

Light plans



PLANS FOR FEWER HEALTH NEEDS		BCN ADVANTAGE HMO-POS Prime Value	MEDICARE PLUS BLUE PPO Essential	BCN ADVANTAGE HMO-POS Elements	BCN ADVANTAGE HMO-POS Community Value
2021 Monthly Premium	Region 1	\$0	\$0	\$8	\$20 Premium For residents of: Genesee, St. Clair, Livingston, Macomb, Oakland, Wayne, Washtenaw counties
	Region 2	\$0	\$0	\$23.20	
	Region 3	\$0	\$10	\$33.80	
	Region 4	\$0	\$0	\$25	
	Regions 5/6	\$0	\$0	\$30	
In-network Medical Deductible	\$0 Regions 1 / 2 / 4 / 5 / 6 \$280 Region 3		\$0	\$160	\$0
Primary Care Office Visit Copay	\$0		\$0	\$0	\$0
Specialist Copay	\$45		\$45	\$40	\$35
Inpatient Hospital Copay (Days 1-6)	\$325		\$325	\$205	\$300
Maximum Out-of-Pocket (MOOP) In-network	\$4,500		\$6,000	\$4,500	\$4,500
Over-the-Counter Allowance (No carry-over)	\$75 per quarter Regions 1 / 2 / 5 / 6 Region 4: \$25 per quarter Region 3: No OTC		\$50 per quarter	\$25 per quarter	\$100 per quarter
Emergency Care Copay	\$90		\$90	\$90	\$90
Urgent Care Copay	\$0-\$45		\$0-\$50	\$0-\$45	\$45
Dental Services					
Two Oral Exams	\$0 copay		\$0 copay	\$0 copay	Comprehensive dental benefits include a \$2,000 annual maximum. \$0 copay
Two Cleanings	\$0 copay		\$0 copay	\$0 copay	
X-Rays	\$0 copay		\$0 copay	\$0 copay	
Vision Services					
Routine Eye Exam	\$0		\$10	\$0	\$0
Lenses	Covered in full once/year		Covered in full once/year	Not covered	Covered in full once/year
Frames or Contacts	\$100 combined maximum allowance every 12 months for either elective contact lenses or frames.		\$100 combined maximum allowance every 12 months for either elective contact lenses or frames.	Not covered	\$150 combined maximum allowance every 12 months for either elective contact lenses or frames.
Hearing Services					
Routine Hearing Exam	\$0-\$45		\$0-\$45	\$0-\$40	\$0-\$35
Hearing Aids	Up to \$600 allowance per ear every 3 years		Up to \$750 allowance per ear every 3 years	Up to \$600 allowance per ear every 3 years	Up to \$750 allowance per ear every 3 years
Prescription Drug Deductible	\$0 on tiers 1, 2, 6 \$50 on tiers 3, 4, 5		\$0 on tiers 1, 2, 6 \$100 on tiers 3, 4, 5	No Prescription Drug Coverage	\$0 on all tiers
Preferred pharmacy network copays / coinsurance					
Prescription drug tiers					
Tier 1 preferred generic	Tier 1: \$3		Tier 1: \$2	Not Covered	Tier 1: \$0
Tier 2 generic	Tier 2: \$11		Tier 2: \$11		Tier 2: \$10
Tier 3 preferred brand	Tier 3: \$42		Tier 3: \$42		Tier 3: \$45
Tier 4 non-preferred drug	Tier 4: 50%		Tier 4: 50%		Tier 4: 50%
Tier 5 specialty tier	Tier 5: 32%		Tier 5: 31%		Tier 5: 33%
Tier 6 select care drugs	Tier 6: \$0		Tier 6: \$0		Tier 6: N/A