> <p>Point-of-service: 35% coinsurance</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies.</p>
<p>Chiropractic Care*</p> <ul style="list-style-type: none"> • Manipulation of the spine to correct a subluxation (when one or more bones in your spine moves out of position) • Routine care • Chiropractic X-rays (one set per year) 	<p>In-network: \$15 copay</p> <p>Point-of-service: 35% coinsurance</p> <p>In-network: \$20 copay</p> <p>Point-of-service: Not covered</p> <p>In-network: \$20 copay</p> <p>Point-of-service: Not covered</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies.</p> <p>If you go to out-of-network providers you pay the full cost.</p> <p>Routine chiropractic visits give members coverage for one set of X-rays (up to three views) per year performed by a chiropractor.</p> <p>One routine office visit per year.</p>

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<p>Durable Medical Equipment/Supplies*</p> <ul style="list-style-type: none"> • Durable Medical Equipment (includes wheelchairs, oxygen, etc.) • Prosthetics (braces, artificial limbs, etc.) • Diabetes supplies (monitoring, shoes or inserts) 	<p>In-network: 20% coinsurance of the cost for Medicare-covered items</p> <p>Point-of-service: 20% coinsurance of the cost for Medicare-covered items</p> <p>In-network: 20% coinsurance of the cost for Medicare-covered items</p> <p>Point-of-service: 20% coinsurance of the cost for Medicare-covered items</p> <p>In-network: 0% coinsurance</p> <p>Point-of-service: 35% coinsurance</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies.</p> <p>If you go to out-of-network providers you pay the full cost.</p> <p>Member may obtain diabetic supplies (except diabetic shoes) from BCN's supplier, J&B Medical Supply Company at 1-888-896-6233 from 8 a.m. to 6 p.m. Monday through Friday, Eastern time. TTY users call 711.</p> <p>Member may obtain diabetic shoes and inserts from BCN's DME supplier, Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m. Monday through Friday, Eastern time. TTY users call 711.</p> <p>Select continuous glucose monitors and other diabetic supplies (except diabetic shoes) may be obtained from any in-network pharmacy.</p> <p>When outside of the plan's service area, members can contact the appropriate vendor listed above.</p> <p>Prosthetics must be obtained from a preferred vendor. Contact us for a list of preferred vendors.</p>

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<p>Health Fitness Program</p> <p>Members are covered for a fitness benefit through SilverSneakers®. SilverSneakers is a comprehensive program that can improve overall well-being and social connections. Designed for all levels and abilities, SilverSneakers provides convenient access to a nationwide fitness network, a variety of programming options and activities beyond the gym that incorporate physical well-being and social interaction.</p>	<p>You Pay \$0 for the health fitness program.</p> <p>SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers GO, SilverSneakers On-Demand and SilverSneakers LIVE are trademarks of Tivity Health, Inc. © 2022 Tivity Health, Inc. All rights reserved.</p>	<p>Benefits include:</p> <ul style="list-style-type: none"> • Use of exercise equipment, classes, and other amenities at thousands of participating locations • SilverSneakers LIVE™ online classes and workshops taught by instructors trained in senior fitness • SilverSneakers On-Demand™ online library with hundreds of workout videos • SilverSneakers GO™ mobile app with on-demand videos and live classes • SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls, and parks) • Online fitness tips and healthy eating information • Social connections through events such as shared meals, holiday celebrations, and class socials • GetSetUp virtual enrichment program with classes on topics ranging from healthy eating to aging in place <p>Go to www.silversneakers.com to learn more or call 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call 711.</p>

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<p>Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 2.</p>		
<p>Home Health Care*</p>	<p>In-network: \$0 copay</p> <p>Point-of-service: \$0 copay</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc. Custodial care is not a benefit.</p>
<p>Home Infusion Therapy*</p> <p>Intravenous or subcutaneous administration of drugs or biologicals to an individual at home.</p>	<p>In-network: 0% coinsurance for Medicare-covered home infusion therapy services.</p> <p>Point-of-service: 0% coinsurance for Medicare-covered home infusion therapy services</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p>
<p>Hospice</p>	<p>\$0 copay for hospice care from a Medicare-certified hospice.</p> <p>You may have to pay part of the cost for drugs and respite care.</p> <p>Hospice is covered outside of our plan.</p> <p>Please contact us for more details (phone numbers are on the back of this booklet).</p>	

Benefits	BCN Advantage HMO-POS Community Value	What you should know
<p>Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 2.</p>		
<p>In-Home Support Services</p> <p>Eligible members will have access to in-home help provided by a non-clinical care team. Care team staff will help eligible members with daily living activities such as transportation, light household help, meal preparation, basic technology support, and grocery shopping.</p> <p>Members can verify their eligibility for this benefit by calling our vendor partner Papa, at 1-888-597-6294, 8 a.m. – 11 p.m. Eastern time, Monday – Friday, and 8 a.m. – 8 p.m. Eastern time, Saturday and Sunday.</p>	<p>\$0 copay for up to 4 hours with a Papa Pal each month for qualified members.</p>	<p>To qualify for this benefit, members must meet the following requirements:</p> <ol style="list-style-type: none"> 1) Live alone, and 2) Require help with activities related to living independently, such as transportation, light housework, meal preparation, etc. <p>An over-the-phone eligibility assessment with Blue Care Network’s approved vendor, Papa, is required to determine if members qualify. Members must use a plan contracted vendor.</p>

Benefits	BCN Advantage HMO-POS Community Value	What you should know
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<p>Meal Benefit</p> <p>Qualified members who have been selected to be a part of our Blue Cross Coordinated Care CoreSM care management program for members with special health needs and have been discharged from a hospital may be eligible for a two-week (14 day) meal benefit. Members are eligible for this benefit during the 30-day period after they return home from the hospital.</p> <p>An assessment with your Blue Cross nurse care manager is required to determine eligibility for the meal benefit. If you qualify for this benefit your Blue Cross nurse care manager will make a referral to the plan-approved meal provider</p>	<p>\$0 copay for qualified members.</p>	<p>Twenty-eight (28) meals will be delivered to your home in a refrigerated cooler pack in two shipments (14 meals per shipment). Meals can be tailored to meet certain dietary needs.</p> <p>There is no annual limit to the number of occurrences.</p>
<p>Outpatient Substance Abuse</p> <p>Individual or Group therapy visit</p>	<p>In-network: \$20 copay each visit</p> <p>Point-of-service: 35% coinsurance each visit</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p>

Benefits	BCN Advantage HMO-POS Community Value	What you should know
<p>Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 2.</p>		
<p>Over-the-Counter (OTC) Allowance: Advantage Dollars</p> <p>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.</p> <p>Covered items include but are not limited to antacids, cough drops, denture adhesive, eye drops, pain medications, toothpaste and first aid items. Food items are covered for members with certain conditions.</p> <p>There are four ways to use your benefit:</p> <p>1) In-store. You will receive an Advantage Dollars card in the mail. You can use this card to purchase many common items at local retailers. You can find a complete list of plan-approved retailers online at www.bcbsm.com/medicareotc.</p>	<p>You receive \$100 per quarter.</p> <p>An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will carry forward into the next quarter but not into the next calendar year. The final day to spend allowance dollars is December 31, 2023. Any unspent allowance will not carry over to 2024.</p> <p>Note: All purchases must be made through plan-approved retailers.</p>	<p>You will receive one card for purchasing approved non-prescription, over-the-counter drugs, health-related items and if you qualify, healthy food at participating retail locations.</p> <p>See <i>Special supplemental benefits for the chronically ill Food Allowance</i> for more information.</p>

Benefits	BCN Advantage HMO-POS Community Value	What you should know
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<p>2) Online. Go to www.bcbsm.com/medicareotc and follow the prompts to place the order using the online catalog. Items will be mailed to you.</p> <p>3) Mail. You may request a printed catalog and order form by calling 1-855-856-7878 from 8 a.m. – 11 p.m. Eastern time (TTY: 711), Monday – Friday. Complete and return the order form. Items will be mailed to you.</p> <p>4) Telephone. Select items using the printed or online catalog and call 1-855-856-7878 from 8 a.m. – 11 p.m. Eastern time (TTY: 711), Monday – Friday. Items will be mailed to you.</p>		
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>In-network: \$0 copay for each Medicare-covered pulmonary rehabilitation service rendered in an office setting.</p> <p>Point-of-service: 35% coinsurance for each Medicare-covered pulmonary rehabilitation service rendered in an office setting.</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p>

Benefits	BCN Advantage HMO-POS Community Value	What you should know
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<p>Renal dialysis</p>	<p>In-network: 20% coinsurance</p> <p>Point-of-service: 35% coinsurance</p>	<p>See Page 31 for more about your point-of-service travel benefit.</p> <p>Point-of-service deductible applies</p>
<p>Special Supplemental Benefits for the Chronically III</p> <p>Food Allowance</p> <p>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:</p> <ul style="list-style-type: none"> • Diabetes • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Stroke • Hypertension • Coronary artery disease (CAD) • Rheumatoid arthritis 	<p>You receive \$100 per quarter.</p> <p>Your Advantage Dollars account will be loaded automatically with the appropriate allowance amount on January 1, April 1, July 1, and October 1. Unused amounts will carry forward into the next quarter but not into the next calendar year. The final day to spend allowance dollars is December 31, 2023. Any unspent allowance will not carry over to 2024.</p> <p>Note: All purchases must be made through plan-approved retailers.</p>	<p>Note: This benefit works in conjunction with the Over-the-Counter (OTC) Allowance: Advantage Dollars benefit and is limited to the maximum OTC allowance.</p> <p>See Over-the-Counter (OTC) Allowance: Advantage Dollars benefit for more information on the over-the-counter items benefit.</p>

Benefits	BCN Advantage HMO-POS Community Value	What you should know
<p>Note: Services with * may require prior authorization, or a referral. For more information on referrals, see page 2.</p>		
<p>Support for caregivers of enrollees</p> <p>Eligible members who have a non-professional caregiver (e.g., a family member or other person who cares for them) may be eligible for access to an online Caregiver Support tool. The tool provides training, coaching and support to family members or other person who care for members with dementia and other high-risk conditions. Caregivers will have access to online coaching, education, and support where they can learn:</p> <ul style="list-style-type: none"> • How to manage stress and social isolation • How to access available resources such as transportation and home health assistance • Home safety improvements • How to prevent falls • About advanced care planning 	<p>\$0 copay for support for caregivers of enrollees</p> <p>An eligibility assessment with a nurse care manager is required to determine if members qualify.</p>	<p>Qualifying members will be referred to this program by their Care Manager.</p> <p>For a caregiver to qualify for this benefit, the <u>member</u> must meet the following requirements:</p> <ol style="list-style-type: none"> 1. Have been selected to be a part of a Blue Cross Coordinated Care CoreSM care management program for members with special health needs. 2. Be cared for at home by a family member or other person who would benefit from the support, training and coaching this program provides.

Benefits	BCN Advantage HMO-POS Community Value	What you should know
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<p>Worldwide Coverage</p> <p>Worldwide coverage consists of:</p> <ul style="list-style-type: none"> • Worldwide emergency coverage • Worldwide urgent coverage • Worldwide emergency transportation. 	<p>\$90 copay for worldwide emergency care services.</p> <p>\$45 copay for worldwide urgent care services.</p> <p>\$250 copay for each one-way trip for worldwide emergency transportation.</p>	<p>If you need care when you're outside of the United States, you have coverage for emergency and urgently needed services only.</p> <p>You have coverage for worldwide emergency medical care.</p> <p>You have coverage for worldwide emergency transportation.</p> <p>There is a combined \$50,000 lifetime plan coverage limit for emergency care, urgent care, and transportation services outside the U.S. and its territories.</p>

BCN Advantage HMO-POS Community 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 “total drug costs” (your payments plus any Part D plan’s payments) total \$4,660.

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

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	\$5	\$0
Tier 2: Generic	\$20	\$10
Tier 3: Preferred Brand	\$47	\$45
Tier 4: Non-Preferred Drug	50%	50%
Tier 5: Specialty Tier	33%	33%

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

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

	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail cost sharing (in-network)	Preferred mail-order cost sharing (in-network)
Tier 1: Preferred Generic	\$15	\$0	\$0
Tier 2: Generic	\$60	\$0	\$0
Tier 3: Preferred Brand	\$141	\$135	\$125
Tier 4: Non-Preferred Drug	50%	50%	50%
Tier 5: Specialty Tier	Not Covered	Not Covered	Not Covered

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online at www.bcbsm.com/medicare-evidence-of-coverage.

Phase 3 & 4: The Coverage Gap & The Catastrophic Stages

You have coverage during the Catastrophic Coverage Stage. During this stage you will pay either a coinsurance of 5% of the cost of the drug, or \$4.15 for a generic drug or a drug that is treated like a generic and \$10.35 for all other drugs, whichever is the larger amount.

Most members do not reach the Coverage Gap stage or the Catastrophic Coverage stage.

For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* online at www.bcbsm.com/medicare-evidence-of-coverage.

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website (www.bcbsm.com/formularymedicare).

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website (www.bcbsm.com/pharmaciesmedicare).

Additional Information about BCN Advantage HMO-POS

What does “point-of-service” mean?

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

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

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

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

For more information

A complete list of services is found in the *Evidence of Coverage*. For a copy of the *Evidence of Coverage*, go to www.bcbsm.com/medicare-evidence-of-coverage, or contact Customer Service at 1-800-450-3680 from 8 a.m. to 8 p.m., Eastern time, seven days a week from October 1 through March 31; 8 a.m. to 8 p.m., Eastern time, Monday through Friday from April 1 through September 30, for more information. TTY users call 711.

You can order a copy of the “Medicare & You” handbook at www.medicare.gov, or you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

For more information, please call us at the phone number below or visit us at www.bcbsm.com/medicare.

If you are not a member of this plan, call toll-free 1-888-563-3307. TTY users should call 711. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 9 p.m. Eastern time. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. Eastern time.

If you are a member of this plan, call toll-free 1-800-450-3680. TTY users should call 711. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Eastern time. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as audio CD and large print. This document may be available in a non-English language. For additional information, call us at 1-800-450-3680. TTY users should call 711.

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BCN AdvantageSM HMO



Medicare and more

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